NHS Fife Audit & Risk Committee

Thu 31 August 2023, 14:00 - 16:00

MS Teams

Agenda

14:00 - 14:00
0 min

1. Apologies for Absence

Alastair Grant

14:00 - 14:00
0 min

2. Declaration of Members' Interests

Alastair Grant

14:00 - 14:00
0 min

3. Minutes of Previous Meeting held on Friday 23 June 2023

Enclosed *Alastair Grant*

Item 3 - Audit & Risk Committee Minutes (unconfirmed) 20230623.pdf (9 pages)

14:00 - 14:10
10 min

4. Matters Arising / Action List

Enclosed *Alastair Grant*

Item 4 - Audit & Risk Committee Action List 20230831.pdf (1 pages)

14:10 - 14:35
25 min

5. GOVERNANCE – INTERNAL AUDIT

5.1. Internal Audit Progress Report

Enclosed *Shona Slayford*

Item 5.1 - SBAR Internal Audit Progress Report.pdf (3 pages)
Item 5.1 - Appendix 1 Internal Audit Progress Report.pdf (6 pages)

5.2. Internal Audit – Follow Up Report on Audit Recommendations 2022/23

Enclosed *Andy Brown*

Item 5.2 - SBAR Internal Audit – Follow Up Report on Audit Recommendations 2022-23.pdf (29 pages)

14:35 - 14:55
20 min

6. GOVERNANCE MATTERS

6.1. Losses & Special Payments Quarter 1

Enclosed *Kevin Booth*

Item 6.1 - SBAR Losses & Special Payments Q1.pdf (3 pages)
Item 6.1 - Appendix 1 Summary of Losses and Special Payments Q1.pdf (2 pages)

6.2. Procurement, Waiver of Competitive Tenders Q1

Enclosed *Kevin Booth*

Item 6.2 - SBAR Procurement, Waiver of Competitive Tenders Q1.pdf (3 pages)

14:55 - 15:40
45 min

7. RISK

7.1. Corporate Risk Register

Enclosed *Margo McGurk / Pauline Anne Cumming*

Item 7.1 - SBAR Corporate Risk Register.pdf (6 pages)
Item 7.1 - Appendix 1 Corporate Risk Register as at 20230817.pdf (13 pages)
Item 7.1 - Appendix 2 Assurance Principles.pdf (1 pages)

7.2. Risk & Opportunities Group and Progress Report

Verbal *Pauline Anne Cumming*

7.3. Risk Management Framework

Enclosed *Pauline Anne Cumming*

Item 7.3 - SBAR Risk Management Framework Update.pdf (3 pages)
Item 7.3 - Appendix 1 Draft Risk Management Framework 2023-2025.pdf (26 pages)

15:40 - 15:55
15 min

8. FOR ASSURANCE

8.1. Audit Scotland Technical Bulletin 2023/2

Enclosed *Kevin Booth*

Item 8.1 - SBAR Audit Scotland Technical Bulletin 2023-2.pdf (3 pages)
Item 8.1 - Audit Scotland Technical Bulletin 2023-2.pdf (24 pages)

8.2. Corporate Calendar – Proposed Audit & Risk Committee Dates 2024/25

Enclosed *Dr Gillian MacIntosh*

Item 8.2 - Proposed Audit & Risk Committee Meeting Dates 2024-25.pdf (1 pages)

8.3. Delivery of Annual Workplan 2023/24

Enclosed *Margo McGurk*

Item 8.3 - Delivery of Annual Workplan 2023-24.pdf (4 pages)

15:55 - 16:00
5 min

9. ESCALATION OF ISSUES TO NHS FIFE BOARD

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

Alastair Grant

16:00 - 16:00
0 min

10. ANY OTHER BUSINESS

16:00 - 16:00

11. DATE OF NEXT MEETING - THURSDAY 14 DECEMBER 2023 FROM 2PM -

0 min **4.30PM VIA MS TEAMS**

Fife NHS Board

Unconfirmed

MINUTE OF THE AUDIT & RISK COMMITTEE MEETING HELD ON FRIDAY 23 JUNE 2023 AT 2PM VIA MS TEAMS

Present:
Alastair Grant, Non-Executive Member (Chair)
Cllr David Graham, Non-Executive Member
Anne Haston, Non-Executive Member
Kirstie MacDonald, Non-Executive Member *(part)*

In Attendance:
Kevin Booth, Head of Financial Services & Procurement
Chris Brown, Head of Public Sector Audit (UK), Azets
Tony Gaskin, Chief Internal Auditor *(part)*
Alistair Graham, Associate Director of Digital & Information
Barry Hudson, Regional Audit Manager
Karen Jones, Director of Audit & Assurance, Azets
Dr Gillian MacIntosh, Head of Corporate Governance & Board Secretary
Margo McGurk, Director of Finance & Strategy
Carol Potter, Chief Executive
Shirley-Anne Savage, Associate Director of Quality & Clinical Governance
Hazel Thomson, Board Committee Support Officer (Minutes)

Chair's Opening Remarks

The Chair welcomed everyone to the meeting.

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

1. Apologies for Absence

Apologies were received from member Aileen Lawrie (Non-Executive Member) and attendee Pauline Cumming (Risk Manager).

2. Declaration of Members' Interests

There were no declarations of interest made by members.

3. Minute of the last Meeting held on 15 March 2023

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

4. Action List / Matters Arising

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

5. MATTERS ARISING

5.1 Chief Internal Auditor Appointment Process

The Director of Finance & Strategy advised that, following a successful recruitment process, the successful candidate for a Chief Internal Auditor will commence in post on 1 August 2023, in advance of T Gaskin retiring on 31 August 2023.

The Committee took **assurance** from the update.

6. ANNUAL ACCOUNTS

6.1 Final Audit & Risk Committee Annual Assurance Statement 2022/23

The Board Secretary advised that the Audit & Risk Committee Annual Assurance Statement was circulated to members in May 2023 for comments, and subsequently, no comments were submitted. The Assurance Statement has been issued to both sets of auditors, as part of the year end process.

The Committee **approved** the final Audit & Risk Committee Annual Statement of Assurance 2022/23, for onward submission to the Board.

6.2 Committee & Directors' Annual Assurances for 2022/23

- **Clinical Governance Committee**
- **Finance, Performance & Resources Committee**
- **Public Health & Wellbeing Committee**
- **Remuneration Committee**
- **Staff Governance Committee**
- **Executive Directors' Assurance Letters**

The Board Secretary advised that the Executive Directors' Assurance Letters are a new addition to the Committee & Directors' Annual Assurances pack, and form part of the Chief Executive's Accountable Officer year-end review process, to provide assurance that the delegated powers to the other Executive Directors are operating effectively and to help inform the content of the Governance Statement.

It was reported that the Committee Annual Assurance Statements appropriately reflect the work carried out throughout the year by each of the Board's Standing Committees and these provide a sufficient level of detail on which members could take assurance on. The Chief Internal Auditor confirmed this, following internal audit's review of the documentation, for Committee members.

The Committee took **assurance** from the Committee & Directors' Annual Assurances for 2022/23.

6.3 Letter from Audit & Assurance Committee Chair - Fife Integration Joint Board

The Director of Finance & Strategy advised that, in previous years, a Statement of Assurance was provided from the Integration Joint Board (IJB) to the Health Board, due to the NHS having a later timeline than this year for completion of the Annual Accounts process. The letter provided is an interim measure, pending the finalisation of the IJB's annual audit report, and it was advised that there are no major control weaknesses expected within that report. It was noted that the process will be firmed up for the following year. The Chief Internal Auditor stated that there are no concerns within the contents of the letter from an internal auditor's perspective and that Internal Audit's report on the IJB will be available in full for the Committee's next meeting, after it has progressed through the IJB's own governance structure.

The Committee took **assurance** from the letter from the IJB Audit & Assurance Committee Chair.

6.4 Internal Audit Annual Report 2022/23

The Chief Internal Auditor discussed the main points and themes in the report, noting the overall positive assessment of NHS Fife against the backdrop of another challenging year of high demand and activity

The Chief Internal Auditor highlighted Internal Audit's opinions from the report that:

- The Board has adequate and effective internal controls in place; and
- The 2022/23 Internal Audit Plan has been delivered in line with Public Sector Internal Audit Standards.

A Haston, Non-Executive Member, highlighted the risk to deliver within our financial constraints, particularly due to the changing external environment. It was noted that this is a national issue and the Chief Internal Auditor requested that this is closely monitored.

The Director of Finance & Strategy explained the recent changes to the financial position, noting that NHS Fife Board will be provided with a detailed update at their meeting on 27 June 2023. It was reported that the impact of the recent funding allocation will be discussed, and assessed, through the Executive Directors' Group, the Governance Committees and then the Board.

The Committee **approved** this report as part of the portfolio of evidence provided in support of its evaluation of the internal control environment and the Governance Statement.

6.5 Service Auditor Reports on Third Party Services

The Head of Financial Services & Procurement spoke to the paper and confirmed that all three reports (NSS Practitioner and Counter Fraud Services, NSS IT Services and NHS Ayrshire & Arran Financial Ledger Services) had come back as unqualified this year.

It was highlighted that an exception was noted during the assessment with regards to the annual disaster recovery process not being tested, as per the documented control for NHS Ayrshire & Arran – National Single Instance Financial Ledger Services.

The Head of Financial Services and Procurement confirmed that the Third Party Service Audit Reports were now all received and had been shared with Azets as part of the Annual Accounts process.

The Committee took **assurance** from the audit opinions and the associated management responses for the services hosted by NHS National Services Scotland (NSS) and by NHS Ayrshire & Arran on behalf of NHS Fife.

6.6 External Annual Audit Report (including ISA 260) 2022/23

C Brown, Head of Public Sector Audit (UK) at Azets, presented the draft report and highlighted the key messages, noting that, since the report was issued, the outstanding matters have now been completed and an unqualified audit opinion has been issued. It was noted a sole adjustment was made in respect of the inclusion of the valuation of the Orthopaedics National Treatment Centre performed at the year end. Conformation was provided that a final report will be issued in advance of the June 2023 Board meeting to confirm that all outstanding matters had now been completed.

C Brown reported that the Board's accounting systems, governance arrangements, financial management arrangements, performance & risk management arrangements and forecasting arrangements are all strong, with no significant weaknesses. The significant risk areas within the report were highlighted and the Chief Executive confirmed that a robust approach will continue for risk management, whilst acknowledging the extent of operating above our risk appetite and giving consideration to the risk tolerance level.

K Jones, Director of Audit & Assurance at Azets, thanked the Director of Finance & Strategy, the Head of Financial Services & Procurement, and team for all their assistance during the audit process.

M McGurk thanked C Brown, K Jones and Finance team for all their hard work in completing their first audit with NHS Fife.

The Committee took **assurance** from the report.

6.7 NHS Fife Independent Auditor's Report - Including Draft Letter of Representation

C Brown, Azets, provided a verbal update on the report and advised that the audit certificate, which is included within the accounts, will be signed off by C Brown and the Chief Executive, and that it is a fully unqualified opinion. It was advised that the Letter of Representation from NHS Fife to the Auditors confirms all relevant information has been submitted. The report and letter will go to the June 2023 Board meeting for formal approval.

The Committee took **assurance** from the verbal update.

6.8 Governance Statement and NHS Fife Annual Accounts for the Year Ended 31 March 2023

The Director of Finance & Strategy introduced the Annual Accounts for the Year Ended 31 March 2023.

It was reported that one of the key purposes of the Annual Accounts is to confirm the financial performance of the organisation. The importance of how resources are spent were highlighted, and it was advised that specific areas of resource allocation have been drawn out within the document. The Director of Finance highlighted a number of significant achievements during the year despite the continued financial pressures and the volatile economic environment that the Board operated under. The new Orthopaedic National Treatment Centre, which was fully commissioned in March 2023 was highlighted along with the service expansion at Queen Margaret Hospital, both of these projects are expected to significantly enhance the capacity and services provided in 2023/24. The Director of Finance & Strategy also highlighted the organisation's focus on staff health & wellbeing, including the investment from the Fife Health Charity for the creation of the staff wellbeing hubs that have been implemented across a number of sites, and all positively received by staff.

Governance Statement

The Chief Executive advised that the Governance Statement is a key document within the Annual Accounts, and she provided an overview on the purpose of the statement.

The key points from the Governance Statement were outlined, including the work undertaken by the Board on active governance, which included reviewing the focus of the Integrated Performance & Quality Report and linking this to the risk management profile. Also outlined were the operationally managed risks around the creation of the Operational Pressures Escalation Levels (OPEL) Framework, which fully supports good governance at operational level. The Population Health & Wellbeing Strategy approved during the year was highlighted, and it was noted that NHS Fife now has a clear framework which sets out the priorities and ambitions going forward.

The Committee **considered** the governance statement and took **assurance** from the content on the internal control environment within NHS Fife over the course of the past year.

Annual Accounts

The Head of Financial Services & Procurement took the Committee through a number of the key financial performance aspects of the financial statements, including the core and non-core revenue and capital resource limits, as well as the cash resource limit which were all met in 2022/23. Key figures from the remuneration report, as well as aspects of the Statement of Financial Position at the Year End including the consolidation of the Boards share of the Integration Joint Board's reserves were highlighted to the committee.

The Chief Executive highlighted an error on page 26 of the Annual Accounts document, under the 'Population Health & Wellbeing Strategy Development' section, second line,

first paragraph, to remove the word 'and' to read correctly: *In April 2021, the NHS Fife Board agreed to the development of a new organisational strategy, focused on reducing health inequalities, delivering excellence in clinical care and improving population health and wellbeing for the people of Fife.* It was agreed this will be amended for the signed version of the Annual Accounts.

Action: Director of Finance & Strategy

The Head of Financial Services & Procurement highlighted that the Annual Accounts and subsequent audit process for 2022/23 concluded successfully, significantly earlier than in 2021/22 as per the requirement of the Scottish Government, which was testament to the robust planning process and the significant endeavours across the Finance Team.

The Audit & Risk Committee:

- **Reviewed** the draft Annual Accounts for the year ended 31 March 2023.
- **Recommended** to the Board that they adopt the Annual Accounts for the year ended 31 March 2023.
- **Recommended** to the Board to authorise the designated signatories (Chief Executive and Director of Finance & Strategy) to sign the Accounts on behalf of the Board.
- **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.
- **Noted** that the accounts are not in the public domain until they are laid before Parliament.

6.9 Annual Assurance Statement to the NHS Fife Board 2022/23

The Board Secretary explained the purpose of the Annual Assurance Statement to the NHS Board 2022/23.

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

6.10 Patients' Private Funds – Receipts and Payments Accounts 2022/23 & Audit Report

In light of the Statutory Auditor, Thomson Cooper being unable to attend, the Head of Financial Services & Procurement advised that he met with the Audit Partner of Thomson Cooper, along with the Director of Finance & Strategy, on 16 June 2023. An overview was provided on the questions submitted from members, prior to the meeting. It was noted that there had been an increase in the number of patient private funds accounts during 2022/23, despite the reduction in the overall value of the funds, it was referenced that the funds are predominantly held by a few individuals. An overview was also provided on the findings at Stratheden Hospital, with it being noted that additional measures have been put in place to address the risks associated with the vulnerable aspects of these patients. In addition, it was confirmed that Internal Audit have carried out an assignment on the Financial Operating Procedures relating to the Patients Funds, and that the subsequent actions will be concluded in Autumn 2023.

It was reported that there were a number of minor matters identified during the assignment and Thomson Cooper were content with the management responses provided to resolve these.

The Director of Finance & Strategy emphasised the importance of the Patients' Private Funds Accounts, which provides security for patients over funds held on their behalf.

The Audit & Risk Committee:

- Took **assurance** from the Independent Auditor Report on the Patients' Private Funds Accounts and Audit completion memorandum

- **Recommended** that the Patients' Private Funds Accounts be approved by the NHS Board and that the attached letter of Representation be signed by the authorised signatories and provided to the Auditors.

7. INTERNAL AUDIT

7.1 Internal Audit Annual Plan 2023/24

The Chief Internal Auditor spoke to the plan, advising that it reflects the organisation's risks and has been influenced by the Population Health & Wellbeing Strategy. It was noted that the plan is subject to change, dependant on potential changes to the risk profile and priorities over the coming year.

The Director of Finance & Strategy advised that the Executive Team reviewed and supported the plan.

The Committee **approved** the draft Internal Audit Annual Plan for 2023/24.

8. RISK

8.1 Final Annual Risk Management Report 2022/23

The Director of Finance & Strategy advised that the report is presented in its final version, and that the report confirms that adequate and effective risk management arrangements were in place throughout 2022/23. It was noted that there is an improved position with the risk management arrangements due to delivery against a number of key activities in the risk management improvement programme, including the introduction of a new Corporate Risk Register.

The linkage between the Annual Risk Management Report 2022/23, and the views within the Internal Audit and External Audit Annual Reports, were highlighted.

The Director of Finance & Strategy thanked the Risk Manager, for all her hard work over the course of the year.

The Committee took **assurance** from the content of the report.

8.2 Corporate Risk Register

The Associate Director of Quality & Clinical Governance and Associate Director of Digital & Information joined the meeting for this agenda item.

The Associate Director of Quality & Clinical Governance highlighted the changes to the overall strategic risk profile, the summary statement, and the proposed changes to the risk description, as detailed in the paper. It was noted that discussions are ongoing around the Covid-19 risk being removed from the Corporate Risk Register and becoming business as usual, and a related new risk around future preparedness for any potential future pandemics, is anticipated to be added in replacement.

It was reported that 8 of the 18 Corporate Risks have undergone a deep dive review, with other risks of particular significance commissioned for deep dives by Committees.

The Associate Director of Digital & Information explained that the Risk & Opportunities Group had reviewed the assurance principles, and they recommended the use of a four-level assurance model, which has since been incorporated into the framework.

The Committee took **assurance** from the Corporate Risk Register update.

9. HEALTH BOARD PARTNERSHIP

9.1 National Services Scotland (NSS) Practitioner Services Partnership Agreement April 2023 – March 2028

The Director of Finance & Strategy explained that the paper describes a set of arrangements that NSS puts in place to register and pay primary care contractors on our behalf, which is reviewed every five years, and that the arrangement applies to all NHS Scotland Health Boards. It was reported that there were no significant amendments from the previous version of agreement. It was noted that the Chief Executive is the Accountable Officer for the payments, arrangements, and expenditure.

The Committee took **assurance** from the paper.

10. WORKPLAN

10.1 Delivery of Annual Workplan 2023/24

The Committee took **assurance** from the tracked workplan.

11. ESCALATION OF ISSUES TO NHS FIFE BOARD

There were no issues to highlight to the Board.

The Director of Finance & Strategy highlighted that the Committee's recommendations on the approval of the Annual Accounts will go to the NHS Fife Board at their June 2023 meeting.

12. ANY OTHER BUSINESS

None.

13. DATE OF NEXT MEETING

Date of Fife NHS Board Meeting to Approve Annual Accounts: **Tuesday 27 June 2023 at 9.30am** in person.

Date of Next Committee Meeting: **Thursday 31 August 2023 at 2pm** via MS Teams.

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

AUDIT & RISK COMMITTEE – ACTION LIST
Meeting Date: Thursday 31 August 2023

NHS Fife

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	TIMESCALE	COMMENTS / PROGRESS	RAG
1.	16/09/21	**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 was provided at the September 2022 meeting.	In progress
2.	23/06/23	**Annual Accounts**	To make an amendment on page 26 of the Annual Accounts, as described in the minutes, for the signed version.	**MM**	June 2023		Closed

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**31 August 2023**
Title:	**Internal Audit Progress Report**
Responsible Executive/Non-Executive:	**M McGurk, Director of Finance & Strategy**
Report Author:	**B Hudson – Regional Audit Manager/J Lyall – Chief Internal Auditor**

1 Purpose

This is presented 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 progress of the 2022/23 Internal Audit Plan, the commencement of the 2023/24 Internal Audit Plan, and the reporting of Fife IJB audit reports.

2.2 Background

The internal audit year runs from May to April. The Internal Audit team continues to progress the remaining reviews from the Internal Audit Plans 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.

A large element of our year-end assurance work was delivered through the Internal Control Evaluation (ICE) and action to progress recommendations from the ICE will be reported within the 2023/24 Annual Internal Audit Report, and monitored through throughout the year via the Audit Follow Up system.

2.3 Assessment

We have experienced delays in finalising audits from the previous audit year due to long term sickness absence within the Fife Internal Audit team and across the FTF portfolio impacting on delivery of audit plans. All these staff have now returned which provides the capacity to deliver both the outstanding reviews and progress current year work.

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 Internal Audit Reports issued since the last Audit and Risk Committee.

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.

Following the retirement of the Chief Internal Auditor, the Regional Audit Manager covering NHS Forth Valley and part NHS Tayside has now been appointed to take over the role. The now vacant Regional Audit Manager post has been advertised and the interview process will be undertaken in the coming weeks.

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 Internal Audit Plan takes into account inherent and control risk for all aspects of the Audit Universe. Individual internal audit assignments identify the key risks at the planning stage and our work is designed to evaluate whether appropriate systems are in place and operating effectively to mitigate the risks identified. Legal requirements are a core consideration in planning all internal audit reviews.

2.3.5 Equality and Diversity, including health inequalities

All internal audit reviews which involve review of policies and procedures examine the way in which equality and diversity is incorporated in Board documentation.

2.3.6 Other impacts

N/A

2.3.7 Communication, involvement, engagement and consultation

All papers have been produced by Internal Audit and shared with the Director of Finance and Strategy.

2.3.8 Route to the Meeting

This paper has been produced by the Regional Audit Manager and reviewed by the Chief Internal Auditor.

2.4 Recommendation

The Audit and Risk Committee is asked to:

- **Discuss** and take **assurance** on the progress of the delivery of the Internal Audit Plan(s)

3 List of appendices

The following appendices are included with this report:

- Appendix A – Internal Audit Progress Report.

FTF Internal Audit Service

Internal Audit Progress Report

Introduction

This report presents the progress of internal audit activity up to 22 August 2023.

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 2023 when internal audit progress was last reported. 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 and 2023/24	Opinion on Assurance	Recommendations	Draft issued	Finalised
Corporate Governance				
B01/24 Annual Planning	N/A	N/A	22 June 2023	22 June 2023
B06/24 and B07/24 Annual Report and Governance Statement	N/A	One Significant Three Moderate Two Merits Attention	13 June 2023	19 June 2023
B21/23 Patients Funds	Reasonable Assurance	Three Merits Attention	11 April 2023	17 May 2023

Fife IJB Completed Audit Work

Audit 2022/23 and 2023/24	Opinion on Assurance	Recommendations	Draft issued	Finalised
F05-22 Strategic Planning	Reasonable Assurance	Two Moderate	28 April 2023	8 June 2023

NHS Fife Draft Reports Issued

	Draft issued
B14/23 Strategic Planning	30 August 2023
B17/23 Workforce Planning • Meeting held with Workforce senior management to clear report, with final version to be completed over the coming weeks	26 May 2023

Fife IJB Draft Reports Issued

	Draft issued
F06-22 Clinical and Care Governance	21 August 2023

NHS Fife Work in Progress and Planned:

Audit 2022/23 and 2023/24		Status	Target Audit and Risk Committee
B13/23	Resilience and Business Continuity • Fieldwork completed and report currently being drafted	WIP	December 2023
B16/23 and B20/24	Medicines Management • Prior year assignment combined with current year	WIP	December 2023
B20/23 and B23/24	Financial Process Compliance • Prior year assignment combined with current year	WIP	December 2023

Fife IJB Work in Progress and Planned:

Audit	Status	Target Audit and Risk Committee
F04-23 Contract/Market Capacity	WIP	December 2023
F05-23 Workforce Planning	WIP	December 2023

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. B01/24 – Annual Planning

Internal Audit Plan for 2023/24 was approved at the June 2023 Audit and Risk Committee meeting.

2. B06 and B07/24 – Annual Internal Audit Report and Governance Statement

The 2022/23 Annual Internal Audit Report was considered at the June 2023 Audit and Risk Committee meeting.

3. B21/23 – Patients Funds

Six wards were visited and the following tested:

- Staff being made aware of their responsibilities over patients' property and having received appropriate training.
- Physical security over property.
- Patients' property is accurately recorded and accounted for.
- Patients' property is returned to individual patients or next-of-kin in a timely manner and is recorded completely and accurately.

The following findings were agreed with management:

- An update to the Patients Funds Financial Operating Procedure (FOP 18) is required to implement various updates due to changing administrative practices.
- FOP18 to be reviewed and updated to include keypad safes if deemed acceptable or otherwise it be clarified for all wards that the current stated requirement remains for all safes to be locked by physical key.
- Personal property disclaimer notices to be displayed at all wards to inform patients and their families that valuables should be taken home for safe keeping when possible and to make it clear that NHS Fife cannot be held responsible for the loss of any valuables which are not placed in safe custody.
- Wards noted as not completing a formal handover reconciliation of items held within safe custody when there is a shift handover to reintroduce this practice.

4. F05-22 – Strategic Planning

The Internal Audit review of the Fife IJB Strategic Plan considered the detailed arrangements for the preparation of Fife IJB Strategic Plan against Strategic Planning principles developed by FTF. The principles incorporated the '5 P's: Process, Products, Parameters, Priorities and Principles, and the extent to which the IJB Board was in a position to understand and influence these.

The Internal Audit review of the development and the production of the Strategic Plan provided an opinion of '*Reasonable Assurance'* with two moderate recommendations with Management Actions for implementation.

The key findings included:

- Whilst the Strategic Plan was substantially compiled in line with legislation and our principles, the scale and volatility of the external environment and the ambition of the Plan itself, which proposes a significant number of developments without a corresponding diminution in other areas, means that it will be exposed to significant risk which will require careful, constant monitoring and the ability and willingness both to deliver substantial transformational change and to review and flex the plan as circumstances change.
- The environment in which the Fife IJB operates is exceptionally complex and challenging, with most supporting strategies and transformation programmes still in development. It is critical that the IJB Board are clear on key priorities for themselves as a board of governance, for management and for staff and resources.
- A methodical approach was used to develop the Strategic Plan, although some of the structures for the Strategic Plan such as the formal governance processes and reporting processes were not formed until the latter part of the process.
- In line with the Strategic Commissioning Plan Guidance by Scottish Government published in October 2015, a Strategic Planning Group was set up to facilitate the development of the Strategic Plan.
- A comprehensive Communication and Engagement Plan was developed and was approved at the July 2022 meeting of the IJB. We commend the use of presentations to key stakeholders such as the Development Sessions to Fife IJB members in 2022.
- The Strategic Plan was originally intended to cover 2022-2025 with a final draft to the Scottish Government by November 2022, but this was extended with the final Strategic Plan approved at the 27 January 2023 IJB meeting. The timeline was extended to enable inclusion of consultation findings from an independent survey commissioned by NHS Fife. The extension added value to the Strategic Plan engagement process and was agreed with the Scottish Government.
- A project methodology and Strategic Timeline was used to monitor and develop the Strategic Plan.
- The strategic risks of Fife IJB are regularly reported to the Audit and Assurance Committee with overt linkages to the Strategic Plan within the recently revised SBAR template used for all committees.

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**31 August 2023**
Title:	**Internal Audit – Follow Up Report on Audit Recommendations 2022/23**
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 for:

- Assurance
- Approval

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.

The Blueprint for Good Governance in NHS Scotland (second edition) includes the following guidance regarding the follow-up of actions to address internal audit recommendations:

> *'It is important that the Audit and Risk Committee adopt a robust approach to the oversight of the completion of actions identified in the audit reports. Where possible, actions should be dealt with in the current financial year rather than being carried forward from one financial year to the next. Any exceptions to this should be closely scrutinised by the Audit and Risk Committee who should seek assurance that the timeline proposed for addressing the risks or issues identified by the auditors is both reasonable and achievable.' [Section D13 – page 59]*

2.2 Background

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

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

Where an action is reported by the Responsible Officer as delayed, the Audit Follow-up Protocol dictates that a reason for the delay must be provided and the proposed extension is subject to approval as follows:

- 1st Extension – Internal Audit
- 2nd Extension – Executive Director
- Subsequent Extensions – Director of Finance & Strategy/Chief Executive.

A revised AFU Protocol is included at appendix G and the Committee is asked to consider this and approve it. The main changes to the protocol are:

- Authorisation of extensions to target implementation dates more explicitly linked to the assessment of risk associated with the finding/recommendation
- The follow-up report to be presented to the Executive Director's Group following, rather than prior to, each Audit & Risk Committee meeting.

This report includes progress regarding recommendations arising from our Internal Control Evaluation (ICE) and Annual reports.

Our report demonstrates compliance to the guidance within the Blueprint for Good Governance in NHS Scotland (second edition), interpreting this as follows:

> ***Actions should be implemented within 1 year of the recommendation having been made. This is calculated from the date the final report, including the recommendation, was issued.***

The tables and graphs included clearly show the actions related to recommendations that were reported more than one year ago so that particular attention can be focussed on clearing these.

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, other than ICE and Annual Report recommendations, as at 23 Aug 2023, with comparable figures from the last Audit Follow-Up (AFU) report as at 30 April 2023 (Ext = Extended, O/S = Outstanding & NYD = Not Yet Due).

	Aug 2023			Apr 2023		
Remaining Actions	**25**			**18**		
	Ext	O/S	NYD	Ext	O/S	NYD
Recommendations more than 1 year (*Appendix C)*	11	0	0	13	0	0
Recommendations less than 1 year (*Appendix C)*	11	0	3	5	0	0

The table below shows the status of all remaining ICE and Annual Report recommendations, as at 23 August 2023 (now includes B06/24 – 2022/23 Annual Report).

	Aug 2023			Apr 2023		
Remaining Actions	**20**			**17**		
	Ext	O/S	NYD	Ext	O/S	NYD
Recommendations more than 1 year (*Appendix C)*	0	0	0	0	0	0
Recommendations less than 1 year (*Appendix C)*	9	0	11	2	0	14

Progress summary

The following reports have either been completed and validated or superseded by recommendations in more recent reports:

Report Removed	**Reason**
B14/21 Sharps Management	Actions completed with 3a, 3b and 3c superseded, as the Sharps Strategy Group has been disbanded with its key responsibilities now overseen by the Acute Service Division & Corporate Directorates H&S Committee and the H&S Sub-Committee.
B20/21 Adverse Events Management	All actions completed and validated
B23/22 Resilience	All actions completed and validated.

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.

Members will note the significant number of extensions. Many of these have been necessary due to underestimating the time that it takes for the required evidence of actions being completed to be available. This often relates to groups or committees approving items therefore the timing of these meetings and availability of minutes is a factor. In line with the process outlined above, all have been reviewed by Internal Audit and authorised by the relevant Executive Director, Director of Finance & Strategy/Chief

Executive, dependent on the number of extensions.

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 and Risk Committee is asked to:-

- Take **assurance** and consider the current status of Internal Audit recommendations recorded within the AFU system.
- **Approve** the revised AFU protocol at Appendix G.

3. List of appendices

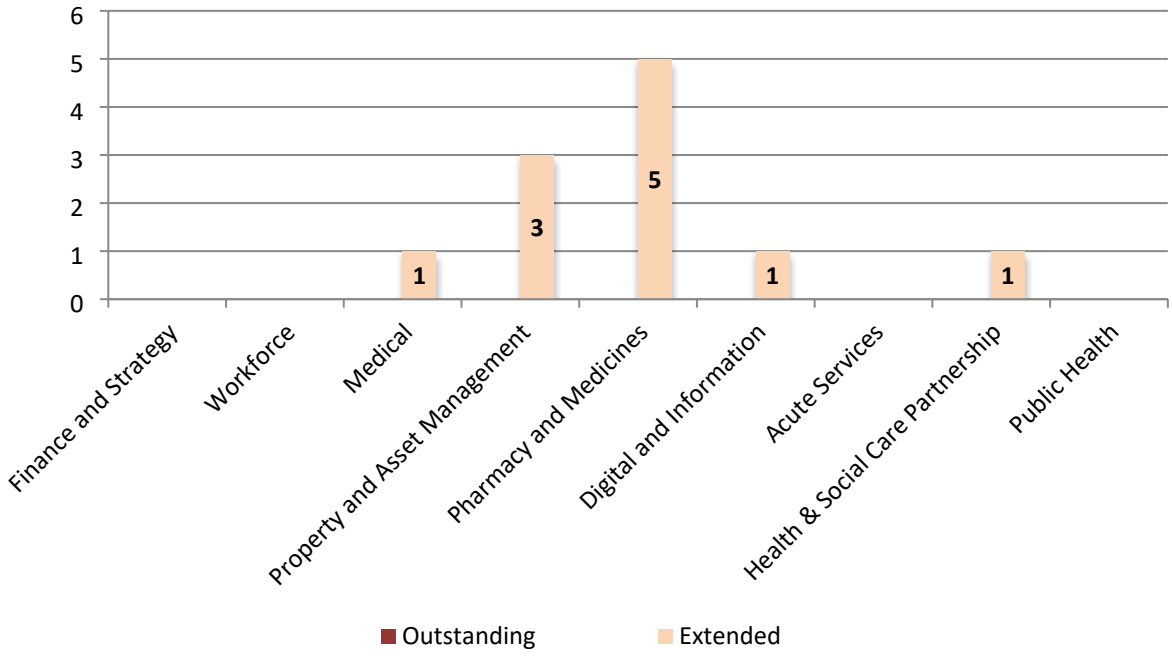
The following appendices are included with this report:

Report Contact

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

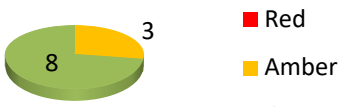
Recommendations More Than 1 Year

Outstanding and Extended by Directorate

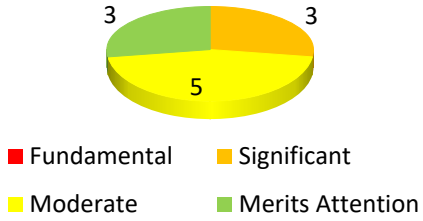


Extended Recommendations RAG Status and Priority

RAG Status

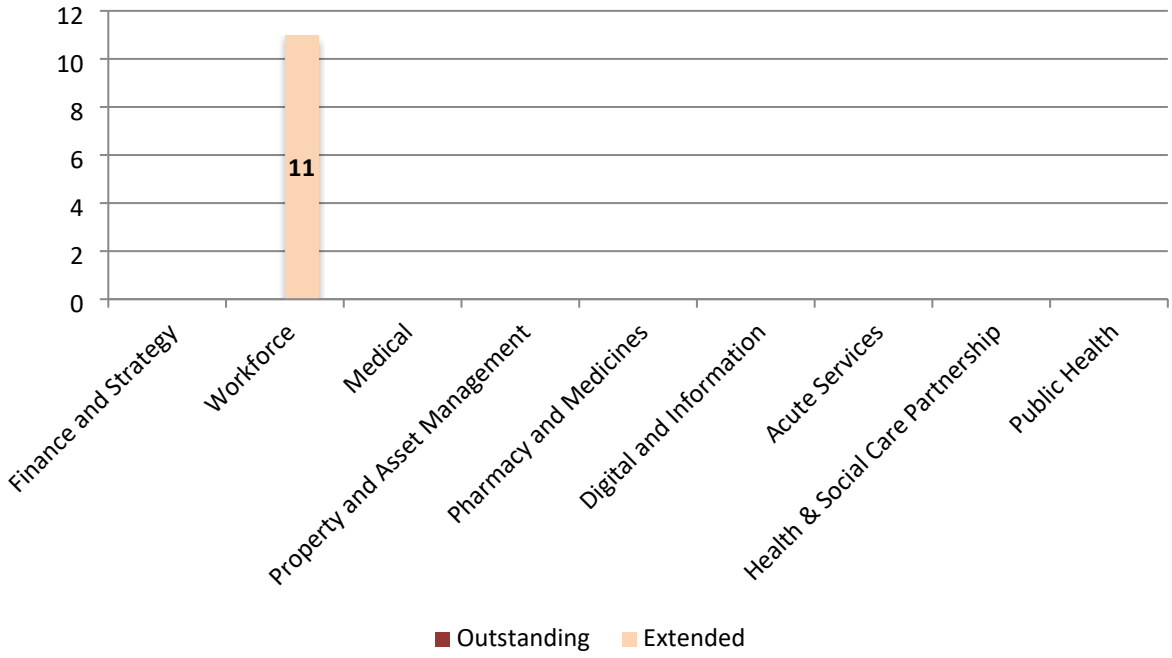


Priority



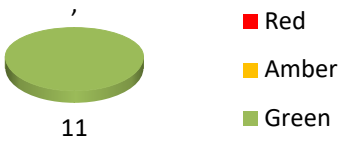
Recommendations Less Than 1 Year

Outstanding and Extended by Directorate

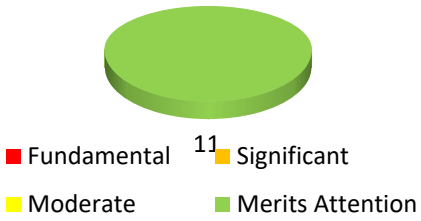


Extended Recommendations RAG Status and Priority

RAG Status



Priority



Internal Audit Reports with Remaining Actions	Date of Issue	Total Recs.	Complete	Superseded	Remaining		Extended	Outstanding	Not Yet Due		Not Validated
2020/21											
B13/21 Risk Management Strategy	Sep 21	5	4	0	1		1	0	0		-
B19/21 Clinical Governance Strategy and Assurance	Sep-21	2	1	0	1		1	0	0		-
B21/21 Medical Equipment and Devices	Nov-21	4	1	0	3		3	0	0		-
B23/21 ITIL Processes	Jul-21	6	5	0	1		1	0	0		-
2020/21 Totals		**17**	**11**	**0**	**6**		**6**	**0**	**0**		**0**
2021/22											
B16/22 Prescription Stationery Security	May-22	11	6	0	5		5	0	0		-
2021/22 Totals		**11**	**6**	**0**	**5**		**5**	**0**	**0**		**0**
2022/23											
B18/23 Whistleblowing	May-23	11	0	0	11		11	0	0		-
B21/23 Patients' Property	May-23	4	1	0	3		0	0	3		-
2022/23 Totals		**15**	**1**	**0**	**14**		**11**	**0**	**3**		**0**
Overall Totals (Actions from reports where recommendations remain unaddressed)		**43**	**18**	**0**	**25**		**22**	**0**	**3**		**0**

Previous ICE and Annual Reports with Remaining Actions	Date of Issue	Total Recs.	Complete	Superseded	Remaining		Extended	Outstanding	Not Yet Due		Not Validated
2022/23											
B08/23 ICE – 2022-23	Mar-23	24	14	1	9		9	0	0		-
2022/23 Totals		**24**	**14**	**1**	**9**		**9**	**0**	**0**		**-**
2023/24											
B06/24 Annual Report – 2022-23	Jun-23	11	0	0	11		0	0	11		-
2023/24 Totals		**11**	**0**	**0**	**11**		**0**	**0**	**11**		**-**
Overall Totals (Actions from reports where recommendations remain unaddressed)		**35**	**14**	**1**	**20**		**9**	**0**	**11**		**-**

Report	3cRec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
2020/21 - Extended							
B13/21 Risk Management Strategy	3	S	Now that there is clarity around responsibility for operations, an Integration Joint Board (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~~ ~~31 Dec 22~~ ~~31 Aug 23~~ 31 Dec 23		The IJB Risk Management Strategy was approved by the IJB on 31 March 2023. The timescale for the development of the revised NHS Fife Risk Management Framework has slipped slightly due to the absence of key staff.
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 and related governance improvements.	Associate Director of Quality and Clinical Governance **Medical Director**	~~31 Jan 22~~ ~~31 May 22~~ ~~31 Oct 22~~ ~~31 Jul 23~~ 31 Mar 24		The recommendation from this report has many component parts 1a to 1h. **The following elements are still to be addressed**: 1c – *NHS Fife Risk Management Framework and IJB equivalent reflecting that ultimate ownership of clinical risk rests with Fife NHS Board to be revised and approved*. As per B13/21 above the IJB Risk Management Strategy was approved in March 2023 and the NHS Fife Risk Management Framework is in development. 1d – *Developing assurance from CGOG to Clinical Governance Committee (CGC)* – elements are completed but some elements still to be done. 1e – *CGC ToR to include its responsibility for providing assurance on Information Governance to Fife NHS Board* – This was not addressed in the latest Code of Corporate Governance but will be in the next issue. 1g – *Reflection on why some CGC sub-groups/committees are required to provide annual assurance before CGC concludes on its own annual assurance report/statement and others don't and for changes to assurance requirements to be made accordingly and*

Report	3cRec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
							reflected in the CGC workplan. - Not yet done. A meeting between internal audit and the Associate Director of Quality and Clinical Governance took place on 24 August 2023 to progress these actions.
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 (CEMG).	Head of Estates **Director of Property and Asset Management**	~~31 Jan 22~~ ~~31 Jul 22~~ ~~30 Jun 23~~ 31 Oct 23 [TBC]		The Medical Equipment Management Policy (GP/E4) and related procedure GP/E4 have been updated and approved with a review date of 1 September 2025 and both are published on Stafflink. The publication of the E14 suite of policies on Stafflink has been delayed by staff absence but is being progressed.
	3	M A	Evidence of new Equipment Request Forms (ERFs) being completed correctly with the added sections fully populated. CEMG membership to be updated to formally include a representative from Digital and Information (D&I).	Head of Estates **Director of Property and Asset Management**	~~31 Jan 22~~ ~~31 Jul 22~~ 30 Sep 23		The new ERF now includes all of the sections recommended and has been put into use with 14 requests made using the new forms. Internal Audit are to check a sample of these completed forms before 30 September 2023. A representative from D&I is now a member of the CEMG.
	4	M A	The CEMG should review the Key Performance Indicators (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 its 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~~ 30 Sep 23		The CEL 35 (2010) KPIs will be considered by the newly established Medical Devices Group. We are awaiting confirmation of this being taken forward from the Chair of this newly established group.

Report	3cRec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
B23/21 ITIL Processes	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 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.	Service Delivery Manager **Associate Director - Digital and Information**	~~31-Aug-21~~ ~~31-Mar-22~~ ~~30-Jun-22~~ ~~31-Mar-23~~ ~~31 Aug 23~~ 30 Nov 23		The change to the ServiceNow system to prompt the reason for Emergency Changes to be recorded for every change is being tested by D&I ahead of being incorporated in the live system. Extension requested to allow the change to be demonstrated to internal audit in the live system. A review of the 73 emergency changes enacted throughout the lifespan of Cherwell has been undertaken and no issues of non-compliance were identified.
20/21 Extended	**6**						

Report	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
2021/22 - Extended							
B16/22 Prescription Stationery Security	1	M	Checking of staff ordering prescription stationery to confirm that they are authorised to order the stationery.	Lead Pharmacist Medicine Governance and Medicines Supply Chain Manager **Director of Pharmacy & Medicines**	~~31 Oct 22~~ ~~30 Apr 23~~ ~~30 Jun 23~~ 30 Sep 23		SOP CPD021 has been updated and approved and is to be communicated to the relevant staff.
	2a	M	Risk assessments of areas used in Pharmacy departments at VHK and QMH for the storage of Prescription Stationery.	Lead Pharmacist Medicine Governance and Medicines Supply Chain Manager **Director of Pharmacy & Medicines**	~~31 Oct 22~~ ~~30 Apr 23~~ 31 Oct 23		Risk assessments have been undertaken and mitigations identified. Recent feedback from Estates indicated that action is imminent regarding replacing combination locks with proximity access.
	2b	M	Implementing a protocol for changing any combination locks remaining in use whenever anyone who knew the code leaves the service.	Lead Pharmacist Medicine Governance and Medicines Supply Chain Manager **Director of Pharmacy & Medicines**	~~31 Oct 22~~ ~~30 Apr 23~~ 31 Oct 23		As per 2a above.
	2d	M	SOP CDP021 updated to include the times that the check of the 'Controlled Stationary – Record of Issues and Receipts log' for each pad is required to be undertaken.	Lead Pharmacist Medicine Governance and Medicines Supply Chain Manager **Director of Pharmacy & Medicines**	~~31 Oct 22~~ ~~30 Apr 23~~ ~~30 Jun 23~~ 30 Sep 23		SOP CPD021 has been updated and approved and is to be communicated to the relevant staff.

Report	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
	3e	M	Details of the process introduced to check prescription stationery orders received to confirm that these are consistent with wards/departments only holding the stock they require (and documentation of this in the SOP or SSUMMP).	Lead Pharmacist Medicine Governance and Medicines Supply Chain Manager **Director of Pharmacy & Medicines**	~~31 Oct 22~~ ~~30 Apr 23~~ ~~30 Jun 23~~ 30 Sep 23		SOP CPD021 has been updated and approved and is to be communicated to the relevant staff.
21/22 Extended	**5**						
Total > 1 Year	**11**						

Report	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
2022/23 - Extended							
B18/23 Whistleblowing	1a	M A	Confidential whistleblowing contacts to be updated.	Head of Workforce Resourcing & Relations **Director of Workforce**	~~31 Aug 23~~ 31 Oct 23		New confidential contacts are to be trained in September and a publicity launch is scheduled for national speak up week at the beginning of October 2023 when updated posters including the new confidential contact details will be included in the materials.
	1b	M A	Whistleblowing posters to be updated with new confidential contacts details.	Head of Workforce Resourcing & Relations **Director of Workforce**	~~31 Aug 23~~ 31 Oct 23		As per 1a above
	1c	M A	Whistleblowing posters to be distributed.	Head of Workforce Resourcing & Relations **Director of Workforce**	~~31 Aug 23~~ 31 Oct 23		As per 1a above
	2a	M A	WB Investigation Terms of Reference Template to be updated.	Head of Workforce Resourcing & Relations **Director of Workforce**	~~30 Sep 23~~ 31 Oct 23		A draft has been developed.
	2b	M A	Stage 2 Letter template to be updated	Head of Workforce Resourcing & Relations **Director of Workforce**	~~31 Jul 23~~ 31 Oct 23		A draft has been developed and sent to the Whistleblowing Champion for approval.
	3	M A	Extensions information to be added to the Staff Governance Committee quarterly report.	Head of Workforce Resourcing & Relations **Director of Workforce**	~~31 Jul 23~~ 31 Oct 23		The template for the report is being updated.

Report	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
	4	M A	The Staff Governance Committee quarterly report to clearly indicate when all investigation actions have been completed.	Head of Workforce Resourcing & Relations **Director of Workforce**	~~31 Jul 23~~ 31 Oct 23		The template for the report is being updated.
	5	M A	The Staff Governance Committee quarterly report to include lessons learned from anonymous concerns.	Head of Workforce Resourcing & Relations **Director of Workforce**	~~31 Jul 23~~ 31 Oct 23		The template for the report is being updated.
	6a	M A	Whistleblowing action plan to be presented to the Staff Governance Committee including target dates and responsible officers.	Head of Workforce Resourcing & Relations **Director of Workforce**	~~31 Jul 23~~ 31 Oct 23		The Staff Governance Committee will be provided with an action plan at their next meeting and this will reflect the recommendations made in the internal audit report.
	6b	M A	The Staff Governance Committee quarterly report to include action plan completion progress.	Head of Workforce Resourcing & Relations **Director of Workforce**	~~31 Jul 23~~ 31 Oct 23		As per 6a above.
	6c	M A	The whistleblowing action plan to the Staff Governance Committee to include scheduling of annual reviews of the format of quarterly and annual reporting prior to annual report preparation.	Head of Workforce Resourcing & Relations **Director of Workforce**	~~31 Jul 23~~ 31 Oct 23		As per 6a above.
22/23 Extended	**11**						
Total < 1 Year	**11**						

ANNUAL and ICE REPORTS Report	Rec Number	Priority	Brief Description	Responsible Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
2022/23							
B08/23 – ICE Report – 2022/23	1b	M A	SBAR template and guidance update regarding completion of the risk management section.	Head of Corporate Governance & Board Secretary **Director of Finance & Strategy**	~~30 Jun 23~~ 31 Dec 23		Draft SBAR and guidance written, reviewed by internal audit and to be approved for use. To allow draft revised SBAR and associated guidance to be approved and evidenced as in use.
	1c	M A	Policy updates to the Finance, Performance and Resources Committee to include risk assessments on risks posed by lapsed policies.	Head of Corporate Governance & Board Secretary **Director of Finance & Strategy**	~~30 Jun 23~~ 31 Dec 23		Reporting on Policies and Procedures to EDG in Oct and FPRC in Nov will include risk assessments on lapsed policies.
	4b	M A	The Clinical Governance Strategic Framework Delivery Plan to reference Adult and Child Protection and the latest guidance - Scottish Government's NHS Public Protection Accountability and Assurance Framework.	Associate Director of Quality and Clinical Governance **Medical Director**	~~31 Aug 23~~ 31 Dec 23		This was not included in the latest Clinical Governance Strategic Framework Delivery Plan but is to be included in the next version.
	4c	M A	Update of the Clinical Governance Oversight Group's Terms of Reference to include their responsibility for monitoring completion of action plans to address recommendations made in external reports.	Associate Director of Quality and Clinical Governance **Medical Director**	~~31 Aug 23~~ 31 Dec 23		The latest version of the Clinical Governance Oversight Group's Terms of Reference agreed on 20 June 2023 does not address the audit recommendation. Internal Audit have provided suggested wording and the Terms of Reference is to be updated.
	4d	M A	The Organisational Learning Group to hold a meeting specifically considering an external review and whether the findings were already reported through internal reporting	Associate Director of Quality and Clinical Governance	~~31 Aug 23~~ 31 Dec 23		A formal Organisational Learning Group meeting is to be scheduled and will potentially be focussed on the recent HIS review at VHK that resulted in the relocation of the ENT ward.

ANNUAL and ICE REPORTS Report	Rec Number	Priority	Brief Description	Responsible Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
			mechanisms.	**Medical Director**			
	4e	M A	Minutes of Organisational Learning Group meetings to be presented to the Clinical Governance Committee.	Associate Director of Quality and Clinical Governance **Medical Director**	~~31 Aug 23~~ 31 Dec 23		The minutes of the August 2023 Organisational Learning Group meeting will be presented to the next Clinical Governance meeting.
	4f	M A	Rewording of Corporate Risk 7 to more clearly communicate the gravity of the situation.	Associate Director of Quality and Clinical Governance **Medical Director**	~~31 Aug 23~~ 31 Dec 23		A reworded corporate risk 7 will be presented to the Finance, Performance and Resources Committee in September 2023.
	10	M A	IG&S Update report to CGC - reasons for any 72 hour ICO incident reporting requirement breaches and any Governance Statement disclosures required.	**Associate Director - Digital and Information**	~~31 May 23~~ 31 Oct 23		IG&SSG Update to CGC on 3 March 2023 – Item 9.1 - Summary of Incident Reporting in the period including assurance that they all complied with the 72 hour timescale for reporting to the ICO but does not include a statement regarding whether or not any of the incidents will warrant disclosure in the Board's Governance statement. This is to be included in the update presented to CGC on 8 September 2023.
	11	M A	Add D&I Workforce Plan to risk 18 mitigations.	**Associate Director - Digital and Information**	~~31 May 23~~ ~~31 Jul 23~~ 30 Nov 23		The CRR extract presented to CGC on 3 March 2023 (Item 6.3) does not include the D&I Workforce Plan as a mitigation to risk 18 – D&I Strategy as was required by the recommendation. This was intended to be included in the update to CGC on 7 July 2023 but the risk management update to that meeting was purely focussed on deep dives into risks 9 and 7 from the corporate risk register. The full list of risks aligned to the Clinical Governance Committee is to be presented to the next Clinical Governance Committee meeting.

ANNUAL and ICE REPORTS Report	Rec Number	Priority	Brief Description	Responsible Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
22/23 Extended	9						
Total	9						

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 AUDIT FOLLOW-UP PROTOCOL

INTERNAL AND EXTERNAL AUDIT REPORT ACTION PLANS AND RECOMMENDATIONS

1. INTRODUCTION

1.1. As Accountable Officer, the Chief Executive is ultimately responsible for ensuring that the organisation has effective management systems in place to safeguard public funds.

1.2. The Audit and Assurance Committee Handbook (March 2018) includes the following good practice requirements for the audit follow up of recommendations:

- ***'holding managers within the organisation to account for the implementation of audit recommendations***
- ***to advise the Board and Accountable Officer on the adequacy of management response to audit recommendations***
- ***key lines of enquiry include obtaining assurance that:***
    - ***Internal Audit recommendations that have been agreed by management are timeously implemented***
    - ***any issues arising from line management not accepting Internal Audit recommendations are appropriately escalated for consideration***
    - ***the implementation of recommendations is monitored and followed up***
- ***output from follow-up audits by Internal Audit is monitored by the committee and the committee considers the adequacy of implementation of recommendations'.***

1.3. The revised Blueprint for Good Governance in NHS Scotland (2nd Edition) states that *'it is important that the Audit and Risk Committee adopt a robust approach to the oversight of the completion of actions identified in the audit reports. Where possible, actions should be dealt with in the current financial year rather than being carried forward from one financial year to the next. Any exceptions to this should be closely scrutinised by the Audit and Risk Committee who should seek assurance that the timeline proposed for addressing the risks or issues identified by the auditors is both reasonable and achievable'*.

1.4. We have interpreted this guidance as follows:

Actions should be implemented within 1 year of the recommendation having been made. This is calculated from the date the final report, including the recommendation, was issued.

2. FOLLOW-UP ON INTERNAL AUDIT REPORTS

Status Update Process

2.1. Internal Audit send a Status Update Request (SUR) Form (see Annex 1) to the Responsible Officer two weeks prior to the due date for the relevant actions requesting a response confirming, by no later than the due date, the completion or otherwise of the actions.

2.2. If the action is reported by the Responsible Officer as completed, appropriate evidence to demonstrate that the required action has been taken and has been effective must be provided to support this.

2.3. If the action is reported by the Responsible Officer as no longer relevant or superseded a valid reason supporting this status must be provided.

2.4. Internal Audit will highlight any responses which do not appear adequate to address the control weakness identified in the original report, or where the evidence does not fully support the conclusion drawn. In such situations further evidence will be requested from the Responsible Officer.

2.5. If the action is reported by the Responsible Officer as delayed, an extension to the original due date must be requested along with provision of a valid reason for the delay. The approval of extensions will be subject to consideration based on the context of the impact of risk as follows:

Finding/Recommendation Assessment of Risk	**1st Extension Approval**	**2nd Extension Approval**	**Subsequent Extension Approvals**
Merits Attention	Internal Audit	Executive Director	Director of Finance or CEO
Moderate	Executive Director	Director of Finance or CEO	
Significant	Director of Finance or CEO		
Fundamental	Director of Finance or CEO		

2.6. The agreement of the new target implementation date will always be subject to consideration as to whether it is reasonable and achievable. The expectation is that all recommendations will be addressed within 12 months of the final report issue date.

2.7. If approval of the proposed extended review date is not granted it is expected that the action will be addressed promptly.

Reminder Process

2.8. If no response is received from the Responsible Officer by the due date, Internal Audit will issue a reminder to the Responsible Officer.

2.9. Where significant inaction or no response is provided by a Responsible Officer, Internal Audit will discuss this initially with the relevant Director/Senior Manager. Where the matter remains unresolved, it will be escalated to the Director of Finance and Strategy and, ultimately, the Chief Executive.

Validation

2.10. All actions notified as completed are checked by Internal Audit to confirm that the evidence supplied is sufficient. Internal Audit will highlight any responses which do not appear adequate to address the control weakness identified in the original report, or, where the evidence does not fully support the conclusion drawn. In these situations further evidence will be requested from the Responsible Officer.

Monitoring

2.11. The Status Update Request Forms will be held as a complete record of the implementation of actions to address recommendations in Internal Audit reports. This includes:

- Reference of the recommendations arising from each Action Plan for reports that have actions remaining to be addresses
- Level of priority given to each recommendation (assessment of risk)
- Dates by which the actions are due to be completed
- Responsible Officer for each recommendation

- Suggested evidence required to allow action to be recorded as completed and validated
- Evidence of completion or updates on progress
- Details of requests for extensions to action by dates and their approval by the appropriate officer
- Validation assessment by Internal Audit.

Reporting

2.12. Internal Audit will be responsible for presenting regular reports on Audit Follow-Up to each Audit and Risk Committee. The report will detail the most recent position on progress in addressing remaining actions from internal audit reports, detailed action status by report, reasons for extensions granted, outstanding recommendations and internal audit validation. For extended actions a RAG status is recorded giving an indication of how much still needs to be done to fully address the recommendation to aid prioritisation (definitions of action status, recommendation priorities and RAG status are provided at Annex 2).

2.13. Following each Audit and Risk Committee meeting, the report will be presented to the Executive Directors Group. This is for consideration of any long outstanding responses, repeated extensions to due by dates, actions not completed, and those which did not fully address the identified control weakness, either because of the content or the accuracy of the response. The expectation being to have these actions addressed before the next Audit and Risk Committee meeting.

2.14. The information from Responsible Officers recorded within the appendices to the report are updates as provided by officers of NHS Fife. Internal Audit will validate updates **only** at the stated completion of an action.

3. FOLLOW-UP OF EXTERNAL AUDIT REPORTS

3.1. The follow up of External Audit reports remains the responsibility of the Director of Finance and Strategy. Audit Scotland reports are far fewer in number and generally speaking will identify a Director as being responsible for the action to be taken. Internal Audit will only review progress against external audit recommendations where relevant to internal audit fieldwork

3.2. All relevant reports are brought to the attention of the Executive Directors Group irrespective of whether or not there are specific action points to be addressed.

3.3. The management follow-up process is set out as below.

Management Follow-Up Process for all External Audit Report Action Plans
1 The Director of Finance and Strategy will present all Audit Scotland Reports to the Executive Directors Group.
2 The relevant Director will prepare an action plan for any specific points to be addressed. These will roll forward for each future meeting of the Executive Directors Group, at which progress and completion are due to be noted (twice yearly) until all outstanding actions are completed.
3 The Director of Finance and Strategy will present an annual update on progress to the Audit & Risk Committee in accordance with the Audit and Risk Committee's Workplan.

BARRY HUDSON

Regional Audit Manager

DATE OF ISSUE: August 2023

REVIEW DATE: March 2024

ANNEX 1

INTERNAL AUDIT FOLLOW UP SYSTEM – STATUS UPDATE REQUEST - B??/?? Assignment Title

Please indicate in the table below the status of the actions to address the indicated recommendations from report B??/?? Assignment Title which were assigned to you.

The suggested **evidence required** to allow actions to be recorded as completed and validated is recorded at **Appendix 1**.

If the action to address recommendation(s) has not been implemented by the agreed implementation date please state the reason for this and, if appropriate, request an **extension** to the implementation date on the **form at Appendix 2**.

The original wording, from the audit report, of the Findings, Recommendations and Management Responses related to these recommendations is included at **Appendix 3**.

B??/?? Assignment Title – Responsible Officer – Name – Job Title									
Ref.	**Original Action by Date**	**Pty**	**Brief Description *2**	**Status *1**	**Evidence of Completion/Progress Update (See appendix 1 for required evidence to be provided)**	**Validated (Yes/No)**	**Validated By**	**Validation Outcome Reason**	**Extension Requested ? *3**
1									
2									
3									

*1 Please record status as Completed (C), In Progress (IP), Not Started (NS), No Longer Applicable (NLA) or Superseded (S)

*2 Full Description is at Appendix 3 below

*3 Please record extension request details at Appendix 2

INTERNAL AUDIT FOLLOW UP SYSTEM – STATUS UPDATE REQUEST B??/?? Assignment Title APPENDIX 1

Evidence to be Provided to Show Completion

Ref.	Evidence Required	Evidence Obtained/Provided
1		
2		
3		

INTERNAL AUDIT FOLLOW UP SYSTEM – STATUS UPDATE REQUEST **B??/?? Assignment Title** **APPENDIX 2**

Extension Requests

As per the Follow-up Protocol the first extension request can be approved by Internal Audit, the second request by the relevant Executive Director and the third and any subsequent requests requiring the approval of the Director of Finance and Strategy or the Chief Executive.

Ref.	Original Action by Date	First Extension					Second Extension				
		Date Requested	Reason for Request	Proposed New Date	Approved by	Date Approved	Date Requested	Reason for Request	Proposed New Date	Approved by	Date Approved
1											
2											
3											

Ref.	Original Action by Date	Third Extension					Fourth Extension				
		Date Requested	Reason for Request	Proposed New Date	Approved by	Date Approved	Date Requested	Reason for Request	Proposed New Date	Approved by	Date Approved

INTERNAL AUDIT FOLLOW UP SYSTEM – STATUS UPDATE REQUEST **B??/?? Assignment Title** **APPENDIX 3**

Findings, Recommendations, Management Response

Ref.	Pty	Finding	Recommendation	Management Response
1				
2				
3				

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
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
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

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:	**31 August 2023**
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 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 quarter one (01/04/23 – 30/06/23).

2.2 Background

The Boards 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.

As per section 16 of the Financial Operating Procedures, any potential losses or special payments 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 Losses and Special payments for the quarter are compiled into a report with a format and 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 following consultation with the Director of Finance & Strategy.

2.3 Assessment

The attached appendix summarises the Boards losses and Special Payments for the period 01/04/23 – 30/06/23. 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 100 Losses and Special Payments in the quarter which is a significant decrease on the previous quarter (193). The cost in the first quarter also decreased in comparison to the fourth quarter of 2022/23 (£1,025,364 compared to £1,600.136) although it should be noted that the quarter four losses was the highest value reported position in 2022/23. This decrease was as a result of the reduction in value of the clinical ex-gratia compensation payments (£924,945 down from £1,411,873) and a further £116,538 of Year End Ledger Losses which were released in quarter four.

The Treasury team carried out their quarterly analytical review to provide additional assurance and the following items were noted:

1 – A higher than historical increase in losses of equipment (section 20C) which relates to the loss of a single piece (£4,100) of Clinical equipment at VHK.

2 - There was one Clinical ex gratia payment in excess of the delegated authority level, and this was notified to Scottish Government as per their requirement.

3 - Non-Clinical ex gratia payments increased in the quarter (£87,885 from £68,067) and this was a result of three payments which were above the 2022/23 average (£9,765).

4 – Compensation payments for Patients and Staff Financial Loss (Section 28) was higher than the 2022/23 average as a result of a claim at Stratheden (£746)

The above findings will be carried into the quarter two review to assist with the identification of any developing trends which may materially affect the Boards expected position at the end of 2023/24.

2.3.1 Quality/ Patient Care

The Losses and Special Payments require to be tightly controlled as they can have a material impact on the Boards financial position and ability to maintain budgets to ensure/enhance Patient Care.

2.3.2 Workforce

The procedural guidance for Managers to ensure the appropriate treatment for any losses or special payments is stated in the Financial Operating Procedures.

2.3.3 Financial

The Losses and Special Payments are included within the Boards Annual Accounts process, subject to external audit and submitted to the Scottish Government for oversight.

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 and Anchor Institution ambitions

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 Climate Emergency and Sustainability 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

This paper is brought to the members attention to give visibility of the Board's losses and special payments in the quarter to 30 June 2023.

2.4 Recommendation

- **Assurance**

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Summary of Losses and Special Payments 01/04/23 – 30/06/23

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'23		JUL'22 - JUN'23	
	Miscellaneous / Theft / Arson / Wilful Damage				
1	Cash			1	125
2	Stores/procurement				
3	Equipment			2	2416
4	Contracts				
5	Payroll *Salary Overpayment Debtors Invoices*			43	34441
6	Buildings & Fixtures *Vandalism*	15	1839	51	6422
7	Other			1	355
	Fraud, Embezzlement & other irregularities (incl. attempted fraud)				
8	Cash				
9	Stores/procurement				
10	Equipment				
11	Contracts				
12	Payroll				
13	Other				
14	**Nugatory & Fruitless Payments**			1	70728
	Claims Abandoned:				
15	(a) Private Accommodation				
	(b) Other *Hardship Accounts / Insurance Excess / Debtors WO's*	59	1202	442	19147
	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 Equipment*	9	7855	19	12266
21	Disclosed at physical check				
22	Other Causes				
	Compensation Payments - legal obligation				
23	Clinical				
24	Non-clinical				
	Ex-gratia payments:				
25	Extra-contractual Payments				
26	Compensation Payments - ex-gratia - Clinical	7	924945	43	4375447
27	Compensation Payments - ex-gratia - Non Clinical	4	87885	22	242778
28	Compensation Payments - ex-gratia - Financial Loss	6	1638	19	3636
29	Other Payments				
	Damage to Buildings and Fixtures:				
30	Incidents of the Service :				
	- Fire				
	- Flood				
	- Accident *Vehicle Expenditure*			2	521
	- Other Causes				
31	**Extra-Statutory & Extra-regulationary Payments**				
32	**Gifts in cash or kind**				
33	**Other Losses**				
		100	1025365	646	4768282

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**31 August 2023**
Title:	**Procurement, Waiver of Competitive Tenders Q1**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Kevin Booth, Head of Financial Services & Procurement**

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Government policy / directive
- Legal requirement

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

- Safe

2 Report summary

2.1 Situation

In order to allow the Audit & Risk Committee to take assurance that the Boards Procurement Function is operating within the legal requirements of the Scottish Government. This paper presents oversight of the Contract Awards over £50,000 in the period April 2023 – June 2023 that were subject to a waiver of competitive tender.

2.2 Background

As per the Guidance in the Public Contracts Scotland Act 2015. Any non-competitive award of a contract with an anticipated value of £50,000 or more (inclusive of vat) must have a Waiver of Competitive Tender completed prior to award and be signed off by both the Head of Procurement and then counter signed by both the Director of Finance & Strategy and the Chief Executive.

The Waiver of Competitive Tender confirms the restricted conditions which when in existence, the Board is permitted to award the contract without following the existing procurement journey route 2 as prescribed in the Act.

The restricted, permitted conditions (as per the Code of Corporate Governance, appendix 3 Standing Financial Instructions, section 9.11) which must be in existence are as follows:

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

Any other justification including the unavailability of time should not be considered without the prior agreement with the Scottish Government.

2.3 Assessment

During the period April 2023 – June 2023 the Procurement Team awarded three contracts of £50,000 or above. Of these contracts one was subject to a waiver of competitive tender and the justification is summarised as follows:

Endoscopy services for NHS Lothian patients, by The Aberdeen Clinic, for £1m.

The Scottish Government had previously made a request to NHSF to provide premises (QMH) over the weekends so that activity could be provided by an external supplier to reduce the backlog of long waiting Lothian Endoscopy patients. This arrangement had been in place since 2019 and funding is allocated to NHS Fife and orders and invoices are settled on a monthly basis.

The waiver of competitive tender to extend the contract with the Aberdeen Clinic was approved based on points 2, 3 and 5 of the criteria above. To provide continuity of specialist services with the current provider, where further competition via the national framework would not have been desirable, due to risk of time constraints with continuity of service provision and minimal or no financial benefits, for the final year of funding to provide the additional capacity to NHS Lothian patients. NHS Lothian were also content with the waiver approach to ensure continuity of patient care with the current provider.

2.3.1 Quality / Patient Care

A waiver of competitive tender will only ever be considered by the procurement department where all applicable information is provided to a high quality, allowing for an effective decision to be made.

2.3.2 Workforce

The current guidance for the application of a waiver of competitive tender is contained within the Financial Operating Procedures section 11(a) for staff to refer to when consideration is

required. The qualifying criteria contained mirrors that within the Boards Standing Financial Instructions.

2.3.3 Financial

As per the Public Contracts Scotland Act 2015 any procurement of £50,000 or above is subject to Procurement Journey Route 2 (or Route 3 if £138,760 or above), where a Tender would be posted through the Public Contracts Tender Portal. The implementation of the Tender Waiver negates the requirement for this process.

2.3.4 Risk Assessment / Management

The implementation of a Waiver of Competitive Tender needs to be robustly controlled to ensure the Board does not expose itself to challenge which could result in legally imposed financial penalties and reputational damage.

2.3.5 Equality and Diversity, including health inequalities and Anchor Institution ambitions

The governed application of the Waiver of Competitive Tender ensures applicable treatment of suppliers across the marketplace.

2.3.6 Climate Emergency & Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

The consideration of the application of a waiver of competitive tender is considered by the Senior Procurement Team following discussions with the order requisitioner before being approved if applicable by the Head of Procurement and then issued to the Director of Finance & Strategy and the Chief Executive for final sign off.

2.3.8 Route to the Meeting

The Procurement Governance Board monitors the Procurement KPI's which includes the number of Competitive Tender Waivers implemented.

2.4 Recommendation

- **Assurance** – Members are asked to take assurance that the Procurement process for the Waiver of Competitive Tenders was correctly applied in the period.

3 List of appendices

N/A

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

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**31 August 2023**
Title:	**Corporate Risk Register**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy, NHS Fife**
Report Author:	**Pauline Cumming, Risk Manager, NHS Fife**

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Annual Delivery Plan
- Emerging issue
- Local policy
- NHS Board / IJB Strategy or Direction / Plan for Fife

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This paper is brought to the Audit and Risk Committee in advance of reporting on the corporate risks to the governance committees in September 2023. It provides:

- an update of the current strategic risk profile since last reported to this Committee in June 2023;
- an overview of the updated Corporate Risk Register since last reported to this Committee in June 2023

The Committee is asked to note that the updated Register largely reflects implementation of the change to the corporate risk review cycle approved by the Committee on 23 June 2023, i.e. to carry out risk reviews every 4 months rather 2 monthly.

The Committee is invited to:

- Note the information provided;
- Consider the information against the Assurance Principles at Appendix 2;
- Conclude and comment on the assurance derived from the report

2.2 Background

The Corporate Risk Register aligns to our 4 strategic priorities. The format presents the corporate risks in a manner designed to prompt scrutiny and discussion around the level of assurance provided on the risks and their management, including the effectiveness of mitigations in terms of:

- relevance
- proportionality
- reliability
- sufficiency

2.3 Assessment

As previously reported, the overall strategic risk profile is unchanged:

- No risks have been closed.
- No new risks have been identified.
- 1 moderate level risk has reduced its current rating within risk level as follows:
  (Likelihood (L) x Consequence (C) from 12 (L- Likely 4 x C - Moderate - 3) to 9 (Possible - 3 x Moderate - 3)

NHS Fife Strategic Risk Profile

The current Strategic Risk Profile is provided below.

Strategic Priority	Total Risks	Current Strategic Risk Profile				Risk Movement	Risk Appetite
To improve health and wellbeing	5	2	3	-	-	▲	High
To improve the quality of health and care services	5	5	-	-	-	◀ ▶	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		

Summary Statement on Risk Profile

Current assessment indicates delivery against 3 of the 4 strategic priorities continues to face 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

Corporate Risk Register Summary

The updated Register is attached at Appendix 1. It contains 18 risks. The risk breakdown is unchanged -13 High level and 5 Moderate level.

The majority of risks remain outwith risk appetite, reflecting the current organisational context and the prevailing challenges across all areas of service delivery.

Following modification of the Risk Target component of the Register, all but one risk now has a discretionary target date. The exception is Risk 7 - Access to outpatient, diagnostic and treatment services. It is not possible to provide a definitive target date pertaining to the service delivery backlog, as the modelling has not been completed nationally, or locally, for some specialties.

Key Updates

Risk 2 - Health Inequalities
The Risk Owner advises there is no change to this risk, and that it has been agreed the risk will be considered at the Public Health and Wellbeing Committee in November 2023.

Risk 3 - COVID 19
This risk was reviewed by the Public Health Assurance Committee (PHAC) on 2 August 2023. It was agreed that the risk should be further lowered to Moderate 9 (Likelihood 3 x Consequence 3) in light of the continued effectiveness of vaccination and the reduced impact of illness in the population.

Next steps are to revisit the deep dive review carried out in March 2023. Based on that assessment, a decision will be taken through the appropriate governance routes to retain or close as a corporate risk.

The Committee is advised that there is recognition of a longer term risk around preparedness for future biological threats (including pandemics). This will require to be considered for inclusion in the Corporate Risk Register. A risk scoping exercise lead by a Consultant in Public Health has started. The risk will be presented In due course to EDG and the appropriate governance groups and committees for a decision.

Risk 7 - Access to outpatient, diagnostic and treatment services
The Committee is advised that in the ICE report B08/23, Internal Audit commented that the pre-existing risk description did not fully convey the gravity of the situation and recommended changing the risk wording from '***could***' in '*This time delay* ***could*** *impact clinical outcomes for the population of Fife*' to '***will***'.

The Risk Owner was asked to consider the suggested rewording and agreed to the change. This is reflected in Appendix 1.

Governance Committees and Aligned Corporate Risk Overview

Clinical Governance Committee

Strategic Priority	Overview of Risk Level				Risk Movement	Corporate Risks	Assessment Summary of Key Changes
To improve health and wellbeing	1	1	-	-	▲	• 3 - COVID 19 Pandemic • 5 - Optimal Clinical Outcomes	Risk 3 - COVID 19 Pandemic. Mitigations updated. Risk rating reduced within moderate level.
To improve the quality of health and care services	1	-	-	-	◀▶	• 9 - Quality and Safety	
To deliver value and sustainability	2	1	-	-	◀▶	• 16- Off Site Area Sterilisation and Disinfection Unit Service • 17- Cyber Resilience • 18 - Digital and Information	Mitigations updated and target date added for risk 16.

Public Health and Wellbeing Committee

Strategic Priority	Overview of Risk Level				Risk Movement	Corporate Risks	Assessment Summary of Key Changes
To improve health and wellbeing	1	2	-	-	◀▶	• 1 - Population Health and Wellbeing Strategy • 2 - Health Inequalities • 4 - Policy Obligations in Relation to Environmental Management and Climate Change	Risk 2- target date added Risk 4 -Mitigations updated and target date added.
To improve the quality of health and care services	1	-	-	-	◀▶	• 10 - Primary Care Services	

Staff Governance Committee

Strategic Priority	Overview of Risk Level				Risk Movement	Corporate Risks	Assessment Summary of Key Changes
To improve staff experience and wellbeing	2	-	-	-	◀▶	• 11 - Workforce Planning and Delivery • 12 - Staff Health and Wellbeing	Mitigations updated for both risks.

Finance, Performance and Resources Committee

Strategic Priority	Overview of Risk Level	Risk Movement	Corporate Risks	Assessment Summary of Key Changes
To improve the quality of health and care services	3 - - -	◀▶	• 6 - Whole System Capacity • 7 - Access to outpatient, diagnostic and treatment services • 8 - Cancer Waiting Times	Mitigations updated for Risks 7 and 15.
To deliver value and sustainability	2 1 - -	◀▶	• 13 - Delivery of a balanced in-year financial position • 14 - Delivery of recurring financial balance over the medium term • 15 - Prioritisation and Management of Capital Funding	

Deep Dive Reviews

To date, 12 of the 18 Corporate Risks have undergone a deep dive review. Additionally, 3 deep dives associated with the Workforce Planning & Delivery corporate risk have been carried out. The following reviews will be presented during the September 2023 governance committee cycle.

Risk Title	Aligned Committee
Policy Obligations in Relation to Environmental Management and Climate Change (corporate)	Public Health & Wellbeing (PH&WC)
Update on Deep Dive on the implementation of the Population Health & Wellbeing Strategy (corporate)	Public Health & Wellbeing (PH&WC)
Off Site Area Sterilisation and Disinfection Unit Service (corporate)	Clinical Governance (CGC)

Next Steps

Following the Committee's approval on 23 June 2023, the revised Assurance Levels model will continue to be embedded in the corporate risk papers and deep dive reviews, and progress monitored. Guidance is being developed to support implementation.

We will carefully monitor how the revised approach to periodic corporate risk review and reporting is received by the committees, and invite feedback in terms of the assurance taken, and further required actions.

2.3.1 Quality / Patient Care

Effective management of risks to quality and patient care will support delivery of our strategic priorities, to improve health and wellbeing and the quality of health and care services.

2.3.2 Workforce

Effective management of workforce risks will support delivery of our strategic priorities, to improve staff health and wellbeing, and the quality of health and care services.

2.3.3 Financial

Effective management of financial risks will support delivery of our strategic priorities including delivering value and sustainability.

2.3.4 Risk Assessment / Management

Subject of the paper.

2.3.5 Equality and Diversity, including health inequalities and Anchor Institution ambitions

An Equality Impact Assessment (Stage 1) was carried out to identify if any items of significance need to be highlighted to EDG. The outcome of that assessment concluded on Option 1: No further action required.

2.3.6 Climate Emergency & Sustainability Impact

This paper does not raise, directly, issues relating to climate emergency and sustainability. These items do form elements of risk for NHS Fife to manage.

2.3.7 Communication, involvement, engagement and consultation

This paper reflects engagement with Executive and Non - Executive Directors, and discussions within the Risks and Opportunities Group.

2.3.8 Route to the Meeting

- EDG on 17 August 2023
- Margo McGurk on 25 August 2023

2.4 Recommendation

- **Assurance**

3 List of appendices

The following appendices are included with this report:

- Appendix No. 1, NHS Fife Corporate Risk Register as at 17 August 2023
- Appendix No. 2, Assurance Principles

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

Updated NHS Fife Corporate Risk Register as at 17/08/23

No	Strategic Priority	Risk	Mitigation	Risk Appetite	Current Risk Level/ Rating	Target Risk level & rating by dd/mm/yy	Current 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.	The strategy was approved by the NHS Fife Board in March 2023. The focus now will be on developing and delivering against an agreed set of outcomes for 2023/24. This is in the context that the management of this specific risk will span a number of financial years. We are now preparing the 3-year Medium Term Plan which flows from our strategy for submission to Scottish Government in July 2023. An update on the deep dive review will be provided to the PHWC in Sept 2023.	Below	Mod 12	Mod12 by 31/03/24	◄►	Chief Executive	Public Health & Wellbeing (PHWC)
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. The Population Health and Wellbeing Strategy will identify actions which will contribute to reducing health inequalities; these will be set out in the delivery plan for the strategy. Consideration of Health Inequalities within all Board and Committee papers. Leadership and partnership working to influence policies to 'undo' the causes of health inequalities in Fife. Deep dive to be updated for the committee meeting in November 2023.	Within	High 20	Mod 10 by 31/03/24	◄►	Director of Public Health	Public Health & Wellbeing (PHWC)

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.	A range of indicators together provide an assessment that overall numbers of people affected by COVID19 in Scotland remain low. Treatments are available for individuals at higher risk of adverse outcomes. National surveillance continues and there are no variants currently under investigation. Tailored support continues to be provided to Care Homes with positive staff or resident cases. The Coronavirus (COVID 19) guidance for extended use of masks and face coverings across health and social care was withdrawn on 16th May. A deep dive was presented to CGC in March 2023 and will be updated in October 2023.	Below	Mod 9	Mod 12 by October 2023	▲ (Rating reduced within risk level)	Director of Public Health	Clinical Governance (CGC)
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 remain in place including an Executive Lead and a Board Champion. Regional working group and representation on the National Board ongoing. Active participation in Plan 4 Fife continues. The NHS Fife Climate Emergency Report and Action Plan have been developed. These form part of the Annual Delivery Plan (ADP). The Action Plan includes mechanics and timescales. The board report which was required by the end of January 2023, as per policy DL38, has been completed and	Below	Mod 12	Mod 10 by 01/04/2025	◄►	Director of Property & Asset Management	Public Health & Wellbeing (PHWC)

			published on the NHS Fife website, via EDG, and PHWC, and sent to Scottish Government (SG). Resource in the sustainability team has increased by 1 FTE via external funding for 12 months. A Head of Sustainability has been seconded from the Estates Service for at least 18 months to drive delivery of the Climate Emergency Action Plan.						
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.  A deep dive was presented to the CGC in May 2023. Following discussion, a Clinical Governance Committee Development Session on Optimal Clinical Outcomes is to be held to discuss this risk in more detail. A date for the session is to be identified.	Within	High 15	Mod 10 by 31/03/24	◄►	Medical Director	Clinical Governance (CGC)

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. 	Above	High 20	Mod 9 by 30/04/24	◄►	Director of Acute Services	Finance, Performance & Resources (F,P&RC)
7		**Access to outpatient, diagnostic and treatment services** There is a risk that due to demand exceeding capacity, compounded by unscheduled care pressures, NHS Fife will see deterioration in achieving waiting time standards. This time delay **will** impact clinical outcomes for the population of Fife.	Planning for 2023/24 has been completed in line with planning guidance letter received on 06/02/23. Confirmed funding 20% less than committed staff costs. Agreement by EDG to continue with original plan acknowledging the gap in funding. Planned capacity for OP is 96% and for IP/DC is 99% of that delivered in 2019/20. Reduction is due in the main to clinical staff vacancies. Demand for OP and IP Imaging both is increasing year on year. Capacity is not meeting current demand for OP/IP/DC or Diagnostics.	Above	High 20	It is still not possible to unable to provide a target risk and date given the uncertainty over level of funding	◄►	Director of Acute Services	Finance, Performance & Resources (F,P&RC)

			The Integrated Planned Care Programme Board is overseeing the productive opportunities work and this along with ongoing waiting list validation seeks to maximise available capacity. Speciality level plans in place outlining local actions to mitigate the most significant areas of risk. Focus remains on urgent and urgent suspicious of cancer patients however routine long waiting times will increase. The governance arrangements supporting this work will inform the level of risk associated with delivering against these key programmes and mitigate the level of risk over time. Discussions continue with Scottish Government around the need for additional funding to help reduce the waiting times for long waiting routine patients.						
8		**Cancer Waiting Times (CWT)** There is a risk that due to increasing patient referrals and complex cancer pathways, NHS Fife will see further deterioration of Cancer Waiting Times 62-day performance, and 31 day performance, resulting in poor patient experience, impact on clinical outcomes and failure to achieve the Cancer Waiting Times Standards.	The prostate project group continues with actions identified to improve steps in the pathway. The nurse-led model is being explored with an expected go live date of August 23. Actions to improve steps in the lung pathway have been agreed funding has been supported for implementation of the lung optimal pathway for 2023-24. The Effective Cancer Management Framework has been updated and actions have been identified for 2023-24. Steps are being taken to introduce the Effective Breach Analysis Standard Operating Procedure in to NHS Fife.	Above	High 15	Mod 12 by 30/04/24	◀▶	Director of Acute Services	Finance, Performance & Resources (F,P&RC)

			Work has commenced to take forward the Re-grading Framework which has now been published. An action plan will be developed based on the recommendations. Weekly meetings with Scottish Government (SG) and quarterly monitoring of the Effective Cancer Management Framework continue. A 6 month review of the Single Point of Contact Hub confirms there has been a reduction in DNAs. Further evaluation will be commenced June 2023. Patient and staff evaluation questionnaires have been sent out and an exercise to assess reduction in patient calls to CNS and feedback from staff users of the service. The Cancer Framework and delivery plan has been launched and priorities are currently being agreed for 2023-24. A deep dive into urology performance challenges is being undertaken. 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.						
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	Above	High 15	Mod 10 by 31/03/24	◄►	Medical Director	Clinical Governance (CGC)

			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. A deep dive review was presented to the CGC in July 2023. This resulted in an agreement to review the risk scores given that several actions had been completed reducing the risk likelihood. The review of the risk scores is work in progress.						
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 services to the population of Fife into the medium-term.	A Primary Care Governance and Strategy Oversight Group is in place. The group, co-chaired by the Medical Director and the Director of Health and Social Care, brings together both the transformation and sustainability initiatives for all four of the independent primary care contractors, whilst also overseeing any critical aspects of governance. It provides assurance to NHS Fife Board and the Integration Joint Board (IJB) through the appropriate sub committees. This group allows governance and scrutiny of all aspects of primary care delivery and provides a focus for improving patient care for the population of Fife. A Primary Care Strategy is in development and is at final draft stage; it was presented to commissioners for discussion and support in February 2023 and will be taken through committees for approval by July 2023. A Primary Care Improvement Plan (PCIP) is in place; subject to regular monitoring and reporting to General	Above	High 16	Mod 12 (3 x4) by 31/03/24	◀▶	Director of Health & Social Care	Public Health & Wellbeing (PHWC)

			Medical Services (GMS) Board, Quality & Communities (Q&C) Committee, IJB and Scottish Government. A workshop took place in January 2023 to review and refresh the current PCIP to ensure it is contemporary and based on current position and known risks to ensure a realistic and feasible PCIP. The refreshed PCIP for 23/24 will be progressed via committees for approval in July 2023. This refreshed PCIP will take into account the further guidance from SG and BMA received in April. The progress with the current programme will continue. Remodelling and recruitment of workforce action plan resulting from earlier Committee report will be completed as part of the refreshed PCIP A review of models of care incorporating the learning from the pandemic is closed. The review of leadership, management and governance structure which has been jointly commissioned by Deputy Medical Director (DMD) and Head of Service (HOS) for P&PC will be completed by July 2023. Pharmacotherapy and CTAC models for care continue to be shaped and developed. The anticipated date for completion is April 2024. A deep dive review was completed and presented to the PHWC meeting in May 2023.						
11		**Workforce Planning and Delivery**	Continued development of the workforce elements of the Annual	Above	High 16	Mod 8 by	◀ ▶	Director of Workforce	Staff Governance

		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.	Delivery Plan, Population Health & Wellbeing Strategy and Strategic Framework; alongside the Workforce Plan for 2022 to 2025 and aligned service based workforce plans. Implementation of the Health & Social Care Workforce Strategy and Plan for 2022 to 2025 to support the Health & Social Care Strategic Plan for 2023 to 2026 and the integration agenda. 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. Harvesting and analysis of SPRA data is underway, so that Directorate and Service based workforce plans can be completed by the end of Quarter 2 of 2023/2024, allowing mapping of Corporate priorities to the SPRA submissions, identifying impacts on the future shape of the staffing complement, and highlight any sustainability pressures. An update on NHS Fife Workforce Planning actions and serviced based workforce plans will be provided at the September 2023 Staff Governance Committee, alongside an update on the HSCP Year 2 Action Plan. Progression of Bank and Agency Programme of Work and Nursing & Midwifery Workforce actions to improve workforce sustainability. A successful mass recruitment event held on 1 June 2023, to support workforce sustainability, attracted over 350 applicants, with over 100 offers of			31/03/25			(SGC)

			employment made to date. Candidates are currently undergoing pre employment checks with start dates being confirmed and allocated to services based on priority of need and skills mixed required. Commencement of local guidance chapter testing to support the implementation of the Health and Care Staffing Act (2019) within NHS Fife. Local HCSA Reference Group well established, with multi disciplinary, Board wide representation informing preparatory work for Act implementation in April 2024.						

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 health and wellbeing opportunities are maximised, to support attraction, development and retention of staff. The Staff Health & Wellbeing Framework for 2022 to 2025, setting out NHS Fife's ambitions, approaches and commitments to staff health and wellbeing, was published in December 2022. Consideration of staff support priorities for 2022-2025 being progressed via Staff Health & Wellbeing Group and other for a, to develop complementary Action Plan. Work progressing on promoting Attendance improvement actions to support reductions in staff absence and wellbeing.	Above	High 16	Mod 8 by 31/03/25	◀▶	Director of Workforce	Staff Governance (SGC)
13		**Delivery of a balanced in-year financial position** There is a risk that due to the ongoing impact of the pandemic combined with the very challenging financial context both locally and nationally, the Board will not achieve its statutory financial revenue budget target in 2023/24 without brokerage from Scottish Government.	Agreed focus on 3 main areas of cost improvement as part of the medium-term financial plan. FIS Programme focus will be on these areas with regular reporting to the EDG& NHS Fife Board. Good progress being made to develop the detailed plans to deliver against the 3 focus areas. Detailed scrutiny locally on delivery planned on receipt of the Q1 results.	Above	High 16	Mod 12 by 31/03/24	◀▶	Director of Finance & Strategy	Finance, Performance & Resources (F,P&RC)
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	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.	Above	High 16	Mod 12 by 31/03/24	◀▶	Director of Finance & Strategy	Finance, Performance & Resources (F,P&RC)

		financial balance over the medium-term.	The Board will maintain its focus on reaching the full National Resource Allocation (NRAC) allocation over the medium- term. Scottish Government have received and supported our 5-year medium-term financial plan which includes significant cost savings across all 5 years, ongoing brokerage and commencement of repayment in the latter years of the plan.						
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. Annual Property and Asset Management Strategy (PAMS) report submitted to F, P&R, NHS Board and Government. A further iteration will be presented to the Board in September 2023. Fife Capital Investment Group (FCIG) reviewed the 2022/23 position which showed full utilisation of significant capital allocation and agreed initial allocations for 2023/24 with agreement of all stakeholders.	Within	Mod 12	Mod 8 (by 01/04/26 at next SG funding review)	◄►	Director of Property & Asset Management	Finance, Performance & Resources (F,P&RC)
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 continues through the NHS Fife Decontamination Group. Establishment of local SSD for robotics is progressing. Health Facilities Scotland (HFS) have agreed the design and the unit at St Andrews Community Hospital (SACH) should be operational by December 2023. An option appraisal for delivery of the	Within	Mod 12	Low 6 (by 01/04/2026 at next SG funding review)	◄►	Director of Property & Asset Management	Clinical Governance (CGC)

			service is being explored. A Deep Dive review on this risk will be presented to the CGC on 08/09/23.						
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 integrity of digital and information required to operate a full health service.	Considerable focus continues in 2023 with heightened threat level to improve our resilience to attack and ability to recover quickly. The primary mechanism for prioritising items is the response to the Network Information Systems Directive (NISD) review report May 2022. Next audit due July 2023.	Above	High 16	Mod12 (4x3) by Sept 2024	◄►	Medical Director	Clinical Governance (CGC)
18		**Digital & Information** There is a risk that the organisation maybe unable to sustain the financial investment necessary to deliver its D&I Strategy and as a result this will affect our ability to enable transformation across Health and Social Care and adversely impact on the availability of systems that support clinical services, in their treatment and management of patients.	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.	Above	High 15	Mod 8 (4x2) by April 2025	◄►	Medical Director	Clinical Governance (CGC)

Risk Movement Key

▲ Improved - Risk Decreased
◄► No Change
▼ Deteriorated - Risk Increased

Assurance Principles

Risk Assurance Principles:

Board

- Ensuring efficient, effective and accountable governance

Standing Committees of the Board

- Detailed scrutiny
- Providing assurance to Board
- Escalating key issues to the Board

Committee Agenda

- Agenda Items should relate to risk (where relevant)

Seek Assurance of Effectiveness of Risk Mitigation

- Relevance
- Proportionality
- Reliable
- Sufficient

Chairs Assurance Report

- Consider issues for disclosure
- Emergent risks or → Escalation / Recording
- Scrutiny or risk delegated to Committee

Year End Report

- Highlight change in movement of risks aligned to the Committee, including areas where there is no change
- Conclude on assurance of mitigation of risks
- Consider relevant reports for the workplan in the year ahead related to risks and concerns

General Questions:

- Does the risk description fully explain the nature and impact of the risk?
- Do the current controls match the stated risk?
- How weak or strong are the controls? Ae they both well-designed and effective i.e., implemented properly?
- Will further actions bring the risk down to the planned/target level?
- Does the assurance you receive tell you how controls are performing?
- Are we investing in areas of high risk instead of those that are already well-controlled?
- Do Committee papers identify risk clearly and explicitly link the strategic priorities and objectives/corporate risk?

Specific Questions when analysing a risk delegated to the committee in detail:

- History of the risk (when was it opened) – has it moved towards target at any point?
- Is there a valid reason given for the current score?
- Is the target score:
  - In line with the organisation's defined risk appetite?
  - Realistic/achievable or does the risk require to be tolerated at a higher level?
  - Sensible/worthwhile?
- Is there an appropriate split between:
  - Controls – processes already in place which take the score down from its initial/inherent position to where it is now?
  - Actions – planned initiatives which should take it from its current to target?
  - Assurances – which monitor the application of controls/actions?
- Assessing Controls
  - Are the controls "Key" i.e., are they what actually reduces the risk to its current level (not an extensive list of processes which happen but don't actually have any substantive impact)?
  - Overall, do the controls look as if they are applying the level of risk mitigation stated?
  - Is their adequacy assessed by the risk owner? If so, is it reasonable based on the evidence provided?
- Assessing Actions – as controls but accepting that there is necessarily more uncertainty
  - Are they on track to be delivered?
  - Are the actions achievable or does the necessary investment outweigh the benefit of reducing the risk?
  - Are they likely to be sufficient to bring the risk down to the target score?
- Assess Assurances:
  - Do they actually relate to the listed controls and actions (surprisingly often they don't)?
  - Do they provide relevant, reliable and sufficient evidence either individually or in composite?
  - Do the assurance sources listed actually provide a conclusion on whether:
    - the control is working
    - action is being implemented
    - the risk is being mitigated effectively overall (e.g. performance reports look at the overall objective which is separate from assurances over individual controls) and is on course to achieve the target level
  - What level of assurance can be given or can be concluded and how does this compare to the required level of defence (commensurate with the nature or scale of the risk):
    - 1st line – management/performance/data trends?
    - 2nd line – oversight / compliance / audits?
    - 3rd line – internal audit and/or external audit reports/external assessments?

Level of Assurance:

Substantial Assurance	Reasonable Assurance	Limited Assurance	No Assurance
			

Document developed from diagram produced by NHS Lanarkshire based on principles compiled by the Assurance Mapping Group of members of Boards covered by the FTF Internal Audit Service, 2022

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**31 August 2023**
Title:	**Risk Management Framework Update**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Report Author:	**Pauline Cumming, Risk Manager**

1 Purpose

This is presented for:

- Assurance
- Endorsement

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 extant NHS Risk Management Framework 2020, and the complementary Risk Register / Risk Assessment Policy GP/R7 (hereafter to be referred to as the Framework and Policy), require to be updated to reflect the changes made to the Board's risk management arrangements since 2022. A draft of the updated Framework is provided at Appendix 1.

2.2 Background

A key deliverable of the risk management improvement programme agreed in 2022, was to update the Framework and the Policy. It was also recognised that the update should incorporate details of the updated risk management arrangements between NHS Fife and Fife Integration Joint Board (IJB), and particularly the responsibilities of all parties.

2.3 Assessment

The updated Framework reaffirms the Board's commitment to embed an effective risk management framework and culture to support the achievement of the strategic priorities,

and the ambitions of the Population Health and Wellbeing Strategy. The update reflects the following developments:

- the Board Risk Appetite and Statement have been reviewed and updated
- a Risks & Opportunities Group has been established
- a Strategic Risk Profile set in the context of the strategic priorities was agreed
- a risk dashboard has been introduced to the IPQR
- a refreshed Corporate Risk Register replaced the Board Assurance Framework
- the approach to assurance reporting has evolved to include:
  - agreement on 'levels of assurance'
  - the formal introduction of a set of Assurance Principles as part of the Corporate Risk Register papers provided to Committees which include the 'levels of assurance'
  - deep dives commissioned on selected corporate risks and scheduled on the work plans of the governance committee to which the risks are aligned

A delivery plan is being developed to support Framework implementation.

Work is underway to update the Policy which will contain the more detailed operational arrangements to support delivery of the Framework. The updated Policy will be taken forward through the process for General Policy approval.

2.3.1 Quality/ Patient Care

Effective risk management will support the achievement of the quality ambitions of safe, effective, person centred care.

2.3.2 Workforce

All staff in the organisation have a responsibility for identifying risk. They will be supported to do so through education and training relevant to their role and responsibilities.

2.3.3 Financial

There are no direct financial implications linked to this paper.

2.3.4 Risk Assessment / Management

The report summarises progress to update key risk management documents.

2.3.5 Equality and Diversity, including health inequalities

An Equality and Diversity (E&D) assessment has not been conducted but there are not considered to be direct E&D implications associated with this paper.

2.3.6 Other impact

None identified.

2.3.7 Communication, involvement, engagement and consultation

Engagement on the components which form the updated Framework, has included the Associate Director of Quality & Clinical Governance, the Associate Director of Digital &

Information, the Director of Finance and Strategy, EDG, the Risks and Opportunities Group, and through discussion within the committees of the Board.

2.3.8 Route to the Meeting

Margo McGurk**,** Director of Finance and Strategy on 25 August 2023

2.4 Recommendation

- the Committee is asked to take **assurance** from and **endorse** the updated Framework for Board approval.

3 List of appendices

Appendix No.1, Draft Risk Management Framework 2023 - 2025

Report Contact
Author Name: Pauline Cumming
Author's Job Title: Risk Manager, NHS Fife
Email Pauline.Cumming@nhs.scot

Risk Management Framework

2023 – 2025

DRAFT

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Published 2023

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1. Executive Introduction

The delivery of healthcare is complex and we operate in a context that inevitably requires the daily management of emerging and inherent risk. It is not always possible or necessary to eliminate all risks. There are occasions where we need to tolerate or take risks in order to develop and improve our care and services and the environment in which we work.

This Framework sets out our ambition, to create a culture which supports each of us, whatever our role, to manage risk in our daily work. In this way, Risk Management is Everyone's Business.

Carol Potter
Chief Executive NHS Fife

DRAFT

2. Purpose

2.1 The purpose of this Risk Management Framework is to promote awareness of risk, and set out the approach, objectives and responsibilities for risk management in NHS Fife.

2.2 The Framework affirms our commitment to risk management and to integrating this more fully within the culture, practice, and values of the organisation. It is supported by a Risk Register/ Risk Assessment Policy which outlines the associated operational arrangements.

2.3 The Framework has been developed in the context of recovering from the impact of the global pandemic on our communities, staff, patients, and partners and as we consider how to redesign services fit for the future.

2.4 The Framework is aligned to the Population Health and Wellbeing Strategy 2023-28 and delivery against the four strategic priorities set out in Figure 1 below.

Figure 1

2.5 Framework Review

The Framework and the Board risk management arrangements will be reviewed every 2 years, with an update provided to the Audit and Risk Committee and the Board. This will ensure that the core framework remains current, reflects local and national developments and priorities, and drives continuous improvement in risk management across the Board.

2.6 What is Risk?

A risk is an 'uncertain future event', (or set of events), which, should it occur, will have an effect on the organisation's ability to achieve its objectives. (The Orange Book, 2023). An effect is a deviation from the expected. It can be positive, negative or both, and can address, create or result in opportunities and threats (ISO, 31000, 2018).

2.7 What is Risk Management?

Risk Management is the co-ordinated activities designed and operated to respond to and manage risk and exercise internal control within an organisation (The Orange Book, 2023). It is a continuous and evolving process which aims to reduce risk to organisations.

2.8 Why is Risk Management Important?

Effective risk management can help to:

- Ensure that decision making is informed and risk-based, to maximise the likelihood of achieving key strategic objectives and effective prioritisation of resources
- Ensure compliance with legislation, regulations, and other mandatory obligations
- Provide assurance to internal and external governance bodies that risks are being effectively controlled
- Prevent injury and / or harm, damage and losses
- Support organisational resilience
- Protect the assets and reputation of the organisation
- Achieve effective and efficient processes throughout the organisation
- Anticipate and respond to changing political, environmental, social, technology and legislative requirements and / or opportunities

2.9 Risk Management - Everyone's Business

It is important that all staff are involved in managing risk, regardless of their role and where they work. Examples of how each of us can manage risk are set out in Figure 2 below.

Figure 2

3. Framework Overview

Our approach to risk management is summarised below.

Objectives 	• The safety of patients, staff and others coming into our services is protected • Risks to the delivery of our strategic priorities and organisational objectives are identified and mitigated through proactive action planning. • Risk management supports organisational change and service development when considering opportunities and risks to improve services. • A proactive approach to risk management as an effective mechanism for managing risks through effective action plans. • Board organisational risk appetite will be agreed and communicated annually.
Enablers 	• Ensure visibility of the organisation's risk profile, to enable effective and informed decision making. • Ensure a structured and consistent approach to managing risk from ward to board. • The Datix system facilitates the consistent recording, management and escalation of risk, across the organisation. • Clear systems and processes will be in place for the escalation or risks. • Effective risk management will be used to support decision making, planning and performance arrangements, by providing appropriate information for assurance to the respective management and governance structures. • Risks will be aligned as appropriate to groups and governance committees and will feature routinely on agendas. The Risk Management Team will: • Provide organisational support to ensure effective risk management practice. • Deliver training, education and development to support staff to fulfil their roles & responsibilities in relation the risk management.
Our Values 	• We will deliver our risk management responsibilities within the context of our core values of; Care and Compassion, Dignity and Respect, Openness, Honesty and Responsibility, Quality and Teamwork.
Assurance and Strategic Oversight 	• The Board will set an effective risk management culture. • The Director of Finance and Strategy will provide executive leadership for risk management arrangements on behalf of the Chief Executive. • The Executive Directors will deliver their responsibilities for ensuring effective risk management through active engagement in the process and reporting through the governance committees and NHS Fife Board. • Governance Committees will deliver their responsibilities in relation to effective scrutiny of risk management in their areas of focus. • The Audit and Risk Committee (A&RC) will support the Board by, reviewing and advising on the effectiveness of the risk identification, management and reporting processes.

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4. Scope

4.1 This Framework applies to the management of risks, including clinical, environmental, financial, staff health and wellbeing across all areas of NHS Fife service provision.

5. Strategic Context

5.1 The diagram below summarises:

- The national documents which influence our approach to risk management;
- NHS Fife strategies with which this Framework and its delivery must align; and
- Local policies and procedures which align to the Framework.

National Policy & Strategy	Board Strategy, Codes & Plans	Policy & Procedures
• Health & Safety at Work etc Act 1974 • NHS Quality Improvement Scotland National standards: Clinical Governance and Risk Management: Oct 2005 • The Reporting of Injuries Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995 (as amended 2013) • Scottish Government (SG) The Healthcare Quality Strategy for Scotland, May 2010 • Scottish Capital Investment Manual, 2017 • SG Audit & Assurance Handbook, 2018 • NHS Scotland Blueprint for Good Governance DL 2022) 02 • HIS Learning from Adverse Events through Reporting and Review: A National Framework for NHS Scotland, Dec 2019, 4th edition • NHS Scotland Whistleblowing Standards, April 2021 • NHS Recovery Plan 2021-2026 • National Workforce Strategy for Health and Social Care in Scotland(2022) • SG Delivering Value Based Health & Care - A Vision For Scotland Realistic Medicine, Dec 2022 • NHS Scotland Climate Emergency and Sustainability Strategy, 2022-26	• NHS Fife Population Health and Wellbeing Strategy 2023-28 • NHS Fife Medium-Term Financial Plan 2023-26 • NHS Fife Property and Assets Strategy 2023-26 • NHS Digital and Information Strategy 2019-2024 • NHS Clinical Governance Strategic Framework 2022-2025 • NHS Fife Workforce Plan 2022-2025 • NHS Fife Greenspace Strategy 2023 • NHS Fife Code of Corporate Governance • NHS Fife Annual Delivery Plans • Fife Integration Joint Board Risk Management Policy and Strategy 2023 • Plan for Fife 2017-2027	• NHS Fife Complaints Handling Procedure, 2021 • NHS Fife Corporate Business Continuity Policy, May 2021 • NHS Fife Data Protection & Confidentiality Policy GP/I5 • NHS Fife Health & Safety Policy GP/H1, 2022 • NHS Fife Infection Control Policy, GP/18, 2022 • NHS Fife Risk Register/ Risk Assessment Policy GP/R7 being updated • NHS Fife Safe &Secure use of Medicines Policy & Procedure V10, April 2023 • NHS Fife Adverse Events Policy GP/I9, 2023 • Fife Council Risk Management Policy and Strategy ,2023

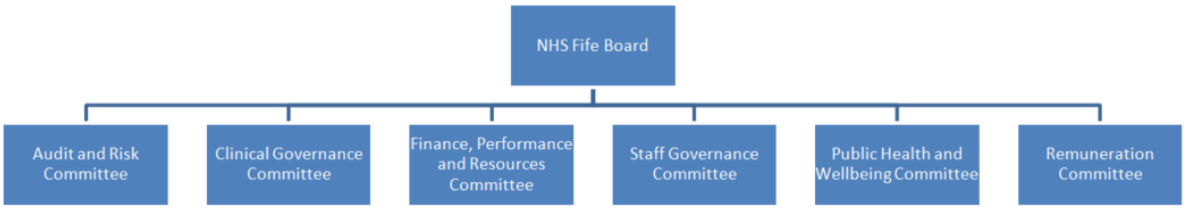
6. Governance Structures

6.1 This section sets out the oversight, assurance and monitoring from the point of service delivery to NHS Fife Board.

6.2 Fife NHS Board is responsible for the management of risk in NHS Fife. There are a number of structures below the Board which have responsibility to assess and monitor the risk management systems and processes and initiate action and improvements when required.

6.3 The Corporate Governance Structure within NHS Fife includes the NHS Fife Audit and Risk Committee (ARC), a key governance committee of the Board as set out in Figure 3 below.

Figure 3 NHS Fife Governance Structure



6.4 The ARC's responsibility is to provide the Board with assurance on the effectiveness of risk management arrangements and confirm that a sound system of internal control is maintained.

6.5 Operationally, the Executive Directors' Group (EDG) acts as a point of escalation for risk management related matters as required through the internal management structure.

6.6 The Chief Executive, as Accountable Officer of NHS Fife, and the Director of Finance & Strategy hold various professional responsibilities for ensuring effective organisational risk management arrangements. EDG is the forum for broader discussion and decision-making, in relation to risks to the delivery of the Board's strategic priorities and key operational, clinical and performance issues, and is a key conduit for overall assurance reporting to the standing committees and the Board.

6.7 A Risks and Opportunities Group (ROG) has been created which has delegated responsibility from the EDG to progress the activities required to support and embed an effective risk management framework and culture through NHS Fife. The ROG will periodically report to EDG and the ARC, making recommendations, providing considerations, or in the form of escalation if required as part of its role and remit. The Group's Terms of Reference are set out in Appendix 1.

6.8 The purpose of the ARC and linkages to the Framework are summarised below:

	Purpose	Where this framework aligns with the ARC role in relation to risk management
1	The main objective of the Audit and Risk Committee is to support the Accountable Officer and Fife NHS Board in meeting their assurance needs.	Supporting the Chief Executive/Accountable Officer and Fife NHS Board formulate their assurance needs, through the implementation of a well-designed assurance framework, with regard to risk management, governance and internal control. The committee reviews and approves the Internal Audit Strategic and Annual Plans having assessed their appropriateness to give reasonable assurance on the whole of risk control and governance. The committee work plan is designed to capture key planning for audit and risk activity with reports scheduled.
2	Review and challenge constructively the assurances that have been provided as to whether their scope meets the needs of the Accountable Officer and Fife Health Board; Review the reliability and integrity of those assurances including the evidence base.	• Promote Committee Assurance Principles. • Propose or endorse modifications to risk management processes to embed the Principles and enhance assurance lines.

3	Draw attention to weaknesses in systems of risk management, governance and internal control, and making suggestions as to how those weaknesses can be addressed.	• Consider strengths and areas of weakness highlighted in internal audit reports including Internal Controls Evaluation (ICE). • Review the effectiveness of risk management arrangements including risk identification and mitigation. • Consider risk management KPI data presented for assurance.
4	The Committee is charged with ensuring that there is an appropriate publicised Risk Management Framework with all roles identified and fulfilled.	The Framework: • Promotes a positive risk management culture where risk is everyone's business. • Describes enablers to effective risk management. **Sets out -** • the approach to managing risk • governance structures and terms of reference • risk management roles and responsibilities • risk appetite and how this is applied • an overview of risk management activities and how these support an effective system of risk management.
5	To discharge its advisory role to the Board and Chief Executive/Accountable Officer, and to inform its assessment on the effectiveness of corporate governance, internal control and risk management, the Committee shall: • seek assurance on the overall system of risk management for all risks and risks pertinent to its core functions; including the adequacy & effectiveness of the Corporate Risk Register, in terms of coverage of key risks to the Board, identification of gaps in control and assurance and the impact of changes to the risk register on the assurance needs of the Board and the Accountable Officer.	A Corporate Risk Register is in place The risks are: • mapped to the strategic priorities • aligned to governance committees for scrutiny and assurance • regularly reviewed • reported bi-monthly to the committees • considered at EDG & Risks & Opportunities Group • subjected to assessment against the Assurance Principles to determine the level of assurance provided • an annual risk management report will be assessed to confirm if there have been adequate and effective risk management arrangements throughout the year.
6	To escalate any issues of concern to the NHS Fife Board.	The Agenda contains' Items for Escalation' by the Committee Chairperson.

6.9 Partnership Working: Integration Framework and Services Delegated to the Integration Joint Board

To ensure there is clarity around governance, it is important that this framework sets out the risk management arrangements for services which are delegated to the Integration Joint Board (IJB).

The IJB Risk Management Strategy and Policy, 2023 sets out details of the risk management approach and vision, how the strategy will be implemented and expectations in relation risk leadership and accountability, resourcing risk management training, learning and development, monitoring and reporting and communication.

Management of operational clinical risks associated with services delegated to the IJB rests with NHS Fife Board. The systems and processes through the stated governance structure support effective management and mitigation of these risks. Risks with the potential to impact more than one partner will be identified for inclusion in one or more of the following risk registers: NHS Fife Corporate Risk Register; IJB Strategic Risk Register.

Any such emerging operational risks should be submitted to the NHS Fife Executive Directors' Group for consideration and decision on action and/or addition to the NHS Fife Corporate Risk Register. Any potential IJB Strategic Risks will be considered through the IJB Governance routes via the IJB Chief Officer.

As a partner body of the IJB, NHS Fife will continue to operate appropriate risk management processes for operational risk. The NHS Board Chief Executive will ensure that processes are in place to alert the IJB Chief Officer to any strategic or operational risks which are likely to impact on the delivery of the IJB's Strategic Plan.

As a partner body of the IJB, NHS Fife will provide formal assurance to the IJB on the operation of its risk management arrangements and of the adequacy and effectiveness of key controls which could impact on the achievement of IJB objectives. The IJB will provide reciprocal assurance, including to other IJBs in their capacity as being responsible for hosted services, on its risk management processes and key controls.

NHS Fife risk management staff will participate in meetings as necessary to consider the implications of risks and provide relevant advice. Additionally, the Board will routinely seek to identify any residual risks and liabilities that it retains in relation to the activities under the direction of the IJB.

7. Risk Management Approach

7.1 This section sets out the key components of our approach to risk management:

- Risk Process
- Risk Definitions
- Risk Registers
- Risk Escalation
- Risk Appetite

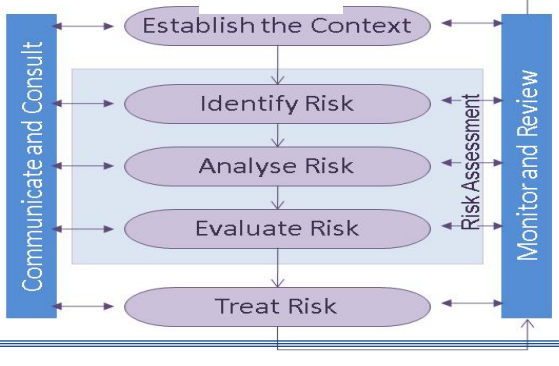
7.2 The NHS Fife methodology for achieving the objectives set out in section 3 above, is detailed in the NHS Fife Risk Register/ Risk Assessment Policy.

7.3 Risk Process

Risk management is a dynamic process. The steps to identifying and responding to risks are summarised in Figure 4 (Australia/New Zealand Risk Management Standard, AS/NZS 4360:2004).

NHS Fife will embed good risk management practice by promoting the consistent application of this process across all areas. Further details and guidance to support implementation of the Framework are provided in the Risk Register/ Risk Assessment Policy.

Figure 4



To support the assessment process, NHS Fife uses a 5x5 risk scoring matrix. This identifies a score between 1 (1x1) and 25 (5x5). The matrix is provided at Appendix 3. Guidance to support implementation is provided in the Risk Register/ Risk Assessment Policy.

7.4 Definitions

Corporate risk- A corporate risk can be defined as something which can either affect, or be created by, our decisions about strategy. For example, internal and external events that may make it challenging for the organisation to achieve its objectives **i.e.** poses a threat to our ability to deliver the Population Health and Wellbeing Strategy. In NHS Fife, these risks are mapped to one of the four strategic priorities.

Operational risk - An operational risk is one which may impact on our internal day-to-day business. These are managed by the Executive Directors and their teams and escalated as necessary**.** These often present due to flawed or failed processes, policies, systems or events that disrupt operational delivery of services.

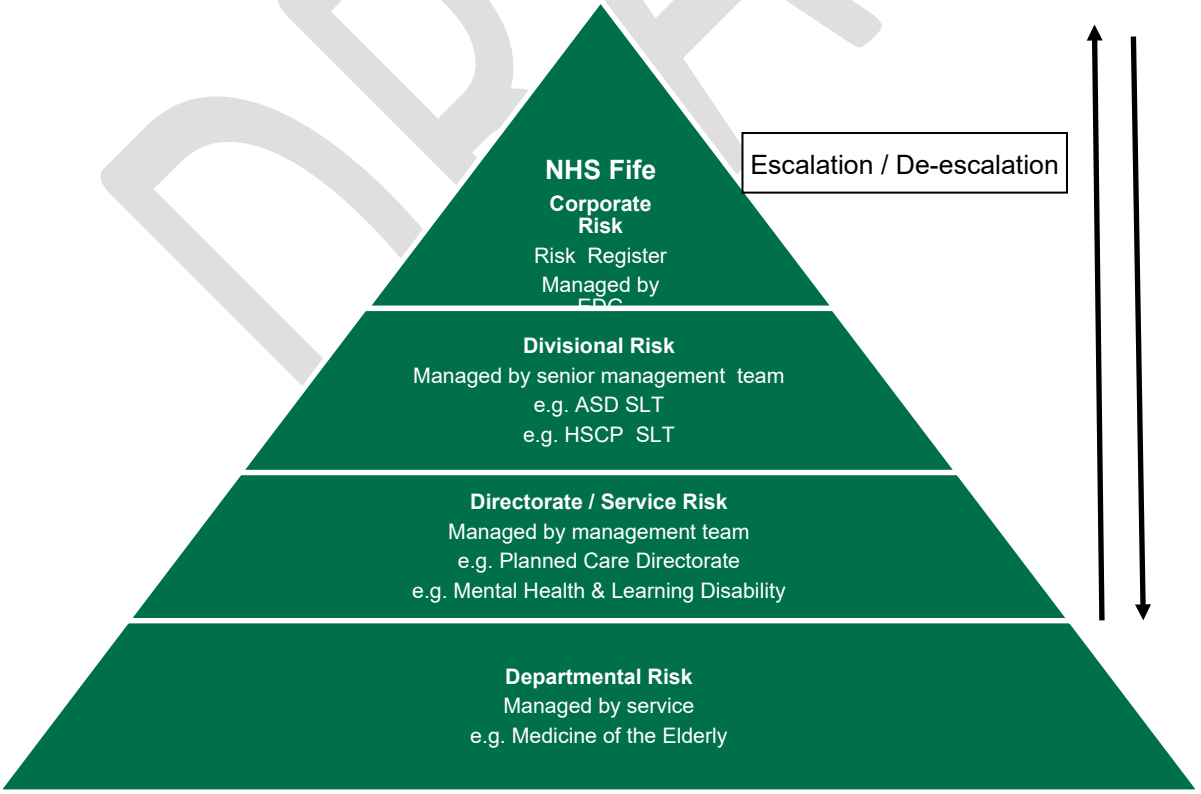
Risks are captured on risk registers. The repository for risks in NHS Fife is the Datix Risk Register module.

7.5 Risk Registers

A risk register is an information repository created by an organisation to record its risks and responses. It is a management tool intended to help managers achieve their objectives. It should drive and provide evidence of risk management activities and act as a means or source for risk reporting. Risk registers must be maintained and reviewed to ensure they are up to date and effective.

Risk registers exist at different levels across the organisation

Risk Register Hierarchy



Acute Services Division (ASD)

Executive Directors' Group (EDG)

Health & Social Care Partnership (HSCP)

Senior Leadership Team (SLT)

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7.6 Risk Escalation

Risk escalation is a process that ensures risks that cannot be managed by a local team, department or specialty are escalated appropriately. To ensure that these risks are managed effectively, they must be escalated in a timely way to the appropriate level in the organisation and to external stakeholders where necessary. If you identify a risk that you think may require escalation, raise this first with your line manager to allow them to decide on the appropriate action having considered factors including:

- the risk likelihood and consequence scores
- the effectiveness or otherwise of current management actions / mitigations
- the threat presented by the risk e.g. to organisational objectives / national standards
- who needs to be made aware

The risk score and organisational risk appetite should be key considerations when considering recommending risks for escalation. The escalation process is set out in the Risk Register/Risk Assessment Policy.

7.7 Risk Appetite

Simply put, risk appetite is the amount of risk the Board is willing to take or tolerate in the pursuit of its objectives. It underpins effective risk management and should reflect our functions, purposes and be balanced against our ambition.

Risk Appetite in Practice:

- supports a consistent approach to risk across an organisation and ensures that we are operating within acceptable limits
- informs decision making - ensures resources are not spent on further reducing risks already at an acceptable level
- allows prioritisation
- removes subjectivity
- innovation vs status quo - risks vs opportunity

Risk appetite is not static; it varies depending on internal and external circumstances and so should be reviewed at least annually. The Board sets the Risk Appetite and captures this in a Risk Appetite Statement.

Risk Appetite Descriptors

To ensure a common understanding of 'levels' of risk appetite, we use the following descriptors:

Low - Regarding statutory functions, we have very little appetite for risk, loss, or uncertainty. We are prepared to accept low levels of risk, with a preference for ultrasafe delivery options, while recognising that these will likely have limited or no potential for innovative opportunities.

Moderate - Prepared to tolerate only modest levels of risk to achieve acceptable, but possibly unambitious outcomes and limited innovation.

High - Willing to consider and / or seek all delivery options (original / ambitious / innovative), and tolerate those with the highest likelihood of successful outcomes, in pursuit of objectives even when there are elevated levels of associated risk.

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Risk Appetite Statement

A Risk Appetite Statement describes the level that an organisation is prepared to accept against certain categories or types of risk. NHS Fife considered its risk appetite for key aspects of the delivery of health and care in 2022, as we emerged from the pandemic and developed the Population Health and Wellbeing Strategy. Our Risk Appetite Statement aligns to the 4 strategic priorities and is set out at Appendix 4. Detail of how risk appetite will be applied in practice is contained within the Risk Register/Risk Assessment Policy.

A Risk Appetite Statement describes the level that an organisation is prepared to accept against certain categories or types of risk. NHS Fife considered its risk appetite for key aspects of the delivery of health and care in 2022, as we emerged from the pandemic and developed the Population Health and Wellbeing Strategy. Our Risk Appetite Statement aligns to the 4 strategic priorities and is set out at Appendix 4. Detail of how risk appetite will be applied in practice is contained within the Risk Register/Risk Assessment Policy.

7.8 Monitor and Review

When monitoring and reviewing risks, we should look to answer the following questions.

- Is the organisation taking the right risks?
- Is the management of risk effective? i.e. Are risks reducing to an acceptable level, increasing or static?
- Is risk management providing useful, timely information that helps improve the organisation's decisions?

Healthcare is delivered in a dynamic and challenging environment. It is therefore necessary to ensure that risks are regularly monitored, reviewed and reassessed for changes in context and risk score, and the current management controls or actions changed as required. As well as reviewing individual risks, it is necessary to review the risk management system as a whole in order to assure the Board on its effectiveness.

Assurance

To assess the level of assurance which can be given on the effectiveness of our risk management arrangements, we require to provide credible, relevant evidence that our risks are being adequately managed, and that key controls have been identified, implemented and are working effectively.

Assurance provides:	Evidence/ Certainty/ Confidence
To:	Directors / Organisation / The Board / The Public / External Agencies
That:	What we are currently doing is making a positive impact on risks

To support our approach and add consistency to our assurance reporting, we have adopted the 4-level assurance model used by Internal Audit.

Level of Assurance		System Adequacy	Controls
Substantial Assurance		A sound system of governance, risk management and control exists, with internal controls operating effectively and being consistently applied to support the achievement of objectives in the area audited.	Controls are applied continuously or with only minor lapses.
Reasonable Assurance		There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified which may put at risk the achievement of objectives in the area audited.	Controls are applied frequently but with evidence of non-compliance.
Limited Assurance		Significant gaps, weaknesses or non-compliance were identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the area audited.	Controls are applied but with some significant lapses.
No Assurance		Immediate action is required to address fundamental gaps, weaknesses or non-compliance identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the area audited.	Significant breakdown in the application of controls.

This model forms part of the Assurance Principles document provided to the EDG, governance Committees and the Board within the Corporate Risk Register report.

The Principles also refer to what is often called the "three lines of assurance" model. This provides a framework for undertaking a comprehensive assessment of the effectiveness of risk controls and actions and allows a conclusion to be reached on the level of assurance obtained. It is summarised below.

1st line:	Management assurance from "front line " or operational areas that own the risks and are responsible for controlling them day-to-day and for taking corrective actions to address deficiencies. e.g. applying policies and procedures, understanding the key controls, and how well those are working**.**
2nd line:	Oversight of management activity, separate from those responsible for delivery, but not independent of the organisation's management chain e.g. corporate governance /compliance functions to assist the first line fulfil their assurance responsibilities. Includes e.g. quality assurance, inspection, to determine compliance with standards / policy / regulatory considerations.
3rd line:	Independent and objective assurance reports on the integrity and effectiveness of risk management & related controls, including the quality of assurance derived from the 1st & 2nd lines. Typically provided by internal audit but also external audit, accreditation bodies, regulators, Royal Colleges.

The Assurance Principles are set out in Appendix 5.

Deep Dive Review

Another component of our assurance approach is a risk deep dive review. Generally, though not exclusively, deep dives will be commissioned into deteriorating corporate risks or other risks, priority areas or concerns by the associated governance committee or via a recommendation from EDG.

Key Performance indicators

Measuring, managing and monitoring risk management performance is key to the delivery of objectives. We will develop and use KPIs to assess the effectiveness of the risk management system and provide assurances to the governance committees and the Board.

7.9 Communicate and Consult

The communication of clear, relevant, reliable risk information is essential to developing effective risk management. The Model Meeting Paper SBAR Template provides a section in which key risks relevant to the report submitted should be described in line with the supporting guidance.

Key organisational risk reports include the following:

Reporting to the Board

The Corporate Risk Register will be reported to the Board on a 6 monthly basis or where indicated, by exception.

Additionally, the Strategic Risk Profile, as a dashboard set in the context of the Board's risk appetite, forms a component of the monthly Integrated Performance & Quality Report (IPQR).

Reporting to the Audit & Risk Committee

The Corporate Risk Register Report will be reported to each meeting of the Committee for consideration, review and comment; this will be at least quarterly. Risk KPIs will also be reported to the Committee.

Reporting to the Governance Committees

An overarching Corporate Risk Register report will go bi- monthly to the committees , according to their areas of scrutiny, with detailed reviews on specific corporate risks every 4 months, unless by exception. A risk may be referred to more than one committee depending on its nature and relevance.

Annual Risk Management Report

An Annual Risk Management Report will be presented to the EDG, the Audit & Risk Committee and the Board.

Directorates and Services

Departments will carry out regular risk reviews which will be monitored and reported through their governance groups and committees to ensure that appropriate oversight, discussion, action planning and where indicated, escalation occurs. The Risk Register/ Risk Assessment Policy outlines the reporting requirements.

Fife Integration Joint Board

The reporting requirements and responsibilities relating to risks to delegated services are set out in the Fife IJB Risk Management Strategy.

Risk management staff from both parties will work together to ensure that risk management arrangements are aligned to facilitate effective escalation of risks and provision of assurance.

Patients and the Public

NHS Fife seeks to inspire confidence and trust in its services and will:

- be open with the public about our understanding of the nature of known risks
- engage with stakeholders as appropriate in relation to risks that affect them
- provide assurance through the Annual Risk Management Report that we have in place adequate and effective systems to manage risk.

Implementation

To support the implementation of this Framework, we will develop an annual delivery plan which will set out how we will achieve our objectives each year. The information will be accessible for staff to download via Staff Link and accessible to patients and members of the public on the NHS Fife web site - nhsfife.org.

Training and Development

For risk management to be effective and embedded across the organisation, staff must understand its benefits and their responsibilities. Risk management training to enable staff to gain the knowledge and skills necessary for their role will be provided and advertised via Staff Link and targeted communications to managers.

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APPENDIX 1

NHS FIFE
RISKS AND OPPORTUNITIES GROUP
TERMS OF REFERENCE

1. Purpose

The Group has been delegated responsibility by the Executive Directors' Group (EDG) to progress the activities described in this document and to prepare regular formal reports on progress and seek approval for proposals from the Group.

The purpose of the Risks and Opportunities Group (ROG) is to support and embed an effective risk management framework and culture through:

- Promoting leadership to ensure the organisation gives risk management the appropriate priority;
- Contributing to the development and implementation of the risk management framework to ensure processes are in place and operating effectively to identify, manage, and monitor risks across the organisation;
- Identifying risks and opportunities in relation to delivery of the NHS Fife Population Health and Wellbeing Strategy and escalating to the EDG as appropriate;
- Assessing risks, opportunities, issues and events that arise and responding accordingly;
- Horizon scanning for future opportunities, threats and risks linked to the delivery of NHS Fife's strategic priorities;
- Considering the external environment for review of risks and opportunities in the context of national directives;
- Ensuring continuous improvement of the organisation's control environment;
- Creating a collective and enabling approach to risk controls and actions

2. Composition

2.1 Core membership who attend all meetings and provide consistent direction for the agenda and work plan is as follows:

Associate Director of Digital and Information (Co-chair)
Assistant Director, Research, Innovation and Knowledge
Director of Allied Health Professions (AHPs)
Associate Director of Communications
Associate Director of Planning and Performance
Associate Director of Quality and Clinical Governance (Co-chair)
Director of Nursing – Corporate
Deputy Director of Finance
Deputy Director of Pharmacy and Medicines
Deputy Director of Workforce
Deputy Medical Director (Acute)
Estates Manager, Compliance
General Manager, Acute Services Division
Head of Corporate Governance and Board Secretary
Healthcare Public Health Consultant
Health & Social Care Partnership (HSCP) Representative
Risk Manager
Staff Side Area Partnership Forum Representative

2.2 A member of the Internal Audit team will be **in attendance** at meetings.

2.3 Other colleagues may be invited to attend meetings to contribute to particular topics as required.

2.4 If a core member is unable to attend, they should identify a deputy to do so on their behalf.

2.5 Members of the group commit to role modelling positive attitudes and behaviours which align to NHS Fife's organisational values.

3. Role and Remit

3.1 The role and remit of the ROG is to:

a) Maintain an overview of the corporate risks and their links to strategic priorities.
b) Assess the corporate risk register using knowledge and understanding from members' respective areas of responsibility and assist the Executive Directors' Group (EDG) and the governance committees with recommendations (by way of a regular exception report) in relation to:
   - the risk levels including target, and corresponding risk appetite level
   - adequacy of controls (stabilising risk) and actions (current and future to reduce risk)
   - specific timescales for impact of risks and ensuring that actions and corresponding timescales for delivery are appropriate
   - identifying risks which require a more detailed assessment to ensure improvement is delivered
   - horizon scanning of risks and opportunities which may impact the risk profile
   - providing assurance that the corporate risk register reflects and aligns to the strategic priorities and in year corporate objectives
   - assessment of immediate, mid and long term risks in terms of proximity
c) Ensure a prioritised programme of work which responds to the Annual Delivery Plan (ADP), the corporate risk register and connects to the Integrated Performance & Quality Report (IPQR) deliverables and the Strategic Planning Resource Allocation (SPRA), with a view to reducing the risk exposure.
d) Maintain oversight of the operational risk profile.
e) Monitor risk performance through the implementation of key performance indicators.
f) Identify operational risks for escalation.
g) Develop a work plan which effectively embeds the NHS Fife Risk Management Framework. This will be submitted to EDG and to the Audit and Risk Committee (ARC).
h) Provide leadership across respective areas of responsibility to promote, support and embed an effective risk management culture.
i) Contribute to and monitor the development of organisational support to ensure effective risk management practice through:
   - delivery of targeted education and training; and
   - regular communications on developments in policy and process

4. Meetings and Reporting Arrangements

4.1 Meetings will be held bi-monthly.
4.2 The group will be quorate when at least one of the co-chairs plus at least 8 other members are present.
4.3 The ROG will report to EDG periodically, making recommendations, providing considerations or in the form of escalation if required as part of its role and remit.
4.4 The ROG will report to ARC periodically, making recommendations or providing considerations from its role and remit.
4.5 Individual members will report into respective local governance groups to ensure a focus on effective risk management arrangements. These groups include: e.g. Clinical Governance Oversight Group (CGOG), Senior Leadership Teams (SLTs), Public Health Assurance Committee (PHAC)
4.6 These reporting arrangements are additional to the existing reporting requirements conducted by the Risk Management team.

5. Review

5.1 These terms of reference will be reviewed on an annual basis.

Date of Approval: 8 August 2023

Review Date: April 2024

Risk Assessment Matrix

Likelihood

Determine the **Likelihood (L)** using **Figure 1** below. When determining the likelihood you should consider the frequency of any previous occurrences.

Figure1 Likelihood Ratings

Descriptor	Remote	Unlikely	Possible	Likely	Almost Certain
Likelihood	Can't believe this event would happen – will only happen in exceptional circumstances	Not expected to happen, but definite potential exists – unlikely to occur	May occur occasionally, has happened before on occasions – reasonable chance of occurring	Strong possibility that this could occur – likely to occur	This is expected to occur frequently / in most circumstances – more likely to occur than not

Consequence

Figure 2 Consequence Ratings

Likelihood	Consequence				
	Negligible	**Minor**	**Moderate**	**Major**	**Extreme**
Almost certain	LR 5	MR 10	HR 15	HR 20	HR 25
Likely	LR 4	MR 8	MR 12	HR 16	HR 20
Possible	VLR 3	LR 6	MR 9	MR 12	HR 15
Unlikely	VLR 2	LR 4	LR 6	MR 8	MR 10
Remote	VLR 1	VLR 2	VLR 3	LR 4	LR

In terms of grading risks, the following grades have been assigned within the matrix.

- **Very Low Risk (VLR)**
- **Low Risk (LR)**
- **Moderate Risk (MR)**
- **High Risk (HR)**

Figure 3 Consequence Descriptors amended in line with NHS HIS 2019

Descriptor	Negligible	Minor	Moderate	Major	Extreme
Patient Experience	Reduced quality of patient experience / clinical outcome not directly related to delivery of clinical care.	Unsatisfactory patient experience / clinical outcome **directly related to care provision – readily resolvable.**	Unsatisfactory patient experience / clinical outcome, short term effects – expect recovery <1wk.	Unsatisfactory patient experience / clinical outcome, long term effects – expect recovery - >1wk.	Unsatisfactory patient experience / clinical outcome, continued ongoing long term effects.
Objectives / Project	Barely noticeable reduction in scope / quality / schedule.	Minor reduction in scope / quality / schedule.	Reduction in scope or quality, project objectives or schedule.	Significant project over-run.	Inability to meet project objectives, reputation of the organisation seriously damaged.
Injury (Physical and psychological) to patient / visitor / staff.	Adverse event leading to minor injury not requiring first aid.	Minor injury or illness, first aid treatment required.	Agency reportable, e.g. Police (violent and aggressive acts). Significant injury requiring medical treatment and/or counselling.	Major injuries/long term incapacity or disability (loss of limb) requiring medical treatment and/or counselling.	Incident leading to death or major permanent incapacity.
Complaints / Claims	Locally resolved verbal complaint.	Justified written complaint peripheral to clinical care.	Below excess claim. Justified complaint involving lack of appropriate care.	Claim above excess level. Multiple justified complaints.	Multiple claims or single major claim/. Complex justified complaint
Service / Business Interruption	Interruption in a service which does not impact on the delivery of patient care or the ability to continue to provide service.	Short term disruption to service with minor impact on patient care.	Some disruption in service with unacceptable impact on patient care. Temporary loss of ability to provide service.	Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked.	Permanent loss of core service or facility. Disruption to facility leading to significant "knock on" effect
Staffing and Competence	Short term low staffing level temporarily reduces service quality (less than 1 day. Short term low staffing level (>1 day), where there is no disruption to patient care.	Ongoing low staffing level reduces service quality. **Minor error** due to ineffective training / implementation of training.	Late delivery of key objective / service due to lack of staff. **Moderate error** due to ineffective training / implementation of training. Ongoing problems with staffing levels.	Uncertain delivery of key objective / service due to lack of staff. **Major error** due to ineffective training / implementation of training.	Non-delivery of key objective / service due to lack of staff. Loss of key staff. **Critical error** due to ineffective training / implementation of training.
Financial (including damage / loss / fraud)	Negligible organisational / personal financial loss (£<10k)	Minor organisational / personal financial loss (£10k-100k)	Significant organisational / personal financial loss (£100k-250k)	Major organisational / personal financial loss (£250 k-1m)	Severe organisational / personal financial loss (£>1m)
Inspection / Audit	Small number of recommendations which focus on minor quality improvement issues.	Recommendations made which can be addressed by low level of management action.	Challenging recommendations that can be addressed with appropriate action plan.	Enforcement action. Low rating Critical report.	Prosecution. Zero rating Severely critical report.
Adverse Publicity / Reputation	Rumours, no media coverage. Little effect on staff morale.	Local media coverage – short term. Some public embarrassment. Minor effect on staff morale / public attitudes.	Local media – long-term adverse publicity. Significant effect on staff morale and public perception of the organisation.	National media / adverse publicity, less than 3 days. Public confidence in the organisation undermined Use of services affected	National / International media / adverse publicity, more than 3 days. MSP / MP concern (Questions in Parliament). Court Enforcement Public Enquiry, FAI

Based on: Australian/New Zealand Standard: Risk Management (AS/NZS4360:2004) Risk Management Standard), (2004) Standards Australia/Standards New Zealand Clinical Governance and Risk Management Standards (2005), NHS Quality Improvement Scotland

APPENDIX 3

NHS Fife Risk Appetite Statement July 2022

Risk Appetite Descriptors

To ensure a common understanding of 'levels' of risk appetite, the following definitions have been adopted by the NHS Fife Board.

Low - Regarding statutory functions, we have very little appetite for risk, loss, or uncertainty. We are prepared to accept low levels of risk, with a preference for ultrasafe delivery options, while recognising that these will likely have limited or no potential for innovative opportunities

Moderate - Prepared to accept only modest levels of risk to achieve acceptable, but possibly unambitious outcomes and limited innovation.

High - Willing to consider and / or seek all delivery options (original / ambitious / innovative), and accept those with the highest likelihood of successful outcomes, in pursuit of objectives even when there are elevated levels of associated risk

Risk Appetite Statement

NHS Fife's Population Health and Wellbeing Strategy (2022-2027) sets an organisational vision that the people of Fife live long and healthy lives. A strategic framework, developed by our staff and built on our vision and values details how our priorities will link to National Care Programmes, underpinned by system enablers.

The Board recognises that it is not possible to eliminate all the risks which are inherent in the delivery of health and care and is willing to accept a certain degree of risk when it is in the best interests of the organisation, and ultimately, the population of Fife and people we serve. The Board has therefore considered the level of risk that it is proposed to accept for key aspects of the delivery of health and care, and these are described in line with our four organisational aims.

1. Improving health and wellbeing

The Board has a *high* risk appetite in this domain.

We are willing to consider original, ambitious, and innovative delivery options and accept those worth the highest likelihood of outcomes in influencing improvements in population health. We will proactively engage and involve 1/3 stakeholders in the design and delivery of services to meet their needs and explore transformational and sustainable change to align with our strategic ambition in this domain.

We will seek to maximise our influence on tackling social determinants of health through our ambitious strategy, and through contributing to the local population as an Anchor institution.

2. Improving the quality of health and care services

The Board has a *moderate* risk appetite in this domain.

We acknowledge that healthcare operates within a highly regulated environment, and we must meet high levels of compliance expectations in line with national standards and various regulatory sources.

We will endeavour to meet those expectations within a framework of prudent controls, balancing the prospect of risk elimination against pragmatic, operational imperatives Our focus is on delivering core health and care services safely. However, with the opportunity of potentially improved outcomes, where appropriate controls are in place, the Board may decide to accept risk and adopt innovative approaches in pursuit of these.

3. Improving staff experience and wellbeing

The Board has a *moderate* risk appetite in this domain.

We acknowledge the standard of expectations placed on the Board and individuals in relation to Staff Governance Standards with no intent to deviate, and we are committed to Partnership working. Our Workforce Strategy identifies the current and anticipated future workforce challenges the Board needs to address and defines the type of organisation and employer we aspire to be.

We acknowledge the innovation required to attract and retain the right people with the right skills and values to deliver our strategic ambition.

4. Delivering value and sustainability

The Board has a *moderate* risk appetite in this domain.

We acknowledge our requirements to adhere to Standing Financial Instructions, and financial statutory duties, as well as maintenance of robust financial controls, including our statutory responsibility to maintain the financial balance and sustainability of the organisation

In relation to investments, we understand we are accountable for the delivery of best value and efficiency in resource allocation. Therefore, capital investment and planning to enhance and develop services will require to demonstrate 'value added'. Realising benefits and efficient resource allocation are key drivers in making financial decisions and opportunities.

We recognise our ambition to achieve 'Net-Zero' status in line with Scottish Government direction. We realise this will require changes to the way we work and deliver services to maximise our reduction in our carbon footprint and maximise benefit to the environment.

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Committee Assurance Principles

Purpose and Remit

The overall purpose of the Board is to ensure efficient, effective and accountable governance, to provide strategic leadership and direction, and to focus on agreed outcomes.

Detailed scrutiny should take place at committee level, with each committee providing assurance and escalating key issues as required.

Sub-committees and groups will frequently have an operational focus but must ensure that they are in a position to provide the required assurances on their operations and on any risks, actions and controls for which they are responsible.

The Assurance Principles set out below have been developed to support the assurance function.

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Assurance Principles

Risk Assurance Principles:

Board

- Ensuring efficient, effective and accountable governance

Standing Committees of the Board

- Detailed scrutiny
- Providing assurance to Board
- Escalating key issues to the Board

Committee Agenda

- Agenda Items should relate to risk (where relevant)

Seek Assurance of Effectiveness of Risk Mitigation

- Relevance
- Proportionality
- Reliable
- Sufficient

Chairs Assurance Report

- Consider issues for disclosure
  - → Escalation
- Emergent risks or
  - → Recording
- Scrutiny or risk delegated to Committee

Year End Report

- Highlight change in movement of risks aligned to the Committee, including areas where there is no change
- Conclude on assurance of mitigation of risks
- Consider relevant reports for the workplan in the year ahead related to risks and concerns

General Questions:

- Does the risk description fully explain the nature and impact of the risk?
- Do the current controls match the stated risk?
- How weak or strong are the controls? Are they both well-designed and effective i.e., implemented properly?
- Will further actions bring the risk down to the planned/target level?
- Does the assurance you receive tell you how controls are performing?
- Are we investing in areas of high risk instead of those that are already well-controlled?
- Do Committee papers identify risk clearly and explicitly link the strategic priorities and objectives/corporate risk?

Specific Questions when analysing a risk delegated to the committee in detail:

- History of the risk (when was it opened) – has it moved towards target at any point?
- Is there a valid reason given for the current score?
- Is the target score:
  - In line with the organisation's defined risk appetite?
  - Realistic/achievable or does the risk require to be tolerated at a higher level?
  - Sensible/worthwhile?
- Is there an appropriate split between:
  - Controls – processes already in place which take the score down from its initial/inherent position to where it is now?
  - Actions – planned initiatives which should take it from its current to target?
  - Assurances – which monitor the application of controls/actions?
- Assessing Controls
  - Are the controls "Key" i.e., are they what actually reduces the risk to its current level (not an extensive list of processes which happen but don't actually have any substantive impact)?
  - Overall, do the controls look as if they are applying the level of risk mitigation stated?
  - Is their adequacy assessed by the risk owner? If so, is it reasonable based on the evidence provided?
- Assessing Actions – as controls but accepting that there is necessarily more uncertainty
  - Are they on track to be delivered?
  - Are the actions achievable or does the necessary investment outweigh the benefit of reducing the risk?
  - Are they likely to be sufficient to bring the risk down to the target score?
- Assess Assurances:
  - Do they actually relate to the listed controls and actions (surprisingly often they don't)?
  - Do they provide relevant, reliable and sufficient evidence either individually or in composite?
  - Do the assurance sources listed actually provide a conclusion on whether:
    - the control is working
    - action is being implemented
    - the risk is being mitigated effectively overall (e.g. performance reports look at the overall objective which is separate from assurances over individual controls) and is on course to achieve the target level
  - What level of assurance can be given or can be concluded and how does this compare to the required level of defence (commensurate with the nature or scale of the risk):
    - 1st line – management/performance/data trends?
    - 2nd line – oversight / compliance / audits?
    - 3rd line – internal audit and/or external audit reports/external assessments?

Level of Assurance:

Substantial Assurance	Reasonable Assurance	Limited Assurance	No Assurance
			

Document developed from diagram produced by NHS Lanarkshire based on principles compiled by the Assurance Mapping Group of members of Boards covered by the FTF Internal Audit Service. 2022

Risk Management Roles and Responsibilities

The Board

- Provide oversight and scrutiny of NHS Fife's risk management arrangements to seek assurance on their effectiveness.
- Agree the Board's risk appetite.

NHS Fife Chief Executive

- The Chief Executive of the NHS Board, as Accountable Officer, is personally answerable to Parliament, and accountable to the Board for the effective management of risk.

Director of Finance and Strategy

- The Director of Finance and Strategy is the executive lead for risk management.

Executive Directors

- Support the Chief Executive in fulfilling their risk management responsibilities;
- Contribute to setting the Board's risk appetite;
- Promote the importance of risk management and foster a good risk culture within their areas of responsibility;
- Ensure that the Board's risk management processes are actively promoted, and adhered to, across their teams and within their areas of responsibility;
- Receive and scrutinise regular risk reports on risks associated with their areas of responsibility;
- Escalate risks to EDG where appropriate;
- Ensure there is a focus on learning from past events, whether these are positive or negative, to improve staff anticipation and preparedness to address future situations.

Risk Manager

- Responsible for the implementation of the Risk Management Framework;
- Ensure risks are properly identified, understood and managed across all levels within the organization;
- Report on the organisation's risk profile at various levels to the standing committees, and the NHS Board;
- Periodically review the Risk Management Framework and arrangements, identifying areas for potential improvement;
- Drive an improving risk culture through risk education, awareness and embedding into day-to-day management

Line Managers (Service Managers, Clinical Nurse Managers Senior Charge Nurses, Directorate, Departmental or equivalent)

- Responsible for ensuring effective systems for risk management are in place in accordance with this policy at ward, service or departmental level.

Risk Owner

- Accountable for ensuring the effective management of a risk, and providing assurance that key controls are operating effectively

Director of Health and Social Care / Chief Officer

- The Director of Health and Social Care/Chief Officer has overall accountability for the IJB's risk management framework, ensuring that suitable and effective arrangements are in place to manage the risks relating to the functions within the scope of the IJB. The Director of Health and Social Care/Chief Officer will keep the Chief Executives of the IJB's partner bodies informed of any significant existing or emerging risks that could seriously impact the IJB's ability to deliver the outcomes of the Strategic Plan or the reputation of the IJB.

Chief Financial Officer

- The Chief Financial Officer will be responsible for promoting arrangements to identify and manage key business risks, risk mitigation and insurance. The Chief Financial Officer is a member of the Fife Council Risk Management strategy group and NHS Fife Risks and Opportunities Group.

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

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

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

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NHS Fife
Hayfield House
Hayfield Road
Kirkcaldy, KY2 5AH

www.nhsfife.org

facebook.com/nhsfife
twitter.com/nhsfife
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linkedin.com/company/nhsfife

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**31 August 2023**
Title:	**Audit Scotland Technical Bulletin 2023/2**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Kevin Booth, Head of Financial Services & Procurement**

1 Purpose

This is presented for:

- Assurance

This report relates to a:

- Emerging issue
- Government policy/directive
- Legal requirement

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

- Effective

2 Report summary

2.1 Situation

The Audit Scotland Technical Bulletin 2023/2 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 2023/2 is arranged by sector with content applicable to specific sectors and also across the public sector as a whole.

Chapter two is of reference to all public sector bodies and this section highlights the Good Practice Note that was published for consideration in the 2022/23 Annual Accounts process following a review across a number of public bodies 2021/22 annual accounts.

From a Health Board perspective Chapter five provides guidance on how the treatment of a Service Level Agreement with another health board should be accounted for at the year-end if an element is undelivered. In addition, the treatment of the junior doctors 2022/23 pay award for inclusion in the 2022/23 annual accounts is clarified.

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 and Anchor Institution ambitions

N/A

2.3.6 Climate Emergency and Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

The Audit Scotland Technical Bulletins are provided to Boards through the Technical Accounts Group meetings and any impending issues are discussed.

2.3.8 Route to the Meeting

This paper has been provided to support the Audit & Risk Committee 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 2023/2

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

Technical Bulletin 2023/2

Technical developments and emerging risks from April to June 2023

AUDIT SCOTLAND

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

June 2023

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		
Professional Support has published a Good Practice Note (GPN) on Remuneration Reports [**paragraph 1**]	Professional Support has published guidance on Independent Auditor's Reports for local government **[paragraph 5]**	CIPFA has issued Bulletin 13 on Local Authority Reserves and Balances **[paragraph 10]**
CIPFA has issued Bulletin 14 on Closure of the 2022/23 Financial Statements **[paragraph 12]**	PWC has provided a report to support auditors when assessing information produced by actuaries in respect of the Local Government Pension scheme (LGPS) **[paragraph 31]**	LASAAC have issued updated guidance on accounting for common good funds **[paragraph 40]**
Professional Support has published guidance on objections to 2022/23 annual accounts **[paragraph 46]**	Professional Support has issued guidance for auditors on certifying the 2022/23 housing benefit (HB) subsidy claim **[paragraph 49]**	The SG has issued the 2022/23 Non-domestic rates notified return and guidance **[paragraph 54]**
The NAO has published a disclosure guide on the 2022/23 financial Statements for bodies covered by the FReM **[paragraph 58]**	The Cabinet Office has published an Employers Pension Notice on the Remuneration Report **[paragraph 61]**	Professional Support has issued a report to auditors following an examination of the CNORIS **[paragraph 65]**
The Scottish Government has issued guidance on the Junior Doctors' pay award **[paragraph 67]**	The FRC has issued an invitation to comment on proposed revisions to ISA 505 **[paragraph 71]**	The FRC has published a thematic review of fair value measurement disclosures **[paragraph 75]**

Consulting with Professional Support

Auditors should consult with Professional Support by sending an email to TechnicalQueries@audit-scotland.gov.uk.

2: All sectors

Good practice note on Remuneration Report

1. Professional Support has published a Good Practice Note (GPN) following a review of the Remuneration Reports in the 2021/22 annual accounts of a sample of public bodies in Scotland.

2. The Remuneration Report was chosen for a good practice review because of the high-profile nature of the information, along with indications that the quality of the disclosures was variable. Good practice is illustrated, where possible, using examples taken from the 2021/22 annual accounts of the bodies in the sample.

3. The review was carried out by a team in Professional Support with knowledge of the relevant financial reporting framework. However, the team does not have a detailed understanding of each body's particular circumstances or the specific underlying transactions. The GPN is available to auditors on SharePoint* and is also freely available from the Audit Scotland website. The review identified the following key messages:

- Public bodies should clearly identify the parts of the Remuneration Report that are subject to audit.
- Bodies should consider carefully how to present the required information and support significant messages with relevant context.
- Important information should be highlighted and not obscured by immaterial detail that causes clutter. To avoid clutter:
  - tables (or columns or rows) which do not contain entries should be removed
  - signposting can be used effectively to provide complementary information.
- The language used in the Remuneration Report should be clear and precise.

4. Auditors are requested to encourage their audited bodies to use the GPN to assess and enhance their own disclosures in 2022/23.

3: Local government sector

Independent auditor's reports for local government accounts in 2022/23

5. Professional Support has published Technical Guidance Note (TGN) 2023/4(LG) to provide auditors with model forms of Independent Auditor's Reports (IAR) which should be used for the 2022/23 annual accounts of local government bodies in Scotland.

6. Auditors are required by the Code of Audit Practice to prepare their IARs in accordance with the TGN. The TGN is available with supporting material to auditors on SharePoint* and is also freely available from the Audit Scotland website.

7. The model forms of IARs set out in the appendices of the TGNs have been tailored to reflect relevant legislation and augmented by the reporting requirements of the Accounts Commission.

8. There are a number of changes to the model forms of IAR and to the application guidance in 2022/23. These are summarised in the following table:

Area	Change
Model IARs	The description of the financial reporting framework has been removed from the 'true and fair' element of the opinion on the financial statements.
	The period of appointment disclosure has been simplified.
	The explanation of the extent to which the audit is capable of detecting irregularities has been enhanced with a view to reducing any perceived need for extensive local tailoring.
Application guidance	The guidance on the period of appointment disclosure has been revised to reflect the amendment in standard wording.
	Auditors should consult with Professional Support on any tailoring of the standard wording of the explanation of the extent to which the audit is capable of detecting irregularities.
	A new Auditor Action has been added in respect of identifying the audited parts of the Remuneration Report.

9. For the 2022/23 audits of local government bodies, auditors should:

- use the relevant model form of IAR for each audited body

- follow the specified wording other than where tailoring adjustments are set out in the application guidance in the TGN
- consult with Professional Support on any modified opinion or conclusion
- complete an Auditor Action Checklist for each IAR prepared.

Revised guidance on reserves

10. The Chartered Institute of Public Finance and Accountancy (CIPFA) has issued Bulletin 13 Local Authority Reserves and Balances to provide guidance on the establishment and maintenance of local authority reserves and balances.

11. It replaces LAAP Bulletin 99 issued in July 2014 to reflect events since then, including changes to the Code of Practice in Local Authority Accounting in the UK (accounting code). There are no significant changes from the previous guidance.

Guidance on the 2022/23 financial statements

12. CIPFA has issued Bulletin 14 Closure of the 2022/23 Financial Statements to provide guidance on closing the 2022/23 financial statements. The guidance is intended to be best practice, but it does not have the formal status of the accounting code.

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

- Reporting impacts of inflation and interest rates.
- Grant recognition and presentation.
- Subsequent measurement of property, plant and equipment.
- Nature and extent of risks arising from financial instruments.
- Accounting standards that have been issued but not yet adopted.
- Accounts closure processes.

Reporting impacts of inflation and interest rates

14. Section 9 of the bulletin highlights the implications of unusually high inflation and interest rates on different parts of the annual accounts. Some key points of the guidance are summarised in the following table:

Area	Summary of guidance
Property, plant and equipment	Increases in materials and labour cost will be reflected in the information used to estimate depreciated replacement cost.

Area	Summary of guidance
	There may be impacts on estimates of residual values and useful lives. For example, high fuel costs might result in inefficient assets being brought out of service earlier than originally intended.
Non-current assets held for sale	Higher interest rates have the potential to discourage buyers which increases uncertainty around whether a sale is deemed 'highly probable', which is one of the key classification criteria.
Impairment of assets	An impairment event is related to a specific asset so if high cost of borrowing results in a general decline in asset value, it is unlikely to be an impairment. However, inflation and the cost-of-living crisis may impact on the use of assets.
Provisions	As high inflation and increased cost of borrowing is likely to have an impact on the time value of money, provisions may require to be discounted if the effect has become material.
Financial instruments	Market expectation of higher interest rates will affect borrowing costs and investment income for any variable rate debt or investments.
Post-employment benefits	Defined benefit inflation assumptions are linked to RPI/CPI and are therefore likely to be affected by high inflation, which may result in a larger liability.

Grant recognition

15. Section 1 responds to queries on the recognition of grant income. Some key points include the following.

- In summary, all grants should be recognised in the Comprehensive Income and Expenditure Statement (CIES) unless there are conditions that have not been met.
- For grants with conditions there is a two-stage process:
  - Recognition as grants received in advance if initially conditions remain outstanding at the Balance Sheet date.
  - Recognition as income when the conditions are satisfied.
- Grants and contributions should not be recognised until there is reasonable assurance that the authority will comply with the conditions attached to them and the grants or contributions will be received.
- Reasonable assurance is not defined in the accounting code and therefore the bulletin provides the following guidance:

- Reasonable assurance is usually in the form of a written agreement or confirmation from the grant-paying body, and any conditions will be set out in the agreement.

- The authority should recognise the grant or contribution when it is satisfied that the grant or contribution will be received and it intends to comply with the conditions.

Subsequent measurement of property, plant and equipment

16. Section 3 addresses issues with the subsequent measurement of property, plant and equipment.

17. Paragraph 3.9 advises that, although the measurement process is undertaken by a valuer, the chief finance officer (CFO) needs to ensure that there are appropriate internal processes to obtain the information from the valuer. Paragraph 3.11 sets out a summary of the information requirements and the commissioning process. Local authorities are advised to discuss the processes with their valuers to ensure that clear instructions are provided, and that information requirements and timetables are understood.

18. Paragraph 3.12 advises the CFO to carry out a critical review of the valuation report and that reasonableness tests are undertaken to ensure they are happy with the estimates provided. For example, if a valuation for an asset has increased by a significant percentage the finance function should seek an explanation as to why that is the case.

19. Paragraph 3.2 highlights that many operational office premises are increasingly underused. Local authority practitioners are required to have dialogue with the valuer to provide clarity around service potential and the status of any unused parts of a building. If parts of the property are not being used, and there is no intention to do so, the appropriate treatment depends on whether they are capable of being sold or leased separately at the valuation date without interfering with the ongoing service function being provided from the retained parts:

- If separate occupation is not possible, any surplus parts would have no more than a nominal existing use value.

- If separate occupation is possible, they may be classified as either surplus assets, investment properties or ‘asset held for sale’ and measured at fair value.

Nature and extent of risks arising from financial instruments

20. Section 4 discusses the impact of the recent significant market volatility on financial instruments held by local authorities. This is particularly relevant for disclosures of the nature and extent of risks arising from financial instruments.

21. Paragraphs 4.3 to 4.5 set out issues for local authorities to consider disclosing that impact on credit, market and liquidity risks.

Accounting standards that have been issued but not yet adopted

22. Paragraph 14.3 lists the accounting standards introduced by the 2023/24 accounting code which require to be disclosed as 'standards issued but not yet adopted' in 2022/23. They include:

- IFRS 16 Leases (but only for those local authorities that have decided to implement IFRS 16 in 2023/24). Where an authority will implement IFRS 16 to PFI/PPP arrangements in 2023/24, information on that specific change will also be required in 2022/23.
- Definition of Accounting Estimates (Amendments to IAS 8).
- Disclosure of Accounting Policies (Amendments to IAS 1 and IFRS Practice Statement 2).

Accounts closure processes

23. Section 7 provides guidance on closing the annual accounts faster.

24. Paragraph 7.3 lists some suggested key processes including:

- thorough planning and timetabling of stages of the process, with stringent deadlines
- follow-up and strict monitoring of progress
- robust financial management through the year so that most issues have been resolved by the year-end
- quarterly closure procedures and monitoring, e.g. Balance Sheets prepared quarterly for internal purposes.

25. Paragraph 7.6 highlights the importance of local authorities ensuring that they produce effective working papers. A clear record of the source of the original information and the treatments that have been applied will allow the confident use of the working paper and avoid work having to be re-performed. Paragraph 7.8 lists the key features of effective working papers.

26. Paragraph 7.4 notes that review and control processes are vital to produce the unaudited accounts. Working papers should be supported by clear evidence of assumptions, judgements and decisions taken by local authority management.

2022/23 disclosure checklist

27. The Chartered Institute of Public Finance and Accountancy (CIPFA) has issued a disclosure checklist* for the 2022/23 financial statements. It is intended for use as an aide-memoire to assist in meeting the requirements of the accounting code.

28. The checklist is in the form of a series of questions and the implications of the answers are set out in the following table:

Answer	Implication
Yes	The accounting code is being complied with.
No	A justification for departing from the accounting code should be given. For example, a legitimate justification may be that the information resulting from a particular disclosure is not material.

29. When evaluating whether the accounting code's disclosure requirements have been met, auditors should:

- request that the body completes the 2022/23 disclosure checklist
- investigate the reasons for any non-compliance that the checklist highlights
- evaluate whether the body's responses in the checklist are consistent with auditor's knowledge.

30. Where the body declines to complete the checklist, auditors should:

- establish the alternative arrangements by which it satisfies itself regarding the completeness of disclosures
- evaluate the adequacy of the arrangements
- consider completing the checklist as part of their audit procedures, where the body's arrangements are judged not to be adequate.

2022/23 report on actuarial information

31. 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 2023. Auditors should refer to paragraphs 15 to 27 in Module 4 of TGN 2022/8(LG) for guidance on using the report and further information.

32. 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 2023.

33. 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 5 of the report

- to establish actual asset returns and compare them with expected returns arrived at using market indices (see page 15).

34. Page 16 highlights the impact of high inflation rates on pension increases and cashflows. All actuaries are proposing to allow for actual pension increase experience allowed for up to the reporting date, including the pension increase from April 2023 of 10.1% (which is the annual CPI inflation rate at September 2022).

35. 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.

36. Page 21 highlights the issue of pay awards, specifically the Firefighters award that has been backdated to July 2022. Backdated pay awards may have an impact on past service final salary benefits and the McCloud allowance. It will not impact service cost for 2022/23 unless employers include an estimate of the backdated pay award in the contribution data provided. Auditors will need to consider whether including an estimate of the impact of the backdated pay award on service cost is material to the audit.

37. Appendix E to the report addresses the extent to which an IAS 19 surplus can be recognised on the balance sheet. This issue is explained at paragraph56..

IFRS 16 Leases

38. CIPFA have issued a guide* for local authority practitioners on IFRS 16 to update the guidance in IFRS 16 – An early guide for practitioners (Technical Bulletin paragraph 19) to support any local authority adopting IFRS 16 in 2022/23..

39. The guidance covers the requirements in Appendix F of the 2022/23 accounting code and the transitional arrangements for moving to these new requirements.

Accounting for common good funds

40. The Local Authority (Scotland) Accounts Advisory Committee (LASAAC) have issued updated guidance on accounting for common good funds.

41. The updated guidance supersedes previous LASAAC guidance on accounting for the common good issued in 2007. The guidance has been updated to reflect current financial management practices and relevant legislative changes. The guidance is mandatory and applies from 2022/23.

42. Common good funds should be the subject of a separate disclosure in the local authority financial statements. The disclosure should take the form of limited financial statements as set out in the following table.

43. The following minimum statements should therefore be applied:

Statement	Proposed content
Narrative Report	Narrative should briefly explain the purpose and background of the Common Good fund. Accounting policies different from the local authority's should be highlighted. Authorities should consider disclosure of their policy position on the use of common good assets and resources.
Income and Expenditure Statement (IES)	The IES should mirror the local authority CIES. Where the local authority manages several funds, they can be aggregated into one single statement. Paragraphs 2.15 and 2.16 set out respectively examples of debits and credits expected to be made to the IES. Paragraph 2.17 sets out an illustrative IES format.
Balance Sheet	Paragraph 2.19 sets out an illustrative Balance Sheet. Assets should be depreciated and set against any surplus in the income and expenditure account. Statutory adjustments are not permitted. No additional balance sheet disclosures are required.
Disclosure Notes	The level of disclosure is left to the local requirements of each local authority. There is no prescribed requirement to disclose the common good asset register, although good practice would include a direct link to the register on the Council's website as supplementary information.

2023/24 accounting code

44. CIPFA/LASAAC has issued the accounting code* to set out local government accounting requirements for 2023/24. The financial reporting framework is based on International Financial Reporting Standards (IFRS) as adopted by the UK, adapted for the local government context where necessary.

45. The most significant changes to the 2023/24 accounting code include:

Section	Amendment
3.3	Amendment to reflect changes to IAS 8, which clarify the distinction between changes in accounting estimates and changes in accounting policies and the correction of errors. The definition of 'change in accounting estimates' at paragraph 3.3.2.2 has been replaced with a definition of accounting estimates which describes them as "monetary amounts in financial statements that are subject to measurement uncertainty".

	Accounting estimates are developed if accounting policies require items to be measured in a way which involves measurement uncertainty. The effects of a change in input or a measurement technique are changes in estimates provided they do not result from the correction of a prior period error. Paragraphs 3.3.2.14 and 15 have been amended to explain that: • an accounting policy may require items to be measured at monetary amounts that cannot be observed directly and must instead be estimated. • a local government body is therefore required to develop an accounting estimate to achieve the objective set out by the accounting policy. • a body uses measurement techniques and inputs to develop an accounting estimate. In addition, paragraph 3.3.2.18 covers the treatment of a change in an input or measurement technique.
3.4	Disclosure of Accounting Policies -Amendments to IAS 1 Presentation of Financial Statement requires an entity to disclose material (rather than significant) accounting policy information. Paragraphs 3.4.2.88 to 3.4.2.93 have been added to provide clarification that accounting policy information may be material because of its nature, even if the related amounts are immaterial. Where an entity discloses immaterial accounting policy information, such information must not obscure material accounting policy information. Paragraph 3.4.2.90 provides examples of when accounting policy information is likely to be material.
Appendix D	Confirmation of the new standards introduced to the 2023/24 accounting code: • Definition of Accounting Estimates (Amendments to IAS 8) • Disclosure of Accounting Policies (Amendments to IAS 1 and IFRS Practice Statement 2) • Deferred Tax related to Assets and Liabilities arising from a Single Transaction (Amendments to IAS 12) • Updating a Reference to the Conceptual Framework (Amendments to IFRS 3)
Appendix F	Appendix F sets out the requirements for local authorities that choose to adopt IFRS 16 on a voluntary basis. The presentation of these requirements differs slightly from Appendix F in the 2022/23 Code, so they can be applied both to local authorities that have already adopted IFRS 16 and to those that are choosing to adopt IFRS 16 in 2023/24.

Guidance on objections to 2022/23 annual accounts

46. Professional Support has published TGN 2023/5(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 2022/23 annual accounts of a local government body
- object to those accounts.

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

48. Auditors should:

- evaluate whether the public inspection notice for 2022/23 is in accordance with applicable legislation
- carry out the actions set out in the TGN for any objections received.

2022/23 housing benefit subsidy claims

49. Professional Support has published TGN/HBS/23 on certifying the 2022/23 housing benefit (HB) subsidy claim. The TGN is provided with supporting material to auditors on SharePoint and is also available from the Audit Scotland website. The TGN:

- provides guidance for auditors on the examination of the HB subsidy claim, including highlighting the main risk areas
- sets out and explains an overview of the certification approach, the preliminary procedures (at section 1), testing procedures (at section 2), procedures for evaluating results and agreeing amendments (section 3) completion procedures (at section 4) and post-certification procedures (at section 5) that auditors should carry out (all summarised in the checklist at Appendix 1)
- provides examples of reporting errors and observations in a letter to the Department for Work and Pensions (DWP) at Appendix 3
- provides examples of reporting the results of any post-certification procedures at Appendix 4.

50. The TGN reflects changes to certification testing for Scottish local authorities that Professional Support has negotiated with the DWP. The changes, which are intended to increase the focus on the higher-risk areas and rationalise the level of testing required, are summarised as follows:

- The introduction of risk-based testing.
- The removal of cumulative assurance knowledge and experience testing.

- The introduction of a de-minimis level for triggering additional testing.
- Where required, additional testing is to be carried out by local authority internal audit teams.

51. The submission deadline for the HB subsidy certification is 31 January 2024.

52. Auditors should certify 2022/23 HB subsidy claims in accordance with TGN/HBS/23.

53. The following modules of the HB subsidy certification approach have been issued. Auditors should refer to these modules when certifying the 2022/23 subsidy claims:

- The 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.
- The workbooks* to be completed for detailed testing.
- The software diagnostic tool* to ensure the subsidy claim has been completed using the recognised software for claim completion and reconciles "benefit granted" to "benefit paid" in accordance with the software suppliers' instructions.

2022/23 NDR return and guidance

54. The Scottish Government has issued the 2022/23 Non-domestic rates (NDR) notified return and guidance*. The most significant changes from 2021/22 are:

- the renaming of retail, hospitality, leisure, and aviation relief to retail hospitality and leisure relief
- additional detail required to categorise the relief and yield loss for unoccupied properties.

55. Professional Support has published TGN/NDR/23 on certifying the 2022/23 return. The TGN is provided to auditors on SharePoint* and also on the Audit Scotland website.

56. Auditors should certify 2022/23 NDR returns using TGN/NDR/23.

Technical consultations with auditors

Professional Support responds to requests from auditors for technical consultations

57. The following tables summarise requests from auditors for technical consultations with Professional Support in respect of issues arising from the audit of the 2022/23 annual accounts of local government bodies, along with the advice offered:

Should bodies recognise a net defined benefit asset when the pension fund reports a surplus as at 31 March 2023?

Where bodies can access the economic benefit arising from the asset in terms of reduced contributions or a refund, they should recognise the net defined benefit as an asset. The net defined benefit asset recognised should be the surplus, adjusted for the effect of any asset ceiling. The surplus is:

- the fair value of plan assets, less
- the present value of the defined benefit obligation.

The asset ceiling is the present value of any economic benefits available in the form of refunds from the plan or reductions in future contributions to the plan. Bodies should engage with their actuaries to help identify the asset ceiling. The emerging view is that that bodies participating in LGPS will have a minimum funding requirement as contribution rates are set in advance. In their report on IAS 19 reporting (paragraph 31), PWC comment that if a surplus arises for a scheduled body, given that this body is expected to participate in the LGPS indefinitely, it would be expected that this surplus will lead to lower future contributions by that entity. They also expect employers to consider contributions in respect of future service to be a minimum funding requirement under IFRIC 14 as they are obligated to pay them. 56.

Where there is a minimum funding requirement for contributions relating to future service, the economic benefit available as a reduction in future contributions is the sum of the estimated future service cost in each period, determined using assumptions consistent with those used to determine the defined benefit obligation, less the estimated minimum funding requirement contributions that would be required for future service in those periods adjusted for any prepayment made. The IFRS Interpretations Committee, in a decision in July 2015, conclude that when an entity estimates the future minimum funding requirement contributions, it should

- include amounts in the schedule of contributions for the fixed period specified by the schedule; and
- beyond that period, make an estimate that assumes a continuation of those factors establishing the minimum funding basis as determined by the pension trustees.

Where actuaries report that the present value of the minimum funding requirement contributions exceeds the future service cost, IFRIC 14 advises that no asset should be recognised. There is no requirement to recognise a liability for the difference.

4: Central government sector

Disclosure guide for 2022/23 financial statements

58. The National Audit Office has published a disclosure guide on the 2022/23 financial Statements for bodies covered by the Government Financial Reporting Manual (FReM).

59. The guide is designed to ensure that bodies covered by the FReM have prepared their 2022/23 financial statements in the appropriate form and have complied with all disclosure requirements. The guide is cross-referenced to the 2022/23 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.

60. When checking that the FReM's disclosure requirements have been met, auditors should in accordance with the Overview Module of TGN 2023/1:

- 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.

2022/23 guidance on Remuneration Report disclosures

61. The Cabinet Office has issued an Employers Pension Notice on the preparation of the pay, pension and compensation disclosures for the Remuneration and Staff Report for 2022/23.

62. An example of the disclosures is provided at Annex 13C. The EPN has been updated to reflect to the requirements of the Government Financial Reporting Manual (FReM) in 2022/23. There are no significant changes from 2021/22.

63. Auditors should refer to this guidance when auditing the 2022/23 Remuneration Report.

Technical consultations with auditors

Professional Support responds to requests from auditors for technical consultations

64. The following tables summarise requests from auditors for technical consultations with Professional Support in respect of issues arising from the

audit of the 2022/23 annual accounts of central government bodies, along with the advice offered:

How should the right of use asset initially be measured under IFRS 16 Leases in 2022/23 for bodies covered by the FReM?

For central government bodies and health boards, IFRS 16 requires the right-of-use asset, and the lease liability, to be initially measured at the present value of unavoidable future lease payments. This will include:

- fixed payments (including in-substance fixed payments)
- variable lease payments that depend on an index or a rate
- amounts expected to be payable by the lessee under residual value guarantees
- the exercise price of a purchase option if the lessee is reasonably certain to exercise that option
- payments of penalties for terminating the lease, if the lease term reflects the lessee exercising a termination option.

The right-of-use asset may require further adjustment for initial direct costs, prepayments or incentives, and costs related to restoration at the end of a lease.

5: Health sector

Assurance report on 2022/23 clinical negligence claims

65. 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 2023
- inform auditors' evaluation of the role of the NHS Central Legal Office as a management expert.

66. Auditors should refer to this report when auditing the 2022/23 provisions for CNORIS.

Guidance on doctors' 2022/23 pay award

67. The Scottish Government has issued guidance* on accounting for the formal pay offer to junior doctors announced in May 2023. This offer included an additional element backdated to 1 April 2022. Although the offer was subsequently rejected, the Scottish Government consider that the backdated element represents an obligation at 31 March 2023 that should therefore be recognised in the 2022/23 financial statements.

68. In Professional Support's view, the backdated element of the rejected pay award should be recognised in the 2022/23 financial statements of individual health boards, where relevant.

69. Auditors should evaluate whether the backdated element of the pay offer has been recognised in the 2022/23 accounts of individual health boards,

Technical consultations with auditor

Professional Support responds to requests from auditors for technical consultations

70. The following tables summarise requests from auditors for technical consultations with Professional Support in respect of issues arising from the audit of the 2022/23 annual accounts of health boards, along with the advice offered:

How should activity under a service level agreement with another health board that is undelivered at the year end be accounted for?

Boards deliver a number of services to patients on behalf of other health boards under annual service level agreements (SLA). The SLA represents a contract between the two boards and payment is based on the terms of the SLA.

A board is required to account for a contract with a customer where all the criteria at paragraph 9 of IFRS 15 are satisfied including the approval by both parties and their commitment to the contract. In line with IFRS 15, boards are required to identify at the inception of the contract each performance obligation within the contract. Income should be recognised when the board satisfies each performance obligation.

The SLA process was amended for the three years from 2020/21 to 2022/23. Auditors should expect boards to consider whether each of the criteria of IFRS 15 still apply, under these amended arrangements. This includes boards consider whether:

- approval of the contract has been withdrawn by both parties
- both parties are still committed to delivering their obligations,
- performance obligations have been amended or withdrawn.

Where a performance obligation is satisfied over time, for example, where a board has delivered a percentage of the activity required, income should be recognised by measuring the progress towards complete satisfaction of that performance obligation.

Where a board has not delivered the full activity under the SLA by the year end, the board should recognise any shortfall in activity as a contract liability (deferred income).

6: Professional matters

Proposed revisions to ISA 505

71. The Financial Reporting Council (FRC) has issued a consultation on proposed revisions to International Standard on Auditing (UK) 505 External Confirmations to reflect recent enforcement findings and to ensure that the standard is reflective of modern approaches to obtaining confirmations.

72. The main proposed revisions to ISA (UK) 505 are summarised in the following table:

Area	Proposed revisions
Clarification on what constitutes an electronic external confirmation	Paragraph 6(a) has been amended to reflect that confirmations may be obtained through directly accessing information held by third parties through web portals or software interfaces.
Prohibition on the use of negative confirmations	Para graph 6(c) prohibits the use of negative confirmations, where the confirming party responds directly only if they disagree with the information provided in the request. This aims improve the quality of audit evidence obtained when auditors make use of external confirmations.
Designing confirmations to provide evidence for relevant assertions	Paragraph 7(c) includes additional material to ensure that auditors design confirmations to obtain sufficient appropriate audit evidence in relation to all assertions identified in respect of ISA (UK) 330. This is applicable to all means of confirmation but can be particularly relevant to certain forms of digital confirmation.
Enhanced requirements in relation to investigating exceptions	Paragraph 14-1 includes enhanced requirements when investigating exceptions. These direct auditors to consider if exceptions are indicative of fraud or a deficiency in the entity's system of internal control and how follow-up procedures will allow the auditor to obtain sufficient appropriate audit evidence.

73. The proposed effective date of revised ISA (UK) 505 is for audits of financial statements for periods beginning on or after 15 December 2024.

74. The FRC is requesting comments on this consultation by 1 September 2023. Comments on the consultation paper should be sent to: AAT@frc.org.uk

Thematic review of IFRS 13 measurement

75. The FRC issued a thematic review of IFRS 13 fair value measurement disclosures. The FRC. The review has a particular focus on disclosure matters, although some measurement issues are also discussed.

76. The thematic review summarises briefly the financial reporting requirements, identifies examples of better disclosure and opportunities for improvement and highlights some key findings including the following:

- Fair value measurements should use market participants' rather than the body's own assumptions. While the transaction price usually reflects fair value, there may be circumstances where this is not the case, for example, in transactions with related parties. Bodies should ensure that appropriate adjustments are made to fair value measurements in such cases.

- Where no internal expertise exists, bodies should consider the need for specialist third party advice when considering fair value measurements.

- Disclosures should be provided for each class of assets and liabilities, determined on the basis of their nature, characteristics and risks (including climate change). When determining an appropriate level of aggregation or disaggregation, bodies should consider which provides the most useful disclosures.

- Where climate-related matters materially affect fair value measurement, bodies should explain how the impact has been incorporated into the measurement and, if relevant, quantify any significant estimation uncertainty. Simply stating that the risk has been incorporated into the fair value measurement is insufficient in such cases.

- Most issues were identified in the disclosure of recurring Level 3 measurements, for which the significant unobservable inputs should be quantified and a sensitivity analysis given. These disclosures are sometimes omitted.

Technical Bulletin 2023/2

Technical developments and emerging risks from April to June 2023

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AUDIT SCOTLAND

Audit Scotland, 4th Floor, 102 West Port, Edinburgh EH3 9DN
Phone: 0131 625 1500 Email: **info@audit-scotland.gov.uk**
www.audit-scotland.gov.uk

AUDIT & RISK COMMITTEE

DATES FOR FUTURE MEETINGS

Date
Thursday 16 May 2024
Thursday 20 June 2024
Thursday 12 September 2024
Thursday 12 December 2024
Thursday 13 March 2025

Please note that all meetings take place via **MS Teams** / in the **Staff Club** (TBC) and start at **2pm**

A pre-meeting of Non-Executive Members is routinely held, beginning at **1.30pm**

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AUDIT & RISK COMMITTEE

ANNUAL WORKPLAN 2023 / 2024

Governance – General		18/05/23 - Meeting Cancelled				
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Minutes of Previous Meetings	**Chair**	✓ Via email	✓	✓	✓	✓
Action Plan	**Chair**	✓ Via email	✓	✓	✓	✓
Escalation of Issues to NHS Board	**Chair**	✓ Via email	✓	✓	✓	✓
Governance Matters						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Audit Scotland Technical Bulletin	**Head of Financial Services**	✓ 2023/1 – Via email		✓ 2023/2	✓ 2023/3	✓ 2023/4
Annual Assurance Statement 2022/23	**Board Secretary**	✓ Via email	✓ Final			
Annual Assurance Statements from Standing Committees 2022/23	**Board Secretary**		✓			
Annual Review of Code of Corporate Governance	**Board Secretary**	✓ Via email				
Committee Self-Assessment	**Board Secretary**					✓
Corporate Calendar / Committee Dates 2024/25	**Board Secretary**			✓		
Delivery of Annual Workplan 2023/24	**Director of Finance & Strategy**	✓	✓	✓	✓	✓
Governance Statement	**Director of Finance & Strategy**	✓ Via email	✓ Final			
IJB Annual Assurance Statement 2022/23	**Board Secretary**		✓ Letter			
Internal Audit Review of Property Transactions Report 2022/23	**Internal Audit**	**No transactions to review for 2022/23**				
Losses & Special Payments	**Head of Financial Services**	✓ Via email		✓	✓	✓

Governance Matters (cont.)						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Review of Annual Workplan 2024/25	**Board Secretary**				✓ Draft	✓ Approval
Review of Terms of Reference	**Board Secretary**					✓ Approval
Significant Issues of Wider Interest	**Director of Finance & Strategy**	**No separate letter required this year**				
Risk						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Annual Risk Management Report 2022/23	**Risk Manager**	✓ **Via email**	✓ Final			
Corporate Risk Register	**Director of Finance & Strategy/Risk Manager**	✓	✓	✓	✓	✓
Risk Management Key Performance Indicators 2022/23	**Risk Manager**			**Deferred to next mtg**	✓	✓
Risk & Opportunities Group and Progress Report	**Risk Manager**	✓ **Via email**		✓ **verbal**	✓	✓
Governance – Internal Audit						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
External Quality Assessment (5 yearly)	**Internal Audit**					✓
FTF Shared Service Agreement / Service Specification	**Internal Audit**				✓	
Internal Audit Progress Report	**Internal Audit**	✓ **Via email**		✓	✓	✓
Internal Audit Annual Plan 2023/24	**Internal Audit**		✓ Final			
Internal Audit Annual Report 2022/23	**Internal Audit**		✓			
Internal Audit – Follow Up Report on Audit Recommendations 2022/23	**Internal Audit**	✓ **Via email**		✓	✓	✓
Internal Audit Framework	**Chief Internal Auditor**					✓
Internal Controls Evaluation Report 2023/24	**Internal Audit**				✓	

Governance – External Audit						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Annual Audit Plan 2023/24	**External Audit**				✓	
External Audit – Follow Up Report on Audit Recommendations	**Director of Finance & Strategy**				✓	✓
Patients' Private Funds - Audit Planning Memorandum	**Director of Finance & Strategy**					✓
Service Auditor Reports on Third Party Services	**Director of Finance & Strategy**		✓			
Annual Accounts						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Annual Accounts Preparation Timeline	**Head of Financial Services**	✓ Via email				
Annual Accounts & Financial Statements 2022/23	**Director of Finance & Strategy / External Audit**		✓			
Annual Audit Report (including ISA 260) 2022/23	**External Audit**		✓			
Letter of Representation (ISA 580) 2022/23	**Director of Finance & Strategy / External Audit**		✓			
Patients' Funds Accounts 2022/23	**Head of Financial Services**		✓			
Annual Statement of Assurance to the NHS Board 2022/23	**Board Secretary**		✓			
Counter Fraud						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Counter Fraud Service – Quarterly Report (Alerts & Referrals)	**Head of Financial Services**	**Deferred to August**		Private Session	Private Session	Private Session
Counter Fraud Standards Update	**Head of Financial Services**	**Deferred to August**		Private Session		

Adhoc						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Private Meeting with Internal / External Auditors	**Committee**			Private Session		Private Session
Appointment of Patients' Funds Auditor	**Director of Finance & Strategy**	**As required**				
Legal & regulatory updates (e.g. Audit Scotland reports; Technical Bulletin etc)	**Head of Financial Services**					
Progress on National Fraud Initiative (NFI)	**Head of Financial Services**					
External Auditors Annual Accounts Progress Update	**External Auditor**	**No update provided as mtg cancelled**				
Additional Agenda Items (Not on the Workplan e.g. Actions from Committee)						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Risk Management Framework and GP/R7 Risk Management Policy	**Director of Finance & Strategy**			✓ **Framework**	✓ **Policy**	
Health Board Partnership Agreement April 2023 – March 2028	**Director of Finance & Strategy**		✓			
Procurement, Waiver of Competitive Tenders Q1	**Head of Financial Services**			✓		
Counter Fraud Standards Assessment 2022/23	**Head of Financial Services**			✓		
Training Sessions Delivered						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Members' Training Session – the Annual Accounts: The Role & Function of the Audit & Risk Committee	**External Auditors**	✓ **Held on 30/05/23**				
Review of the effectiveness of the new Corporate Risk Register process	**Director of Finance & Strategy**			**12/10/23**		