NHS Fife Audit & Risk Committee

Thu 17 March 2022, 14:00 - 16:00

MS Teams

Agenda

14:00 - 14:00
0 min

1. Apologies for Absence

Martin Black

14:00 - 14:00
0 min

2. Declaration of Members' Interests

Martin Black

14:00 - 14:00
0 min

3. Minutes of Previous Meeting held on 9 December 2021

Enclosed *Martin Black*

Item 3 - Audit & Risk Committee Minutes - 20211209.pdf (8 pages)

14:00 - 14:10
10 min

4. Action List / Matters Arising

Enclosed *Martin Black*

Item 4 - A&R Action List - 17 March 2022.pdf (1 pages)

14:10 - 14:20
10 min

5. STRATEGY / PLANNING

5.1. NHS Fife Population Health & Wellbeing Strategy Development Proposal

Enclosed *Margo McGurk*

Item 5.1 - SBAR NHS Fife Population Health & Wellbeing Strategy Development Proposal.pdf (4 pages)

14:20 - 14:40
20 min

6. GOVERNANCE - GENERAL

6.1. Losses & Special Payments Quarter 3 Report (Oct – Dec 2021)

Enclosed *Kevin Booth*

Item 6.1 - SBAR Losses & Special Payments Quarter 3 Report (Oct – Dec 2021) .pdf (3 pages)
Item 6.1 - Appendix 1 Summary of Losses and Special Payments (Oct - Dec 2021).pdf (1 pages)

6.2. Annual Review of Committee's Terms of Reference

Enclosed *Gillian MacIntosh*

Item 6.2 - SBAR Review of Committee's Terms of Reference.pdf (2 pages)
Item 6.2 - Appendix 1 Audit & Risk Committee's Terms of Reference.pdf (8 pages)

6.3. Committee Self-Assessment Report

Enclosed *Gillian MacIntosh*

Item 6.3 - SBAR Committee Self-Assessment Report 2021-22.pdf (10 pages)

6.4. Annual Audit & Risk Committee Workplan 2022/23

Enclosed *Margo McGurk*

Item 6.4 -SBAR Annual Audit & Risk Committee Workplan 2022-23.pdf (8 pages)

14:40 - 14:55
15 min

7. RISK

7.1. Risk Management Framework Refresh

Enclosed *Margo Mcgurk*

Item 7.1 - SBAR Risk Management Framework Refresh .pdf (13 pages)

7.2. Board Assurance Framework (BAF)

Enclosed *Pauline Anne Cumming*

Item 7.2 - SBAR NHS Fife Board Assurance Framework (BAF) .pdf (7 pages)
Item 7.2 - Appendix 1 NHS Fife BAF Financial Sustainability .pdf (1 pages)
Item 7.2 - Appendix 2 NHS Fife BAF Environmental Sustainability .pdf (1 pages)
Item 7.2 - Appendix 3 NHS Fife BAF Workforce Sustainability .pdf (2 pages)
Item 7.2 - Appendix 4 NHS Fife BAF Quality & Safety.pdf (2 pages)
Item 7.2 - Appendix 5 NHS Fife BAF Strategic & Planning .pdf (1 pages)
Item 7.2 - Appendix 6 NHS Fife BAF Integration Joint Board (IJB) .pdf (2 pages)
Item 7.2 - Appendix 7 NHS Fife BAF Digital & Information .pdf (2 pages)

14:55 - 15:25
30 min

8. GOVERNANCE - INTERNAL AUDIT

8.1. Internal Audit Progress Report

Enclosed *Barry Hudson*

Item 8.1 - SBAR Internal Audit Progress Report .pdf (4 pages)
Item 8.1 - Appendix A Internal Audit Progress Report.pdf (4 pages)

8.2. Internal Audit – Follow Up Report on Audit Recommendations

Enclosed *Barry Hudson*

Item 8.2 - SBAR Internal Audit – Follow Up Report on Audit Recommendations .pdf (18 pages)

8.3. Internal Audit Framework

Enclosed *Tony Gaskin*

Item 8.3 - SBAR Internal Audit Framework .pdf (3 pages)
Item 8.3 - Appendix1 FTF Audit Charter and Specification for Internal Audit Services.pdf (27 pages)

8.4. Internal Control Evaluation – Final Report

Enclosed *Tony Gaskin*

Item 8.4 - SBAR Internal Control Evaluation – Final Report.pdf (3 pages)
Item 8.4 - Appendix A Internal Control Evaluation B08-22.pdf (37 pages)

15:25 - 15:45
20 min

9. GOVERNANCE - EXTERNAL AUDIT

9.1. Audit Scotland Annual Audit Plan

Enclosed *Trish Fraser*

Item 9.1 - Audit Scotland Annual Audit Plan.pdf (17 pages)

9.2. Annual Accounts 2021/22 - Follow up Report on External Audit Recommendations

Enclosed *Margo McGurk*

Item 9.2 - SBAR Annual Accounts 2021-22 - Follow up Report on External Audit Recommendations.pdf (8 pages)

9.3. NHS in Scotland 2021 Report

Enclosed *Trish Fraser*

Item 9.3 - NHS in Scotland 2021 AS report.pdf (43 pages)

15:45 - 15:55
10 min

10. COUNTER FRAUD

10.1. Partnership Agreement between Health Boards & Counter Fraud Service

Enc *Kevin Booth*

Item 10.1 - Partnership Agreement between Health Boards & Counter Fraud Service.pdf (3 pages)

15:55 - 16:00
5 min

11. ESCALATION OF ISSUES TO NHS FIFE BOARD

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

Martin Black

16:00 - 16:00
0 min

12. ANY OTHER BUSINESS

16:00 - 16:00
0 min

13. DATE OF NEXT MEETING - WEDNESDAY 18 MAY 2022 AT 2PM

MINUTE OF THE AUDIT & RISK COMMITTEE MEETING HELD ON THURSDAY 9 DECEMBER 2021 AT 2PM VIA MS TEAMS

Present:
Martin Black, Non-Executive Member (Chair)
Alastair Grant, Non-Executive Member
Cllr David Graham, Non-Executive Member
Kirstie MacDonald, Non-Executive Member

In Attendance:
Kevin Booth, Head of Financial Services & Procurement
Andy Brown, Principal Auditor *(agenda item 9.3 only)*
Pauline Cumming, Risk Manager
Tony Gaskin, Chief Internal Auditor
Alistair Graham, Associate Director of Digital & Information *(agenda item 1 only)*
Barry Hudson, Regional Audit Manager
Dr Gillian MacIntosh, Head of Corporate Governance & Board Secretary
Margo McGurk, Director of Finance & Strategy
Carol Potter, Chief Executive *(agenda item 9.3 only)*
Shona Slayford, Principal Auditor *(agenda item 9.3 only)*
Hazel Thomson, Board Committee Support Officer (Minutes)

1. MEMBERS' TRAINING SESSION – CYBER SECURITY

The Associate Director of Digital & Information gave a presentation on Cyber Security Resilience. The Chair thanked Mr Graham for an informative session, noting that the potential risks in this area were significant.

It was suggested to present the Cyber Security Resilience session to the Board at a future Board Development Session. The Board Secretary will take this forward in discussion with the Board Chair.

Action: Board Secretary

The forthcoming plan to cascade cyber security information to all staff was queried, and in response the wider communication plan was outlined. It was noted there is a commitment to share cyber security information across the organisation, so that staff are aware of the risks and how to mitigate themselves against common threats.

It was questioned if there is an expectation to raise the percentage compliance against the NIS target. It was advised there is an aspiration to reach 80% by the next audit, with incremental improvement thereafter. A benchmarking exercise is currently ongoing across all NHS Health Boards in Scotland, which will support learnings and improvements, plus identify areas in which 'quick wins' could be achieved. It was noted that reaching nearer 100% compliance is increasingly difficult to achieve giving the changing nature of guidance in this area.

The Committee **noted** the Cyber Security Resilience update and thanked Mr Graham for his attendance at the session.

2. Welcome / Apologies for Absence

The Chair welcomed everyone to the meeting and extended a warm welcome to A Grant, who is attending his first meeting of the Committee since being appointed as a new Non-Executive Director of the Board.

Apologies were received from A Lawrie, Non-Executive Member, and attendees P Fraser, Audit Scotland and A Clyne, Audit Scotland.

3. Declaration of Members' Interests

There were no declarations of interest made by members.

4. Minutes of the Previous Meeting held on 16 September 2021

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

5. Action List / Matters Arising

National Datix System

The Risk Manager provided an update on the National Datix System, progress on which is currently in a holding position. Exploratory discussions are ongoing at a national level around procurement of risk management systems. It was noted that the preference would be for a Datix Cloud IQ, and outcomes of discussions at a national level are awaited. It was advised that the Board would need to consider whether we proceed on a unilateral basis. It was also advised an update was included in the Strategic Planning & Resource Allocation 2022/23 (SPRA) response at the end of November 2021 and is part of the strategic planning considerations being undertaken by the Clinical Governance Committee.

Corporate Risk Register

The timeline for updating the Corporate Risk Register item was confirmed as March 2022.

The Director of Finance & Strategy provided an explanation on extending the Corporate Risk Register item to March 2022 and advised that this action is closely linked to discussions that are ongoing on taking forward the review of our risk management arrangements, which will be the focus of the Board Development Session later this month.

The action list will be updated following the updates.

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

6. GOVERNANCE – GENERAL

6.1 Financial Operating Procedures Review 2021

The Head of Financial Services & Procurement spoke to the paper. He advised that the Financial Operating Procedures (FOPs) were last updated in 2018 and a full review has now concluded. Most sections have been updated, given the length of time since the last update. It was noted that there were a number of audit recommendations to be addressed within the FOPs and the Regional Audit Manager confirmed all the audit recommendations are concluded, which will have a positive impact on the audit follow up reporting in March 2022.

The Head of Financial Services & Procurement highlighted section 16 of the FOP and advised of improvements in process in relation to the management of losses.

It was confirmed the FOP will be widely available for staff via publication on StaffLink.

The Committee **approved** the revised Financial Operating Procedures, commending the work done to review these.

6.2 Losses and Special Payments Overview

The Head of Financial Services & Procurement noted the losses and special payments overview is a new report for the Committee's assurance. The losses and special payments form part of the statutory financial statements and annual report.

An overview of the latest quarter for losses and special payments was provided and it was noted the largest areas are within clinical and non-clinical payments.

It was questioned how assured we are that compensation payments, already paid out, will not reoccur. The Director of Finance & Strategy explained there is no guarantee these types of cases will not reoccur; however, everything is done to take learning from cases. The Chief Internal Auditor advised that alongside learning, internal systems are carefully looked at, often via Adverse Events reviews, and this is being built into the new clinical governance framework.

It was reported that all legal claims, clinical and non-clinical, go through a significant review process, and normally a serious adverse event process would be initiated immediately (and likely before) any claim. It was noted legal claims can take a number of years to work through and the process is complex, often utilising the Central Legal Office.

The Committee agreed to receiving an update on significant areas of losses and special payments on a regular basis, the timing of which will be factored into the Committee's workplan.

Action: Head of Financial Services & Procurement / Board Committee Support Officer

The Head of Financial Services & Procurement was commended for the work on losses and special payments.

The Committee **took assurance** from the overview on Losses and Special Payments.

6.3 Revised Code of Corporate Governance

The Head of Corporate Governance & Board Secretary advised that the Code of Corporate Governance is reviewed annually by the Committee, normally in April. However, with the establishment of the new Public Health & Wellbeing Committee, the Code of Corporate Governance has been reviewed earlier, to include the new Committee.

Within the Code of Corporate Governance, the Committee **agreed** to adding to the list on p.16 the new Population Health & Wellbeing Portfolio Board, which formally reports into the new Public Health & Wellbeing Committee.

It was noted the Board approved the Terms of Reference for the new Public Health & Wellbeing Committee at their meeting on 30 November 2021.

The Committee **recommended** approval to the Board of the updated Code.

6.4 Update on Board Action Plan for the Implementation of the NHS Scotland 'Blueprint for Good Governance'

The Head of Corporate Governance & Board Secretary provided background on the Blueprint for Good Governance, noting it aims to standardise governance processes across NHS Boards, through providing examples of best practice. On its release, all Boards across Scotland were asked to undertake an assessment of their current local governance arrangements (known as the Blueprint survey) against the Blueprint for Good Governance document. An action plan was subsequently developed for areas that require improvement, to ensure that we are fully implementing the Blueprint. A refresh of the survey is expected in Spring 2022. This will allow new Board members to input into the assessment of the survey.

Key areas from the action plan were highlighted, as follows: developing the IPQR and improving information that is reported to the Board; and building on the Active Governance Session (a summary of actions from the session are included in the SBAR). It was advised there have been areas of improvement since the last update. It was noted the new website is more manageable and has been kept up to date in terms of the uploading of meeting papers, and Board members' information. Standardisation of committee minutes and papers has had the helpful input of the Board Committee Support Officer, which is proving to be a vital role in delivering a quality service to the Board.

It was advised that the Board has now approved the Integration Scheme Review, and it is now with the Scottish Government for final sign off.

A review of the way we engage with the public, communities and third sector organisations need to be undertaken in light of Covid, since this has meant it impossible to resume the face-to-face engagement sessions with the Board that were successful with in the past.

The Head of Corporate Governance & Board Secretary was thanked for all the hard work carried out and the positive progress made in improving governance arrangements in Fife.

The Committee **noted** the information provided in the paper, which closes off the previous Board action plan against the initial assessment against the Blueprint for Good Governance.

7. GOVERNANCE - INTERNAL AUDIT

7.1 Internal Audit Progress Report

The Regional Audit Manager provided an update and advised advice and input has been provided to Officers of the Board, in particular, around Whistleblowing Assurance reporting and the Quality Management Assurance Terms of Reference.

Internal Audit are developing their own website, which is almost complete, and will cover the FTF Consortium Boards and the Integrated Joint Boards (IJB). The web link will be shared as part of the next progress report in March 2022.

The remaining reviews from 2021 have now concluded, and the 2021/2022 plan is progressing. Since the June 2021 meeting, a total of 10 audits have been finalised and 7 audits are currently at fieldwork stage.

Appendix A summarises reports that have been completed. It was highlighted some of the contents in the report and related action points have progressed since they were issued, and progress updates are included in the following Internal Control Evaluation report.

The Chair thanked the team for all their hard work undertaken.

The Committee **noted** the progress on the delivery of the Internal Audit Plans.

7.2 Internal Audit – Follow Up Report on Audit Recommendations

The Regional Audit Manager advised that the report represents progress against internal audit recommendations and an overview was provided on the status of all remaining internal audit recommendations as at 30 November 2021. The number of the extended recommendations with revised dates will reduce in the coming months.

The six actions relating to the Financial Operating Procedures (FOPs) are now completed and validated, following completions of the FOP review.

It was reported all Officers responded to the audit recommendations and updates on actions from Officers have clear end dates. It is anticipated the number will reduce significantly by March 2022.

The Committee **noted** and **considered** the current status of Internal Audit recommendations recorded within the report.

7.3 Internal Control Evaluation

The Chief Internal Auditor provided background and explained the purpose of the Internal Control Evaluation, noting the report covers the entirety of the organisation's governance structures and represents a mid-year position, intended to give prior warning of any potential issues prior to the financial year-end. It was noted it is a more positive report than the previous year. Very good progress, in challenging circumstances, has been made. There are more recommendations than the previous year, however they relate to suggestions to enhance and improve ongoing improvement activity. An overview was provided on the key themes, as described in the paper.

It was noted the report is not in its final version, and still requires a final proof check, particularly around the management actions now provided.

The Internal Audit team were thanked for all their hard work.

The Committee **considered** the Internal Control Evaluation and **took assurance** from its conclusions.

8. GOVERNANCE - EXTERNAL AUDIT

8.1 Annual Accounts 2020/21– Progress Update on External Audit Annual Report Recommendations

The Director of Finance & Strategy explained the purpose of the progress update was to highlight progress against the audit recommendations.

The Director of Finance & Strategy expanded on the key five recommendations and advised the recommendations are in the process of being worked through.

The ongoing difficulty in recruitment of payroll staff was highlighted, and key challenges explained. A further recruitment campaign is being progressed. Following a question on whether recruitment in this area is a national problem or one distinct to Fife, the Director of Finance & Strategy explained recruitment is not an issue in the central belt. Location of these roles within Fife has provided challenges in attracting suitably qualified candidates. For NHS Fife to deliver a resilient payroll service, we need to operate as a regional consortium. A business case, for the new Regional model, is currently being reviewed through the Committees before going to the Board for approval. It was noted one of the key changes with a consortium is the transfer of staff to NHS National Services Scotland (NSS). It was also noted staff are engaged in the move to a consortium, and assurance was provided there will be no physical movement of staff, with staff still located in Fife (although all staff are currently working from home). If approved by the Board, the phasing of the consortium will commence from June 2022.

It was reported both Internal and External Auditors have appropriately challenged the lack of firm plans to address our underlying savings gap over the last few years, and a Financial Improvement Sustainability Programme has now been launched that reports into the Portfolio Board which underpins the development of the new strategy. Four specific areas have been established to create productive opportunities and create capacity, and there are a range of key projects to deliver cash releasing savings next

financial year. Assurance was provided that we will be in a position to respond positively with agreed management actions in place.

The most recent update on the Transformation Programmes was questioned. The Director of Finance & Strategy advised that a Portfolio Board has been created to oversee all the different programmes of work and projects that would fall into the category of transformation. Two examples of programmes of transformation work were described, and it was advised the scrutiny of progress will be managed through the Portfolio Board.

The Committee **noted** the progress made in this area.

9. RISK

9.1 Risk Management Key Performance Indicators (KPI) Report

The Risk Manager provided an update and advised a review of risk management arrangements are currently underway.

The seven indicators were outlined, and it was reported there has been some improvement in relation to risks being reviewed, with the Risk Manager supporting and encouraging staff on reviewing risks.

The Committee **noted** the Risk Management KPI Report.

9.2 Board Assurance Framework (BAF)

The Risk Manager advised that the paper explains the summary position of the BAF

The Risk Manager informed the Committee that a review of arrangements is ongoing, which is providing an opportunity to examine the baseline of the BAF and question the most appropriate model of the BAF going forward.

The Committee **noted** the Board Assurance Framework update.

9.3 Risk Management Arrangements – Reviewing our Approach

The Director of Finance & Strategy gave a presentation on reviewing our approach to risk management arrangements, with discussion from the Committee on the presentation contents.

Slide 3
The Committee broadly **agreed** the Board responsibilities in terms of their role and oversight of corporate level risks. The Chief Internal Auditor made comment and said that what was described is in line with recognised practice at Board level.

Slide 4
A definition of strategic and operational risks was discussed.

It was questioned who determines the high risks. In response, it was advised each of the risk owners have a responsibility for reviewing the scoring of the risk and are ultimately responsible for indicating if a risk is high level

Slide 5
The Committee were generally supportive of more focussed reporting on risks, this being an area recognised for improvement.

Slide 6 & 7
The Committee were generally supportive of the risk dashboard reporting format that was presented.

Slide 8 & 9
It was noted defining risk appetite of the Board will determine how we focus on active risk management.

The team were thanked for all the hard work that has already been carried out. It was noted the Board will discuss this item at their forthcoming Development Session on 21 December, which will be helpful in moving this forward.

10. ESCALATION OF ISSUES TO NHS FIFE BOARD

There were no issues to highlight to the Board.

11. ANY OTHER BUSINESS

There was no other business.

Date of Next Meeting: Thursday 17 March 2022 at 2pm via MS Teams

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

AUDIT & RISK COMMITTEE – ACTION LIST
Meeting Date: Thursday 17 March 2022

NHS Fife

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	TIMESCALE	COMMENTS / PROGRESS	RAG
1.	16/09/2021	**National Datix System**	Exploratory discussions are ongoing at a national level around procurement of risk management systems. The preference is for a Datix Cloud IQ, and outcomes of discussions at a national level are awaited. The Board would need to consider whether we proceed on a unilateral basis.	**PC**	On hold	07/03/22 – The Associate Director of Quality & Clinical Governance advised it is intended a business case will be submitted in April 2022 for Datix Cloud IQ. More detail can be provided, if requested.	On hold
2.	16/09/2021	**Corporate Risk Register**	A full report will be provided on the outcomes of the review of the Corporate Risk Register at a future Committee meeting.	**PC**	May 2022	16/02/22 – report will be brought to the May meeting.	Deadline not reached
3.	09/12/2021	**Cyber Security**	The Board Secretary will take forward the suggestion to present the Cyber Security Resilience session to the Board at a future Board Development Session.	**GM**	March 2022	03/02/22 - this has been added to the schedule of forthcoming topics for Q1, 2022/23.	Closed
4.	09/12/2021	**Losses and Special Payments Overview**	An update on significant areas of losses and special payments to be provided to the Committee on a regular basis.	**KB/ HT**	Timing to be factored into the Committee's workplan	03/02/22 – workplan updated.	Closed

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**17 March 2022**
Title:	**NHS Fife Population Health & Wellbeing Strategy Development Proposal**
Responsible Executive:	**Carol Potter, Chief Executive**
Report Authors:	**Margo McGurk, Director of Finance & Strategy**

1 Purpose

This is presented to the Audit & Risk Committee for:

- Assurance

This report relates to:

- Population Health and Wellbeing Strategy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

In April 2021 the Chief Executive presented to the NHS Fife Board on the proposals to commence the development of the new organisational strategy. The NHS Fife Board supported the approach and specifically the ambition to focus the new strategy on delivering both excellence in clinical care, reducing health inequalities and improving population health and wellbeing for the people of Fife.

2.2 Background

During April through to June 2021 the EDG developed the approach to 3 stages of the strategy development. This involved a review of best practice and guidance from across NHS Scotland and internationally to ensure appropriate learning from others could be woven into our approach. The Director of Public Health also initiated the planning and early work on the Population Health Assessment; developing the key set of baseline data and population

information to help shape the strategy objectives. Work also commenced on the development of a Community and Staff engagement/conversation.

In July 2021 the NHS Fife Board approved the establishment of the Public Health and Wellbeing Committee and assigned responsibility to the Committee for oversight on the development of the new strategy. At the second meeting of the Committee in November 2021 progress was confirmed in relation to the 3 stages noted above and also the introduction of the Portfolio Board to coordinate strategy development.

In December 2021 the Omicron variant of COVID 19 emerged as a significant threat to public health and NHS Scotland retracted services, stepping back all non-essential clinical and non-clinical work. Our Strategy development work was paused with the exception of the launch of the Community and Staff conversation.

2.3 Assessment

NHS services remained under challenge coming into the new year, with the Omicron wave causing significant levels of community transmission. The population benefitted from high uptake of vaccination, rapid access to testing and reduced social mixing in response to well publicised concerns about this variant. These measures together provided additional resilience. The proportion of people developing severe illness requiring hospitalisation was lower than predicted and as a result hospital admissions and specifically critical care beds were not overwhelmed.

Given this context, retracted services have begun to remobilise and preparation to restart important aspects of corporate activity including strategy development work has commenced.

As we restart this work it will be important to consider the Board Chief Executives group portfolio approach to recovery planning, redesigning for renewal and the national transformation Care & Wellbeing Programmes (C&WB). A national C&WB Portfolio has been agreed with a mission to “Improve Healthy Life Expectancy and Fairer Outcomes” through delivering the wellbeing vision, this aligns well with the ambition and focus of the NHS Fife emerging strategy.

The sections below detail a proposal to restart a phased approach to our strategy work.

Stage 1 – Transitional one-year Strategic Plan for 2022/23

Whilst activity was paused on strategy development in December 2021, work continued on our annual SPRA process and consequently we are close to finalising our proposals on specific objectives for 2022/23. This work also includes the proposed financial and workforce plans for next financial year. The proposal is that this work will continue and will be considered through committees and presented for approval by the NHS Fife Board in March 2022.

Stage 2 – Population Health and Wellbeing Strategy Development 2023/24 – 2027/28

The proposal for the progression of the more medium to longer-term strategy is that we embark on a series of specific activities during April through to December 2022 to develop this work. A draft milestone plan indicating the specific activities and sequencing of the work is shown in the table below. The sequencing importantly reflects the interdependence between activities and how they individually influence the delivery of our strategy. The table also creates the proposed governance route for each stage of the work ensuring that the EDG, governance committees and the NHS Fife Board can review, influence and prioritise as the content for the strategy develops. This iterative engagement reflects the importance of the NHS Fife Board in supporting and guiding the strategy delivery for the organisation.

The governance route is in draft form and the committee is invited to comment and advise on any changes required.

Milestone Plan	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
	Outline Phased Approach to Strategy Development and Transitional 1-year Strategic Plan for 2022/23	Propose our Strategic Framework Approach for 2022-2027		Propose and Agree NHS Fife Programme Plans and Priorities as aligned to the 5 National Care Programmes		Propose enabling strategic Plans PAMS, Digital, Workforce, Financial		Review & Refine - NHS Fife Programme Plans and Priorities as aligned to the 5 National Care Programmes	Review & Refine all enabling strategic Plans PAMS, Digital, Workforce, Financial	Validate our Strategic Framework Approach for 2022-2027
	Propose Milestone Plan and Governance Route		Prepare Report detailing Outcomes from Current Clinical Strategy	Initial Prioritisation and phasing across Programmes and 5-year timeline				Final Prioritisation and phasing across Programmes and 5-year timeline		Finalise Draft Strategy & Delivery Plan
		Propose Population Health Assessment The Role of NHS Fife in Creating Health & Wellbeing	Review Community and Staff Engagement Survey - Inform Focused Engagement Approach	Finalise proposal in relation to the specific role of NHS Fife in Creating Health & Wellbeing		Launch Focussed Community and Staff Engagement Programme	Progress Focussed Community and Staff Engagement Programme	Report on Outcomes from Focussed Community and Staff Engagement Programme	Refine/Validate against Engagement Outcomes - NHS Fife Programme Plans and Priorities as aligned to the 5	Propose Draft Strategy and Delivery Plan to NHS Fife Board
Governance Route										
Public Health & Wellbeing Committee	√	√	√	√		√	√	√	√	√
Portfolio Board		√	√	√		√	√	√	√	√
Finance Performance & Resources Committee						√			√	
Staff Governance Committee						√			√	
Clinical Governance Committee			√	√		√			√	
Audit & Risk Committee	√									
Area Partnership Forum	√					√			√	√
Individual Programme Boards	√			√		√		√	√	
Area Clinical Forum	√		√			√			√	√
NHS Fife Board	√	√	√	√		√	√	√	√	√

2.3.1 Quality/ Patient Care

Quality of patient care and safety are both significantly important in the development of the Population Health and Wellbeing Strategy.

2.3.2 Workforce

The availability of the workforce required to deliver the ambitions of the Population Health and Wellbeing Strategy will be a critical component of this work.

2.3.3 Financial

The financial framework required to support the delivery of the Population Health and Wellbeing Strategy will be a key component of this work.

2.3.4 Risk Assessment/Management

The Population Health and Wellbeing Strategy will contain a robust risk assessment that will be monitored throughout the development and implementation of the Strategy.

2.3.5 Equality and Diversity, including health inequalities

An Equality Impact Assessment stage 1 has been completed and the plan to progress to EQIA stage 2 is in development.

2.3.6 Other impact

n/a

2.3.7 Communication, involvement, engagement, and consultation

Communication and engagement with our population, our staff and our partners is key to the delivery of an informed and effective strategy for the future. An initial Community and Staff survey was completed in December 2021, the response is being reviewed and will be reported to the Committee in May 2022. We will use the outcome of this review to propose a more focussed set of engagement activity with our communities to ensure full engagement with the population, this will also consider how we engage, and with the lifting of most of the COVID 19 restrictions we may be in a position to engage in more face to face conversations than has been possible thus far.

2.3.8 Route to the Meeting

Key aims have been socialised with members of EDG and the Chair and Vice-Chair of the NHS Fife Board. A version of this paper has been considered by the Public Health & Wellbeing Committee on 8 March 2022.

2.4 Recommendation

The Committee is asked to take assurance on the process described in the proposal to phase the development of the strategy as set out in section 2.3.

3 List of appendices

None

Report Contact
Margo McGurk
Director of Finance & Strategy/Deputy Chief Executive
Margo.mcgurk@nhs.scot

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**17 March 2022**
Title:	**Losses and Special Payments Quarter 3 Report (Oct – Dec 2021)**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Report Author:	**Kevin Booth, Head of Financial Services & Procurement**

1 Purpose

This is presented to the Audit & Risk Committee for:

- Assurance

This report relates to a:

- National policy

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

- Effective

2 Report summary

2.1 Situation

This paper presents a summary of the Board's Losses and Special Payments covering the period 01/10/21 – 31/12/21. The attached appendix quantifies the Board's Losses and Special payments into categories defined by the requirements of the Scottish Government. These categories include losses relating to fraud, damage to buildings/equipment, Debtors balances written off, damage/loss of equipment and stock, Vehicle accident and insurance excess payments and compensation payments covering financial losses suffered by patients amongst others. The report also quantifies both the clinical and non-clinical ex-gratia compensation payments for legal claims that are negotiated on the Board's behalf by the Central Legal Office.

2.2 Background

The Losses and Special Payments are controlled by the Financial Services Department and are reported to the Scottish Government as part of the Annual Accounts process. All losses and Special Payments as per section 16 of the Financial Operating Procedures are approved by the relevant Directorate/Department Head. The Loss, theft or damage forms are then provided to the Deputy Director of Finance for final approval. The ex-gratia

compensation payments for both clinical and non-clinical legal claims are agreed on the Boards behalf by the Central Legal Office. The Finance Business Partner for Corporate Services liaises with the Central Legal Office to ensure that settlements are as communicated and recharged accordingly. The Losses and Special Payments are then collated in the prescribed categories/format presented as per the requirements of the Scottish Government.

2.3 Assessment

The attached appendix summarises the Boards losses and Special Payments for the period 01/10/21 – 31/12/21. The reports categorise the types of losses and special payments made in the period while also quantifying the number of cases of each and the total monetary value. A second coulomb has also now been added to the report to inform the comparative position over the previous twelve-month period.

There were 222 losses and special payments in the quarter which was in line with the 12-month figure of 849. The cost however was significantly higher in the last quarter (£3,025,449) compared to £4,980,229 as a result of £2.856,232 cost of Clinical ex-gratia compensation payments, with the single largest payment being for £2,000,000.

Non-Clinical ex-gratia payments at £160,593 were also significantly up in quarter 3 compared to the last 12 months (£357,824), with the single largest claim being for £85,000.

It is noted in the period that there was a significant number of reports relating to vandalism losses (29) in the quarter, compared to the twelve-month period (56) although this increased number does not correlate to the cost.

To identify and minimise areas or types of recurrent loss an annual analysis report is planned to be prepared after quarter 4 and where required the Head of Financial Services will liaise with the relevant Directorate Manager/Department Head to consider and implement any changes to current working practices, which may reduce future losses.

2.3.1 Quality/ Patient Care

N/A

2.3.2 Workforce

N/A

2.3.3 Financial

The Losses and Special Payments need to be tightly controlled as they can have a material impact on the Boards financial position.

2.3.4 Risk Assessment/Management

The level of the Board's Losses and Special Payments is monitored to minimise any potential reoccurrence and future exposure to the Board.

2.3.5 Equality and Diversity, including health inequalities

The Board's treatment of its losses and special Payments is consistently applied and follows the Financial Operating Procedures where relevant to ensure equity of treatment.

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

The Boards quarterly Losses and Special Payments are complied by the Treasury Team and are provided to the Head of Financial Services and Procurement. These losses and Special Payments have already been approved by the appropriate Directorate/Department Head or in the case of legal settlements have come through following agreement/notification by the Central Legal Office.

2.3.8 Route to the Meeting

The Quarters 1 & 2 Losses and Special Payments were previously brought to the Audit and Risk Committee on the 9th of December 2021.

2.4 Recommendation

This paper is brought to the members attention to give visibility of the Board's losses and special payments in the quarter to 31st December 2021.

- **Assurance**

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Summary of Losses and Special Payments 01/10/21 – 31/12/21

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	OCT-DEC'21		JAN'21-DEC'21		
	Miscellaneous / Theft / Arson / Wilful Damage					
1	Cash					
2	Stores/procurement					
3	Equipment					
4	Contracts					
5	Payroll *Historic Superannuation*			1	1,604.00	
6	Buildings & Fixtures *Vandalism*	29	2,202.64	56	13,836.68	*standard*
7	Other					
	Fraud, Embezzlement & other irregularities (incl. attempted fraud)					
8	Cash					
9	Stores/procurement					
10	Equipment					
11	Contracts					
12	Payroll					
13	Other					
14	**Nugatory & Fruitless Payments**					
	Claims Abandoned:					
15	(a) Private Accommodation					
	(b) Other *Hardship Accounts / Insurance Excess / Debtors WO's*	155	1,195.52	656	10,718.84	*standard*
	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*	10	2,735.87	29	9,156.00	*standard*
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	12	2,856,232.76	39	4,577,421.57	*620k, 2m, 263k*
27	Compensation Payments - ex-gratia - Non Clinical	8	160,593.25	24	357,824.35	*standard*
28	Compensation Payments - ex-gratia - Financial Loss	6	2,012.00	34	7,854.94	*standard*
29	Other Payments					
	Damage to Buildings and Fixtures:					
30	Incidents of the Service :					
	- Fire					
	- Flood					
	- Accident *Vehicle Expenditure*	2	477.23	10	1,813.32	*standard*
	- Other Causes					
31	**Extra-Statutory & Extra-regulationary Payments**					
32	**Gifts in cash or kind**					
33	**Other Losses**					
		222	3,025,449.27	849	4,980,229.70	

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**17 March 2022**
Title:	**Review of Committee's Terms of Reference**
Responsible Executive:	**Margo McGurk, Director of Finance**
Report Author:	**Gillian MacIntosh, Board Secretary**

1 Purpose

This is presented to the Audit & Risk Committee for:

- Decision

This report relates to a:

- Local policy

This aligns to the following NHSScotland quality ambition:

- Effective

2 Report summary

2.1 Situation

All Committees are required to regularly review their Terms of Reference, and this is normally done in March of each year. Any changes are then reflected in the annual update to the NHS Fife Code of Corporate Governance, which is reviewed in full by the Audit & Risk Committee and then formally approved by the Board thereafter.

2.2 Background

The current Terms of Reference for the Committee were last reviewed in March 2021, as per the above cycle.

2.3 Assessment

An updated draft of the Committee's Terms of Reference is attached for members' consideration, with suggested changes tracked for ease. The proposed amendments relate to the addition of the Risk Manager as a regular attendee and updating changes to the sections on annual accounts and risk. Note, further updates to the section on Risk Management will likely be required, after the Board has considered the forthcoming changes to risk reporting and the BAFs.

Following review and approval by each Committee, an amended draft will be considered by the Audit & Risk Committee as part of a wider review of all Terms of Reference by each

standing Committee and other aspects of the Code. Thereafter, the final version of the Code of Corporate Governance will be presented to the NHS Board for approval.

2.3.1 Quality / Patient Care

N/A

2.3.2 Workforce

N/A

2.3.3 Financial

N/A

2.3.4 Risk Assessment/Management

The regular review and update of Committee Terms of Reference will ensure appropriate governance across all areas and that effective assurances are provided to the Board.

2.3.5 Equality and Diversity, including health inequalities

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

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

N/A

2.3.8 Route to the Meeting

This paper has been considered initially by the Committee Chair and Lead Executive Director.

2.4 Recommendation

This paper is provided for

- **Decision** – consider the attached remit, advise of any proposed changes and approve a final draft version for further consideration by the Board.

3 List of appendices

The following appendices are included with this report:

- Appendix 1 – Audit & Risk Committee's Terms of Reference

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

AUDIT AND RISK COMMITTEE
CONSTITUTION AND TERMS OF REFERENCE

Date of Board Approval: ***

1. PURPOSE

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

2. COMPOSITION

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

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

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

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

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

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

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

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

reporting, the Board shall ensure that at least one member can engage competently with financial management and reporting in the organisation, and associated assurances.

3. QUORUM

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

4. MEETINGS

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

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

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

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

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

5. REMIT

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

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

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

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

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

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

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

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

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

Internal Control and Corporate Governance

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

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

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

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

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

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

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

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

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

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

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

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

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

Internal Audit

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

5.10 To monitor audit progress and review audit reports.

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

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

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

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

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

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

External Audit

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

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

5.18 To consider all statutory audit material, in particular:

- Audit Reports;
- Annual Reports;
- Management Letters

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

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

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

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

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

Risk Management

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

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

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

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

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

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

- Receive and review a quarterly report summarising any significant changes to the Board's Corporate Risk Register, and what plans are in place to mitigat~~anag~~e them;

- Assess whether the Corporate Risk Register is an appropriate reflection of the key risks to the Board, so as to advise the Board;

- Consider the impact of changes to the risk register on the assurance needs of the Board and the Accountable Officer, and communicate any issues when required;

- Receive and review a quarterly update on the Board Assurance Framework;

- Assess whether the linkages between the Corporate Risk Register and the Board Assurance Framework are robust and enable the Board to identify gaps in control and assurance;

- ~~Reflect on the assurances that have been received to date, and identify whether entries on the Board's risk management system requires to be updated;~~

- Receive an annual report on risk management, confirming whether or not there have been adequate and effective risk management arrangements throughout the year, and highlighting any material areas of risk;

- The Committee shall seek assurance on the overall system of risk management for all risks and risks pertinent to its core functions.

- The Committee may also elect to request information on risks held on any risk registers within the organisation.

Standing Orders and Standing Financial Instructions

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

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

Annual Accounts

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

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

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

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

Other Matters

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

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

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

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

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

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

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

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

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

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

6. AUTHORITY

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

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

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

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

7. REPORTING ARRANGEMENTS

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

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

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**17 March 2022**
Title:	**Committee Self-Assessment Report 2021-22**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Gillian MacIntosh, Board Secretary**

1 Purpose

This is presented to the Audit & Risk Committee for:

- Discussion

This report relates to a:

- Local policy

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

- Effective

2 Report summary

2.1 Situation

The purpose of this paper is to provide the outcome of this year's self-assessment exercise recently undertaken for the Audit & Risk Committee, which is a component part of the Committee's production of its annual year-end statement of assurance.

2.2 Background

As part of each Board Committee's assurance statement, each Committee must demonstrate that it is fulfilling its remit, implementing its agreed workplan and ensuring the timely presentation of its minutes to the Board. Each Committee must also identify any significant control weaknesses or issues at the year-end that it considers should be disclosed in the Governance Statement and should specifically record and provide confirmation that the Committee has carried out an annual self-assessment of its own effectiveness. Combined, these processes seek to provide assurance that a robust governance framework is in place across NHS Fife and that any potential improvements are identified and appropriate action taken.

Following the comprehensive review undertaken in 2019 of the format and range of self-assessment questions previously used, a more light-touch review of the question set was undertaken this year, taking account of members' feedback on the length and clarity of the

previous iteration of the questionnaire. Board Committee Chairs each approved the set of questions for their respective committee.

To conform with the requirement for an annual review of their effectiveness, all Board Committees were invited to complete a self-assessment questionnaire in early February 2021. The survey was undertaken online, following overwhelmingly positive feedback on the move to a non-paper system of completion, and took the form of a Chair's Checklist (which sought to verify that the Committee is operating correctly as per its Terms of Reference) and a second questionnaire (to be completed by members and regular attendees) comprising a series of effectiveness-related questions, where a scaled 'Agree/Disagree' response to each question were sought. Textual comments were also encouraged, for respondents to provide direct feedback on their views of the Committee's effectiveness. Given the events of the past year, an additional question was added to capture any comments related to the Committee's operation during the pandemic period.

2.3 Assessment

As previously agreed, Committee chairs have received a full, anonymised extract of the survey responses for their respective committee. A summary report assessing the composite responses for the Audit & Risk Committee is given in this paper. The main findings from that exercise are as follows:

Chairs' Checklist (completed by Chair only)

It was agreed that the Committee was currently operating as per its Terms of Reference. The frequency of training opportunities for members was noted and the input of the Committee overall, despite the ongoing challenges of the Covid-19 pandemic, was commended.

Self-Assessment questionnaire (completed by members and attendees)

In total, 3 of the 4 eligible members (excluding the Chair) and 5 regular attendees completed the questionnaire. In general, the Committee's current mode of operation received a positive assessment from its members and attendees who participated. The recent training opportunities have been welcomed, particularly those timed around the scrutiny of the annual accounts, the briefing sessions delivered by colleagues from Counter Fraud Services and the recent information session on cybersecurity. The quality and detail of reports and minutes, and the timeliness of the issue of meeting papers, were highlighted positively. Satisfaction was also expressed as to how the Committee has operated during the pressures of the Covid-19 pandemic period.

Some areas for improvement were, however, highlighted. Initial comments identified for further discussion include:

- improving the processes around risk management presentation and reporting, so as to allow for appropriately prioritised scrutiny and assurance in this area (note, this is already being addressed and an update report is the subject of a separate agenda item);

- ensuring that scrutiny around the Governance Statement and preparation for the annual accounts overtly reflects on how meaningful and accurate Executive assurances are (the work around adopting Committee Assurance Principles is of importance here);
- re-introducing the tabling to the Committee of relevant Audit Scotland Technical Bulletins, to improve the information given on the work of external regulatory and inspection bodies; and
- ensuring that the Committee remains responsive and well-informed around new initiatives, such as the soon-to-be introduced Counter Fraud Standards due in April 2022.

In relation to training, it is suggested that the Committee continues to receive briefing sessions at least twice a year on matters specifically relevant to the Committee's remit. This should take the form of a briefing being delivered ideally at stand-alone sessions (given comments made from members about the existing pressure of heavy agendas at scheduled meetings) and may make use of external advisors. It is therefore suggested that the Chair and Lead Director agree a briefing programme for the forthcoming year, after seeking the Committee's input on relevant topics, and these are formally factored into the Committee's agenda planning.

2.3.1 Quality/ Patient Care

N/A

2.3.2 Workforce

N/A

2.3.3 Financial

N/A

2.3.4 Risk Assessment/Management

The use of a comprehensive self-assessment checklist for all Board committees ensures appropriate governance standards across all areas and that effective assurances are provided.

2.3.5 Equality and Diversity, including health inequalities

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

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

N/A

2.3.8 Route to the Meeting

This paper has been considered initially by the Committee Chair and Lead Executive Director.

2.4 Recommendation

This paper is provided for:

- **Discussion** – what actions members would wish to see implemented to address those areas identified for improvement.

3 List of appendices

The following appendices are included with this report:

- Appendix 1 – Outcome of Committee's self-assessment exercise

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

		Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Comments
A. Committee membership and dynamics							
A1.	The Committee has been provided with sufficient membership, authority and resources to perform its role effectively and independently.	3 (37.5%)	5 (62.5%)	-	-	-	I think there is a good balance to the Committee, which helps with constructive discussions. Agree. This is my impression and experience as a relatively new attendee. I am not aware of any discourse within the Committee indicating otherwise.
A2.	The Committee's membership includes appropriate representatives from the organisation's key stakeholders.	3 (37.5%)	5 (62.5%)	-	-	-	From recent experience and review of other similar committees, membership appears appropriate. If not, I assume this would have been raised as a concern and I am unaware that this has occurred.
A3.	Committee members are clear about their role and how their participation can best contribute to the Committee's overall effectiveness.	-	8 (100%)	-	-	-	Certainly, from my own standpoint, I feel clear on my role/participation. I believe this to be the case and I'm clear about my own role and expectations.
A4.	Committee members are able to express their opinions openly and constructively.	3 (37.5%)	5 (62.5%)	-	-	-	I feel the debates are very open and opinions are well considered by the Chair. My experience is that the Committee is welcoming, inclusive, encouraging and invites contributions. People are given opportunities and time to speak.
A5.	There is effective scrutiny and challenge of the Executive from all Committee members, including on matters that are critical or sensitive.	1 (12.5%)	6 (75%)	1 (12.5%)	-	-	I feel there is constructive questioning from the Non-Exec members at the Committee. The embedding of Committee Assurance Principles is likely to enhance and further elevate critical discussions in which the review and constructive challenge of the assurances provided in terms of reliability, integrity and evidence base are fundamental.
A6.	The Committee has received appropriate training / briefings in relation to the areas applicable to the Committee's areas of business.	2 (25%)	6 (75%)	-	-	-	During my relatively short time on the Committee, training and briefings have been highly relevant i.e., D&I & cyber security, and counter fraud.
A7.	Members have a sufficient understanding and knowledge of the issues within its particular remit to identify any areas of concern.	-	7 (87.5%)	1 (12.5%)	-	-	I believe there is a significant level of knowledge and experience at present to be able to actively discuss matters of concern.

B. Committee meetings, support and information							
B1.	The Committee receives timely information on performance concerns as appropriate.	1 (12.5%)	6 (75%)	1 (12.5%)	-	-	-
B2.	The Committee receives timely exception reports about the work of external regulatory and inspection bodies, where appropriate.	2 (25%)	5 (62.5%)	1 (12.5%)	-	-	Apart from year end Governance Statement, not sure this happens?
B3.	The Committee receives adequate information and provides appropriate oversight of the implementation of relevant NHS Scotland strategies, policy directions or instructions.	1 (12.5%)	7 (87.5%)	-	-	-	-
B4.	Information and data included within the papers is sufficient and not too excessive, so as to allow members to reach an appropriate conclusion.	1 (12.5%)	6 (75%)	1 (12.5%)	-	-	-
B5.	Papers are provided in sufficient time prior to the meeting to allow members to effectively scrutinise and challenge the assurances given.	2 (25%)	6 (75%)	-	-	-	-
B6.	Committee meetings allow sufficient time for the discussion of substantive matters.	3 (37.5%)	5 (62.5%)	-	-	-	I feel the time allotted is managed well to give appropriate time to consider matters.
B7.	Minutes are clear and accurate and are circulated promptly to the appropriate people, including all members of the Board.	4 (50%)	4 (50%)	-	-	-	-
B8.	Action points clearly indicate who is to perform what and by when, and all outstanding actions are appropriately followed up in a timely manner until satisfactorily complete.	4 (50%)	4 (50%)	-	-	-	-

B9.	The Committee is able to provide appropriate assurance to the Board that NHS Fife's policies and procedures (relevant to the Committee's own Terms of Reference) are robust.	1 (12.5%)	7 (87.5%)	-	-	-	-
B10.	Committee members have confidence that the delegation of powers from the Board (and, where applicable, the Committee to any of its sub-groups) is operating effectively as part of the overall governance framework.	2 (25%)	5 (62.5%)	1 (12.5%)	-	-	-
C. The Role and Work of the Committee							
C1.	The Committee reports regularly to the Board verbally and through minutes, can escalate matters of significance directly and makes clear recommendations on areas under its remit when necessary.	2 (25%)	6 (75%)	-	-	-	-
C2.	In discharging its governance role, the focus of the Committee is at the correct level.	-	7 (87.5%)	1 (12.5%)	-	-	-
C3.	The Committee's agenda is well managed and ensures all topics within the Committee's Terms of Reference are appropriately covered.	3 (37.5%)	5 (62.5%)	-	-	-	-
C4.	Key decisions are made in a structured manner and can be publicly evidenced.	1 (12.5%)	6 (75%)	1 (12.5%)	-	-	I think the Chair ensures this effectively.
C5.	What actions could be taken, and in what areas, to further improve the effectiveness of the Committee in respect of discharging its remit?	I think that the level of the Committee is correct for what is it charged to do. The Committee would benefit from increased focus on scrutiny of financial / commercial statements and risk management. The Risk Management Review and Policy Renewal will enable a greater level of assurance that risks are identified, managed and reported consistently. And will enable a greater strategic focus and clarity on mitigation. It would be helpful if we had a complete understanding of this by end of financial year 21/22.					

		More concise papers of a limited size with clear executive summaries. As has been discussed, consider repositioning the risk management items to an earlier point in the agenda.					
C6.	Particularly in reference to the challenges faced during the ongoing Covid pandemic, are you content with the Committee's input and oversight of areas of NHS Fife's response relevant to the Committee's particular remit? Please provide comments.	Yes, with the caveat of Risk Management being a work in progress. New member - can't comment. Risks relating to the COVID pandemic have been regularly reported to EDG and referenced in some components of the Board Assurance Framework but not overtly reported to this Committee. There may be merit in considering if such risks should be reported in the year ahead.					
D. Audit & Risk Committee specific questions							
AR1.	At least one of the Audit & Risk Committee members has sufficient relevant and recent financial experience.	2 (25%)	5 (62.5%)	1 (12.5%)	-	-	Non Exec and Exec qualified accountants.
AR2.	All members, including the chair, are suitably independent of the Executive function.	3 (37.5%)	5 (62.5%)	-	-	-	-
AR3.	Members are sufficiently independent of the other key committees of the Board.	1 (12.5%)	6 (75%)	1 (12.5%)	-	-	I am not aware of any positions that compromise independence. I believe this to be the case.
AR4.	The Audit & Risk Committee annual schedule of meetings is suitable for NHS Fife's business and governance needs, as well as the requirements of the financial reporting calendar.	1 (12.5%)	6 (75%)	1 (12.5%)	-	-	The Committee is considerate of the financial calendar.
AR5.	The Audit & Risk Committee appropriately satisfies itself that the arrangements for risk management, control and governance have operated effectively throughout the reporting period.	2 (25%)	5 (62.5%)	1 (12.5%)	-	-	-
AR6.	The Audit & Risk Committee effectively considers how accurate and meaningful the Governance Statement is.	2 (25%)	6 (75%)	-	-	-	Agree this is improving, however continued focus is required.

AR7.	The Audit & Risk Committee appropriately considers how it should coordinate with other Committees that may have responsibility for risk management and corporate governance.	-	6 (75%)	2 (25%)	-	-	-
AR8.	The Audit & Risk Committee has satisfied itself that NHS Fife has adopted appropriate arrangements to counter and deal with fraud.	2 (25%)	6 (75%)	-	-	-	I agree, although I anticipate that with the introduction of the Counter Fraud Standards this stance may need to be reviewed.
AR9.	The Audit & Risk Committee has been made aware of the role of risk management in the preparation of the internal audit plan.	2 (25%)	6 (75%)	-	-	-	Agree. However, the risk management arrangements across the organisation have been identified as an area requiring greater focus and improvements on presentation.
AR10.	The Audit & Risk Committee's role in the consideration of the annual accounts is clearly defined.	3 (37.5%)	5 (62.5%)	-	-	-	I believe it was clearly spelled out in the year past.
AR11.	The Audit & Risk Committee has gained an appropriate understanding of management's procedures for preparing NHS Fife's annual accounts.	2 (25%)	6 (75%)	-	-	-	I think the work carried out by Audit Scotland this year was beneficial to refresh the Committee's understanding. Agree, however continued focus is required.
AR12.	The Audit & Risk Committee approves, annually and in detail, the internal audit plans, including consideration of whether the scope of internal audit work addresses NHS Fife's significant risks.	2 (25%)	6 (75%)	-	-	-	Agree, however the noted improvements required in relation to risk management are important in this regard.
AR13.	Outputs from follow-up audits by internal audit are appropriately monitored by the Audit & Risk Committee and the Committee considers the adequacy of implementation of recommendations.	3 (37.5%)	5 (62.5%)	-	-	-	-
AR14.	There is appropriate co-operation between the internal and external auditors.	1 (12.5%)	6 (75%)	1 (12.5%)	-	-	New member - can't comment.

AR15.	The Audit & Risk Committee reviews the adequacy of internal audit staffing and other resources.	-	4 (50%)	4 (50%)	-	-	This is reviewed as part of the Internal Audit Annual Plan. New member - can't comment.
AR16.	Internal audit performance measures are appropriately monitored by the Audit & Risk Committee.	1 (12.5%)	6 (75%)	1 (12.5%)	-	-	New member - can't comment.
AR17.	The external auditors effectively present and discuss their audit plans and strategy with the Audit & Risk Committee (recognising the statutory duties of external audit).	4 (50%)	3 (37.5%)	1 (12.5%)	-	-	-
AR18.	The Audit & Risk Committee appropriately reviews the external auditor's annual report to those charged with governance.	3 (37.5%)	4 (50%)	1 (12.5%)	-	-	-
AR19.	The Audit & Risk Committee adequately ensures that officials are monitoring action taken to implement external audit recommendations.	2 (25%)	5 (62.5%)	1 (12.5%)	-	-	-
AR20.	The Audit & Risk Committee assesses effectively the performance of external audit.	-	5 (62.5%)	3 (37.5%)	-	-	-
AR21.	Agenda papers are circulated timely in advance of the meeting, to allow adequate preparation by Audit & Risk Committee members.	4 (50%)	3 (37.5%)	1 (12.5%)	-	-	-
AR22.	Reports to the Audit & Risk Committee communicate relevant information at the right frequency, time and in a format that is effective.	1 (12.5%)	6 (75%)	1 (12.5%)	-	-	When the Committee identify room for improvement, this is considered and appropriate action taken.

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**17 March 2022**
Title:	**Annual Audit & Risk Committee Workplan 2022-23**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Gillian MacIntosh, Board Secretary**

1. Purpose

This is presented to the Audit & Risk Committee for:

- Approval

This report relates to a:

- Local policy

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

- Effective

2. Report Summary

2.1 Situation

The Audit & Risk Committee last agreed its annual workplan in May 2021, to manage effectively the work of the Committee throughout the year. The extant plan took account of the impact of Covid on the Committee's schedule of business, particularly the extended timetable for the approval of the 2020-21 annual accounts. The version of the workplan for this year reflects the July 2022 date for the consideration of this year's annual financial statements, as agreed with the External Auditors.

2.2 Background

The Audit & Risk Committee normally sets out the planned work for the financial year in its annual workplan, which is used to inform the content of individual meeting agendas. The NHS Fife *Code of Corporate Governance* states that all Committees "will draw up and approve, before the start of each year, an annual workplan for the Committee's planned work during the forthcoming year".

2.3 Assessment

An updated version of the Audit & Risk Committee workplan is attached for the Committee's consideration. Included therein, are two post-meetings each year (September

and March) for members to meet privately with the Internal and External Auditors, without management present.

2.3.1 Quality/ Patient Care

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

2.3.2 Workforce

N/A.

2.3.3 Financial

Ensuring appropriate scrutiny of NHS Fife's financial accounting processes is a core part of the Committee's remit.

2.3.4 Risk Assessment/Management

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

2.3.5 Equality and Diversity, including health inequalities

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

2.3.6 Other impact

N/A.

2.3.7 Communication, involvement, engagement and consultation

N/A.

2.3.8 Route to the Meeting

This paper has been considered in draft by the Director of Finance & Strategy and Head of Financial Services and takes account of any initial comments thus received. Input has also been sought from Internal Audit, External Audit and the Risk Manager on the timings and schedule of their particular items.

2.4 Recommendation

The paper is provided for:

- **Approval** – subject to members' comments regarding any amendments necessary

3 List of appendices

The following appendices are included with this report:

- Appendix 1 – Annual Workplan 2022-23

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

AUDIT & RISK COMMITTEE

PROPOSED ANNUAL WORKPLAN 2022 / 2023

Governance - General							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**08/12/22**	**16/03/23**
Minutes of Previous Meetings	**Chair**	✓	✓	✓	✓	✓	✓
Action Plan	**Chair**	✓	✓	✓	✓	✓	✓
Escalation of Issues to NHS Board	**Chair**	✓	✓	✓	✓	✓	✓
Governance Matters							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**08/12/22**	**16/03/23**
Committee Self-Assessment	**Board Secretary**						✓
Corporate Calendar / Committee Dates	**Board Secretary**				✓		
Review of Annual Workplan	**Board Secretary**	✓	✓	✓	✓	✓	✓ Approval
Review of Terms of Reference	**Board Secretary**						✓ Approval
Annual Review of Code of Corporate Governance	**Board Secretary**	✓					
Annual Assurance Statement 2021/22	**Board Secretary**		✓ Draft	✓			
Annual Assurance Statements from Standing Committees 2021/22	**Board Secretary**		✓				
IJB Annual Assurance Statement 2021/22	**Board Secretary**		✓				
Significant Issues of Wider Interest	**Director of Finance & Strategy**		✓ Draft	✓			
Governance Statement	**Director of Finance & Strategy**	✓ Draft	✓				
Internal Audit Review of Property Transactions Report 2021/22	**Internal Audit**				✓		
Losses & Special Payments	**Head of Financial Services**		✓		✓	✓	✓

Risk							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**08/12/22**	**16/03/23**
Annual Risk Management Report 2021/22	**Risk Manager**	✓ Draft	✓				
Risk Management Key Performance Indicators 2021/22	**Risk Manager**	✓			✓	✓	✓
Board Assurance Framework (BAF)	**Risk Manager**	✓			✓	✓	✓
Risk Management Framework – Progress Report	**Risk Manager**	✓			✓	✓	✓
Governance – Internal Audit							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**08/12/22**	**16/03/23**
Internal Audit Progress Report 2021/22	**Internal Audit**	✓			✓	✓	✓
Internal Audit Annual Report 2021/22	**Internal Audit**		✓				
Internal Audit – Follow Up Report on Audit Recommendations 2021/22	**Internal Audit**	✓			✓	✓	✓
Annual Internal Audit Plan 2022/23	**Internal Audit**	✓ Draft	✓				
FTF Shared Service Agreement / Service Specification	**Internal Audit**					✓	
External Quality Assessment (5 yearly)	**Internal Audit**				✓		
Governance – External Audit							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**08/12/22**	**16/03/23**
Annual Audit Plan 2022/23	**External Audit**						✓
Audit Planning Memorandum – Patients' Private Funds	**Director of Finance & Strategy**	✓					
External Audit – Follow Up Report on Audit Recommendations	**Director of Finance & Strategy**					✓	✓

Governance – External Audit (cont.)							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**08/12/22**	**16/03/23**
Service Auditor Reports on Third Party Services	**Director of Finance & Strategy**	✓ Draft	✓				
Annual Accounts							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**08/12/22**	**16/03/23**
Annual Accounts & Financial Statements 2021/22	**Director of Finance & Strategy / External Audit**			✓			
Annual Audit Report (including ISA 260) 2021/22	**External Audit**			✓			
Letter of Representation (ISA 580) 2021/22	**Director of Finance & Strategy / External Audit**			✓			
Patients' Funds Accounts 2021/22	**Head of Financial Services**			✓			
Annual Statement of Assurance to the NHS Board 2021/22	**Board Secretary**			✓			
Counter Fraud							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**08/12/22**	**16/03/23**
Counter Fraud Service – Quarterly Report (Alerts & Referrals)	**Head of Financial Services**	Private Session			Private Session	Private Session	Private Session
Adhoc							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**08/12/22**	**16/03/23**
Private Meeting with Internal / External Auditors	**Committee**				✓		✓
Appointment of Patients' Funds Auditor	**Director of Finance & Strategy**	**As required**					

Adhoc (cont.)							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**08/12/22**	**16/03/23**
Progress on National Fraud Initiative (NFI)	**Head of Financial Services**	**As required**					
Legal & regulatory updates (e.g. Audit Scotland reports; Technical Bulletin etc)	**Head of Financial Services**						
Additional Agenda Items (Not on the Workplan e.g. Actions from Committee)							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**08/12/22**	**16/03/23**
Training Sessions Delivered							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**08/12/22**	**16/03/23**

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**17 March 2022**
Title:	**Risk Management Framework Refresh**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Report Author:	**Gemma Couser, Associate Director of Quality and Clinical Governance and Pauline Cumming, Risk Manager**

1 Purpose

This is presented to the Audit & Risk Committee for:

- Assurance

This report relates to a:

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

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

NHS Fife is committed to embedding an effective risk culture. Further to the risk management session with EDG on 23 September 2021 and the Board Development Session on 21 December 2021, this paper provides a summary of the plan to refresh the NHS Fife Risk Management Framework. Included in this paper is an overview of the plan to develop and implement the following:

I. A Board Strategic Risk Profile
II. A Corporate Risk Register to replace the current Board Assurance Framework
III. Risk dashboard to complement the updated Integrated Performance and Quality Report (IPQR) and to support effective performance management
IV. An updated process to support the escalation, oversight and governance of risks

V. A Risks and Opportunities Group

This year there has been a reset across NHS Fife with two key strategic workstreams being progressed:

1. In the last financial year a new consolidated and system wide Strategic Planning and Resource Allocation (SPRA) process was launched. The SPRA is intended to create a planning and resource allocation framework to support the development and delivery of a 3-year organisational plan for NHS Fife. This collaborative approach will identify priorities and ensure alignment of resource to deliver these across the full organisation including the Health and Social Care Partnership.

2. Refresh of the Clinical Strategy for NHS Fife which will be taken forward as part of the development of the Population Health and Wellbeing Strategy for NHS Fife, with NHS Fife aspiring to become an Anchor Institution.

In order to deliver these crucial workstreams it is paramount that organisational risk management is fully integrated in the process. Effective risk management arrangements will contribute to successful delivery of these two workstreams through:

- Supporting operational teams to identify and manage operational risks effectively;
- Alignment with the SPRA process to identify organisational risks to assist in informing organisational objectives;
- Identifying risks which may comprise delivery of the objectives;
- Managing and foreseeing risks generated through delivery of the Population Health and Wellbeing Strategy and;
- Supporting the organisation to identify possible opportunities for innovation.

2.2 Background

Risk Management in NHS Fife

NHS Fife is committed to embedding a risk management culture which:

- Ensures the safety of patients and staff
- Fully integrates risk management with the strategic planning process
- Foresees operational, financial and strategic risks that may comprise delivery of organisational objectives through proactive planning and mitigation
- Is supported by an effective and visible risk management framework which is used proactively across the organisation from ward to Board

Resource and Leadership for Risk Management

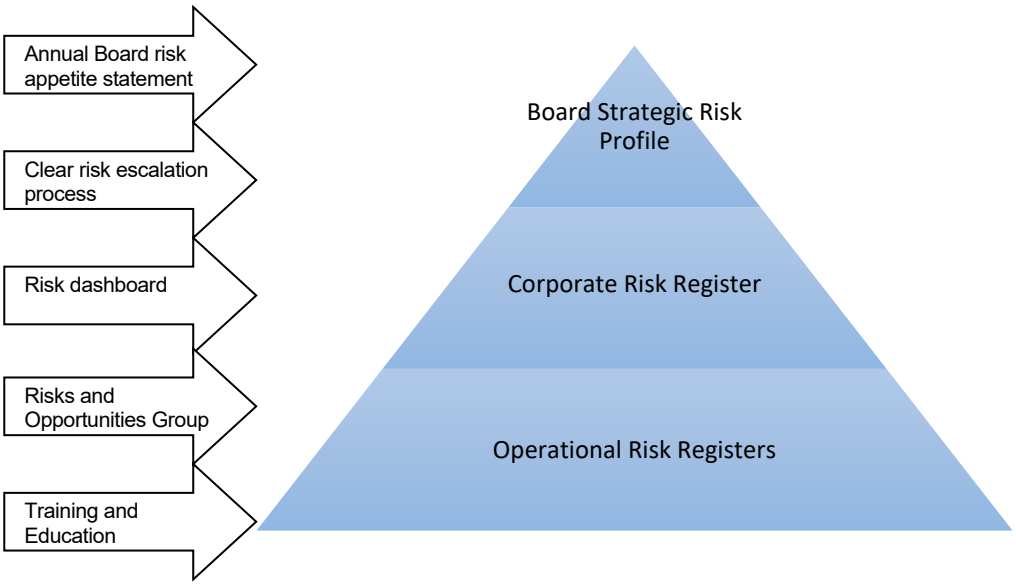
In April 2021, EDG approved funding band 8A funding for 1 year to release the Risk Manager from Adverse Events to provide dedicated leadership for risk and drive forward the refresh of the Risk Management Framework. The need for dedicated risk expertise is recognised and in order to sustain this position it is recommended that this funding is allocated on a substantive basis.

2.3 Assessment

Strategic and operational risks are an inherent part of healthcare delivery. An effective risk management structure and approach is paramount in supporting the organisation to achieve strategic priorities. The objective is to deliver:

- A structured approach where risks are reviewed, addressed and controlled through governance structures of the Board
- Alignment of the organisational risk profile to the strategic planning agenda
- Promotion of a just culture to encourage the proactive identification and mitigation of risks from ward to Board
- Development of an annual Board risk appetite statement; stating the nature/ level of risks to be accepted/tolerated and the balance of risk versus reward

The current Risk Management Framework will be replaced with the following structure:



A summary of the plan to refresh the Risk Management Framework is summarised below:

	Workstream	Description/ Actions	By when
1	Board Strategic Risk Profile	Development of a risk profile against our strategic priorities: 1. To improve health and wellbeing 2. To improve the quality of health and care services 3. To improve staff experience and wellbeing 4. To deliver value and sustainability	Draft Complete (see appendix 1)
2	Corporate Risk Register to replace Board Assurance Framework	Corporate Risk Register (CRR) - contains the highest scoring risks from across the organisation that have the potential to affect the whole organisation, or operational risks which have been escalated e.g. can no longer be managed by a service or require senior ownership and support to mitigate. The register will be routinely reviewed and monitored by Executive Directors. The CRR will be comprised of the following components: 1. Clinical Quality and Safety 2. Property and Infrastructure (including Digital and Information) 3. Workforce 4. Finance Engagement sessions will be held in March and April with Senior Leadership Teams for Acute Services, HSCP, Workforce, Finance, Pharmacy, Digital and Information, Property and Asset Management Review of risks to clarify strategic risks v corporate risks v operational risks There will be a containment of number of risks on the CRR to ensure focus and impact	June 2022
3	Risk Dashboard	This will support a proactive risk management culture in supporting performance management. The dashboard will consider current risk level, target risk level, and related improvement or deterioration. It will consider risk mitigation and anticipated timescales to achieve risk reduction. The dashboard will also align to the refreshed IPQR. For risks which are deteriorating, it is proposed a 'deep dive' summary risk profile will be provided.	April 2022

4	Escalation Process	All staff throughout the organisation have a responsibility for identifying risk. To ensure that risks are managed effectively, they must be escalated to the appropriate levels in the organisation and to external stakeholders where necessary. Directors will have overall responsibility for establishing effective risk escalation procedures supported by: • Risk reviews; • Governance group risk reviews; and Risk Leads who chair the Management Groups and provide advice on risk under the following broad categories :Clinical Quality and Safety, Property and Infrastructure (including Digital and Information), Workforce and Finance • EDG review risks and escalate to the Board any strategic risks **ESCALATION PROCESS** This will include consideration of the following: EDG • Discuss risk at EDG or proposed Risk & Opportunities Group • Develop action plan • Manage through risk register and Directorate or equivalent Management Group Executive Risk Owner • Can this risk be managed with directorate? • Does the risk impact on the wider organisation? • Share with EDG. Line Manager, Risk Owners, Portfolio, Project and Programme leads • Can this risk be managed locally? • Is the risk on the register? • Who is the risk owner? Other directorate? Escalate to appropriate Directorate senior manager • Escalate to Executive risk owner.	June 2022

		All Staff • Can the risk be managed as part of Business As Usual (BAU)? • What is the impact and likelihood of the risk? • Escalate to line manager	
5	Risks and Opportunities Group	Establish a Risks and Opportunities Group to: • Promote leadership to ensure the organisation gives risk management the appropriate priority; and facilitates and delivers effective risk management arrangements within NHS Fife • Provide assurance that appropriate systems are in place to support delivery of the strategic objectives • Develop, implement and monitor the implementation of the risk management framework to ensure processes are in place and operating effectively to identify, manage, and monitor risks across the organisation; • Identify risks and opportunities to the strategic objectives of the organisation • Assess risks, opportunities, issues and events that arise and respond accordingly • Horizon scan for future opportunities, threats and risks linked to the delivery NHS Fife's strategic priorities • Consider the external environment for review of risks and opportunities in the context of national directives • Ensure continuous improvement of the organisation's control environment	August 2022

2.3.1 Quality/ Patient Care

Elevating the risk management framework in NHS Fife will support the further development of the quality and patient safety agenda through improved operational governance and strategic planning.

2.3.2 Workforce

There is a requirement to ensure that the appropriate workforce is in place to support the changes to the framework including updates to the Datix system. Arrangements for this are currently being explored.

The refresh of the Risk Management Framework will also include a training needs analysis to design an effective training and education strategy to support this change.

2.3.3 Financial

Once the workforce arrangements to support this change are confirmed an update to summarise the financial impact will be provided.

2.3.4 Risk Assessment/Management

This paper summarises actions to enable NHS Fife to progress an effective risk management framework and culture to support the achievement of the strategic priorities.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment has not been conducted.

2.3.6 Other impact

The separation of risk management and adverse events will have a beneficial impact of providing equal focus on these respective fundamental activities.

2.3.7 Communication, involvement, engagement and consultation

This paper has been developed in discussion with the following key stakeholders and groups:

- The Risk Manager
- Director of Finance and Strategy
- Associate Director for Quality and Clinical Governance
- Principles and approach discussed at the Audit and Risk Committee

2.3.8 Route to the Meeting

This paper has been developed in collaboration with stakeholders set out above.

- EDG, 17 February 2022

2.4 Recommendation

The Committee is asked to take assurance from the proposed workplan to refresh the Risk Management Framework.

Report Contact
Gemma Couser
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Email gemma.couser2@nhs.scot

Appendix 1

DRAFT STRATEGIC PRIORITIES AND RISKS

STRATEGIC PRIORITY	Comments
To Improve Health and Wellbeing	
RISKS	
1.There is a risk that after more than 23 months of reduced levels of healthcare service as a consequence of the COVID -19 pandemic, and foreseeable continuation into the future compounded by the challenges of emerging variants and other respiratory pathogens, population health and wellbeing will be adversely affected which could result in: • increased population morbidity and mortality • increased pressure on healthcare and support services affecting service delivery • reduced capacity for non urgent services • high levels of employee absence due to personal illness and caring responsibilities • limited capacity to develop, transform and sustain services • non delivery on key quality performance measures	
2. There is a risk that the development and the delivery of the NHS Fife Population Health and Wellbeing Strategy is not adequately supported by the required planning and programme management capacity, capability and governance arrangements, resulting in delays to progression and implementation of this critical component of Fife's strategic approach to delivering the 4 national Care Programmes: Integrated Unscheduled Care, Integrated Planned Care, Place and Wellbeing and Preventative and Proactive Care.	
3. There is a risk that if the Population Health & Wellbeing Strategy does not incorporate learning from the COVID-19 pandemic and align with the motivations, aspirations and expectations of the people of Fife, the Board's vision, corporate objectives and key priorities will not be achieved, resulting in services that are neither transformational nor sustainable in the long term.	
To Improve the Quality of Health and Care Services	
RISKS	
1. There is a risk that due to failure of clinical governance, performance and management systems (including information governance & information	

security), NHS Fife may be unable to provide safe, effective, person centred care. Additionally, there is a risk that the effects of the COVID - 19 pandemic, including restricted capacity, reduced elective & non urgent services, and workforce pressures, will impact on the quality & safety of patient care and service delivery.	
2. There is a risk that sustained whole system pressures due to factors including COVID -19, and demand outstripping capacity within acute, primary and social care services will result in: • inability to timeously discharge medically fit patients, thus increasing their length of stay resulting in: o increased clinical risk including healthcare associated infection and deconditioning o reduced number of downstream beds o delayed patient pathways and negative impacts on safe capacity and patient flow o financial and workforce impacts due to the need to open and staff additional beds o increased Emergency Department (ED) attendances o unmet performance targets including those relating to: • 4 hour ED access • patients in delay • waiting times • treatment times • Remobilisation Plan • sub optimal patient experience and outcomes • reputational harm	
3.There is a risk that if we do not implement effective strategic workforce planning (including aligning funding requirements), we will not have the right size of workforce, with the right skills and competencies, organised appropriately within an affordable budget, to deliver business as usual services, respond to the ongoing challenges of COVID-19, and implement necessary transformation, resulting in sub optimal delivery, reputational harm, and further impacts on staff wellbeing and recruitment / retention rates.	
4. There is a risk that failure to invest appropriately in D&I resilience including the D&I Strategy and current operational lifecycle commitment, may result in an inablity to make essential transformation across Health and Social care to deliver sustainable and integrated services that are safe, secure and compliant with governance frameworks and associated legislation including Cyber Essentials and Network & Informations Systems Regulations, and future proofed as far as reasonable and practicable.	
To Improve Staff Experience and Wellbeing	
RISKS	

1. There is a risk that because of current pressures and capacity challenges, staff may be unable to fully engage with the development of the Population Health and Wellbeing Strategy which underpins our aspiration to be an Anchor Institution i.e. one that positively influences the health and wellbeing of our communities. This may result in a strategy which does not: • recognise staff opinions and experiences • reflect staff values and motivations • reinforce the vital contribution of staff to creating a listening and learning organisation • relate to staff understanding of how we will achieve our ambition to develop and deliver a person-centred health and care system that reduces health inequalities and improves health and wellbeing for all citizens across Fife	
2. There is a risk that operating under restrictions including social distancing and working from home through subsequent waves of the pandemic whilst trying to recover / maintain services and manage increased public need, expectations and tensions, may result in result in: • sub optimal working relationships • staff feeling isolated • reduced staff resilience • increased staff absence • impact on safety and quality of patient care and services	
3. There is a risk that at a time of significant pace and scale of change, we are unable to meet our obligations in relation to required staff training and development, resulting in: • staff feeling unsupported and vulnerable due to not having the correct competencies • reduced staff resilience • reduced job satisfaction • negative impacts on role performance and the safety and quality of patient care and services • reputational damage • impacts on retention and recruitment rates	
To Deliver Value and Sustainability	
RISKS	
1.There is a risk that the funding required to deliver the current and anticipated future service models, particularly in the context of the EU exit and the COVID - 19 pandemic, and associated supply chain issues and increased prices, will not	

match costs incurred, which may result in an inability to maintain and develop services and meet legislative requirements.	
2.There is a risk that failure to implement, monitor and review an effective financial planning, management and performance framework, including fully identifying the level of savings required to achieve recurring financial balance, may result in the Board being unable to deliver on its required financial targets.	
3.There is a risk that failure to assess our property and assets, and secure resources to support improvements to the condition, capacity and resilience of the estate and infrastructure may: • affect compliance with statutory obligations in relation to environmental & sustainability legislation • limit our ability to redesign and accommodate reconfigured services and different models of care to meet clinical demand • impede delivery of the Population Health and Wellbeing Strategy	

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**17 March 2022**
Title:	**NHS Fife Board Assurance Framework**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Report Author:	**Pauline Cumming, Risk Manager**

1 Purpose

This is presented to the Audit & Risk Committee for:

- Assurance

This report relates to a:

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

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Board Assurance Framework (BAF) identifies risks to the delivery of NHS Fife's strategic objectives and priorities, including the NHS Fife Strategic Framework, the NHS Fife Clinical Strategy and the Fife Health & Social Care Integration Strategic Plan. The BAF integrates information on strategic risks, related operational risks, controls, assurances, mitigating actions and an assessment of current performance. This is an update to the Committee since the last report on 9 December 2021.

Due to the emerging Omicron picture and system pressures, the governance committees scheduled for January 2022, had condensed agendas which did not include the BAF. This paper therefore summarises the updates on the BAF components that will be reported to the governance committees in March 2022.

2.2 Background

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

At the last meeting of the Committee on 9 December 2021, the Director of Finance & Strategy gave a presentation on the review of the effectiveness of our risk management arrangements including the BAF. She highlighted areas to consider for improvement and outlined a possible approach to simplify and add focus to our reporting, and fulfil the Board requirements in terms of active governance of risk. These will include:

- Development of a Board Strategic Risk Profile
- Transition from the BAF to a Corporate Risk Register (CRR)
- Creation of a risk dashboard to complement the updated Integrated Performance and Quality Report (IPQR) and to support effective performance management

The presentation generated discussion from the Committee and support for further consideration at the Board Development session on 21 December 2021.

Following that session and the Board's endorsement of the proposed principles and approach, a paper including an overview of an implementation plan was presented to EDG on 17 February 2022. This received unanimous support. The paper is provided separately for the Committee's attention.

Key considerations to emerge from EDG include the following:

- As we move from the BAF to a CRR, it will be important to map out the changes in order to provide assurance that nothing falls through at point of transition;
- In terms of strategic risks and priorities, we must increase visibility of the climate emergency and consider if this sits within value and sustainability or separately;
- The need to make explicit linkages with organisational values and a just culture;
- Consider how the changes will impact on committee agendas

2.3 Assessment

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

Table 1 - Risk Level and Rating over time

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

Key points from updates to be provided to Committees

The BAFs are provided separately in appendices.

Financial Sustainability BAF

The Director of Finance & Strategy will report to the Finance, Performance & Resources (FP&R) Committee on 15 March 2022 as follows:

The BAF current risk level has been reviewed and reduced from high to moderate in terms of likelihood and consequence.

The update reflects the current position where, following our Quarter 3 reporting submission, and a follow up meeting with Scottish Government, confirmation of non repayable funding support to allow the Board to break even this financial year will be forthcoming. In addition, full funding of COVID - 19 costs is anticipated in full for this financial year. To that end, Scottish Government support for our financial gap is more certain (pending receipt of our January funding allocation letter).

Linked Risk Updates

Risk 1513 - Financial and Economic impact of Brexit. As the current risk level has reduced from high to moderate, the risk has been unlinked from the BAF.

Environmental Sustainability BAF

The Director of Property & Asset Management will report to the FP& R Committee on 15 March 2022 as follows:

Linked Risk Updates

Risk 1007 - Theatre Phase 2 Remedial Work. Works have been carried out as far as possible, and this risk, and Risk 1296 relating to Evacuation from Phase 2, Victoria Hospital, will remain until the Fife Orthopaedic Elective Centre is commissioned towards the end of 2022. Good progress is being made on site with respect to the new build.

The BAF current risk level remains high.

Workforce Sustainability BAF

The Director of Workforce will report to the Staff Governance (SG) Committee on 3 March 2022 as follows.

Linked Risk Updates

Risk 1652 - Lack of Medical Capacity in Community Paediatric Service. Risk unlinked from the BAF as risk level reduced from high to moderate due to the appointment of 2 consultant paediatricians and a trainee Advanced Nurse Practitioner. The service is also undertaking work on referral criteria and developing a multi disciplinary neuro - developmental service.

Risk 2214 - Nursing and Midwifery staffing levels, Risk remains high and will be reported separately to the Staff Governance Committee.

The BAF current risk level remains high.

Quality & Safety BAF

The Medical Director will report to the Clinical Governance Committee (CGC) on 10 March 2022 as follows:

Following discussion at the committee on 3 November 2021, members agreed with the proposal to revise the BAF risk description to better capture the principles essential to providing assurance that safe, quality and effective care is being delivered, to reflect risks

associated with the impact of the pandemic, and to ensure that its future development aligns with the evolving Population Health & Wellbeing Strategy.

Members will be asked to consider and approve the following revised wording.

- There is a risk that due to failure of clinical governance, performance and management systems (including information & information systems), NHS Fife may be unable to provide safe, effective, person centred care". Additionally, there is a risk that the effects of the COVID - 19 pandemic, including restricted capacity, reduced elective & non urgent services, and workforce pressures, will impact on the quality & safety of patient care and service delivery.

Linked Risk Updates

Risk 43 - Vascular Access for Haematology / Oncology. Risk rating reduced from a high (20) to a high (16) due to a reduction in likelihood from likely to possible.

Risk 529 - Information Security. Risk closed, unlinked from BAF and split into 3 new risks
Risk 2216 - Information Security
Risk 2217 - Information Governance Records Management and
Risk 217 - Network Security / Cyber Attack Risk

Risk 1652 - Risk unlinked from the BAF as for reasons above at Workforce Sustainability.

Additionally, to ensure that relevant risks are linked to the BAF, a review of all high risks (92) has been completed, most recently at the end of January 2022.

The review identified several high risks on operational risk registers relating to COVID -19 related staff absence, and the impact on service delivery, as well as other existing and pending vacancies. The committee will be asked to support the development of a generic linked risk relating for inclusion on the BAF.

The review also identified several risks around capacity and flow, and delays in patient pathways. A recommendation will be made to consider developing a system wide risk.

The CGC will be assured that next steps will include:
- revision of the current BAF risk rating and related rationale
- update and strengthening of the assurance components
- inclusion of data to support the performance statement

The BAF current risk level remains high.

Strategic Planning BAF

The Director of Finance & Strategy will report to the CGC on 10 March 2022, and to FP&R on 15 March 2022 as follows:

Since the last update to the committee, the BAF current risk level has been reviewed and reduced from high to moderate as a result of a reduction in likelihood. This is possible due to the governance and monitoring arrangements now in place and the progress being made to develop the Population Health and Wellbeing Strategy.

- Work will continue on the development of the Population Health and Wellbeing Strategy in respect of revised timescales.
- The results from the public and staff surveys have been received.

Digital and Information BAF

The Medical Director will report to the CGC on 10 March 2022 as follows

Linked Risk Updates

Risk 1932 - User Error in use of O365 Products. This risk has been unlinked from the BAF as the risk level has been mitigated from high to moderate, due to the sustained provision of training and education materials during the adoption of O365 products resulting in an associated reduction in likelihood.

Other Changes

Risk 1422 - Unable to meet NIS and Cyber Essentials compliance. This risk, while retaining a current high risk level, has reduced its rating from 20 to 16 as a result of mitigations including sustained awareness, education and development of controls that reduce the likelihood of occurrence. The risk level also takes into consideration the external threat rating to NHS organisations.

The BAF current risk level remains high.

Integration Joint Board (IJB) BAF

The Director of Health and Social Care provides the following update.

Following the conclusion of the review of the Fife Integration Scheme through NHS Fife and Fife Council governance structures in September 2021, and submission to Scottish Government (SG) for approval, comment has been received from SG; this is currently being considered. Legal advice and comment is being sought via Fife Council's Head of Legal Services. The current Scheme will remain in place until finally approved.

The BAF current risk level remains moderate.

2.3.1 Quality/ Patient Care

Risks to quality and safety are detailed in Appendix 4.

2.3.2 Workforce

Risks to workforce sustainability are detailed in Appendix 3.

2.3.3 Financial

Risks to financial sustainability are detailed in Appendix 1.

2.3.4 Risk Assessment/Management

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

2.3.5 Equality and Diversity, including health inequalities

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

2.3.6 Other impact

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

2.3.7 Communication, involvement, engagement and consultation

This report reflects the engagement of Executive Directors, Non Executives and other key stakeholders.

2.3.8 Route to the Meeting

Via Margo McGurk, Director of Finance and Strategy on 3 March 2022

2.4 Recommendation

- Assurance

3 List of appendices

The following appendices are included with this report:

- Appendix 1, NHS Fife BAF Financial Sustainability for FP& RC on 150322
- Appendix 2, NHS Fife BAF Environmental Sustainability for FP& RC on 150322
- Appendix 3, NHS Fife BAF Workforce Sustainability for SGC on 030322
- Appendix 4, NHS Fife BAF Quality & Safety for CGC on 100322
- Appendix 5, NHS Fife BAF Strategic Planning for CGC on 100322
- Appendix 6, NHS Fife BAF Integration Joint Board (IJB) as at 020322
- Appendix 7, NHS Fife BAF Digital and Information for CGC on 100322

Report Contact
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NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Financial Sustainability																											
1671	Sustainable	14/02/2022	31 March 2022	There is a risk that the funding required to deliver the current and anticipated future service models, particularly in the context of the COVID 19 pandemic, will not match costs incurred. There is a risk that the organisation may not fully identify the level of savings required to achieve recurring financial balance. Thereafter there is a risk that failure to implement, monitor and review an effective financial planning, management and performance framework would result in the Board being unable to deliver on its required financial targets.	LIKELY	MAJOR	16	HIGH RISK	POSSIBLE	MODERATE	9	MODERATE RISK	SG have confirmed they will provide funding support to Breakeven in 2021/22 however a number of actions must be completed by the board including minimising the requirement for support as much as possible.	Margo McGurk Director of Finance	Finance, Performance & Resources (F,P&R) Rona Laing	*Ongoing actions designed to mitigate the risk including:* 14 Feb 2022 We have submitted our Quarter 3 reporting to SG indicating our 21/22 Covid-19 funding requirements across HB retained and HSCP; and have signposted the level of financial support to deliver a break even RRL position for 21/22. Whilst formal funding notification has yet to be received, indications at our Q3 review meeting with SG suggest funding support, following our significant efforts reported each month, will be forthcoming. Hence the risk level is updated to moderate risk.	Nil	1. Produce monthly reports capturing and monitoring progress against financial targets and efficiency savings for scrutiny by all responsible managers and those charged with governance and delivery. 2. Undertake regular monitoring of expenditure levels through managers, Executive Directors' Group (EDG), Finance, Performance & Resources (F,P&R) Committee and Board. As this will be done in parallel with the wider Integrated Performance Reporting approach, this will take cognisance of activity and operational performance against the financial performance.. Responsible Person: Director of Finance Timescale: Ongoing	1.Forecast position is delivering in line with key financial planning assumptions.	1. Internal audit reviews on controls and process; including Departmental reviews. 2. External audit review of year end accounts and governance framework.	1. Enhanced reporting on various metrics in relation to supplementary staffing. 2. Confirmation via the Director of Health & Social Care on the social care forecasts and the likely outturn at year end.	The level of risk to the delivery of the in-year financial position has reduced to moderate given greater certainity on cost levels and funding available to support effective management of the in-year position. In relation to financial sustainability, the organisation has launched a Financial Improvement/Sustainability (FIS) Programme. This programme will report through the Portfolio Board and aligns firmly with one the strategic priorities to “Drive Value and Sustainability”. This is a key enabling programme to support the delivery of our 2022/23 corporate objectives and longer-term strategy development.	POSSIBLE	MODERATE	9	MODERATE RISK	Increasing certainty on funding levels and forecast year-end position allows the risk level to be reduced.

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

Previously Linked Operational Risk(s)

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

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Environmental Sustainability																											
1672	Clinically Excellent, Sustainable	23/12/2021	31 January 2022	There is a risk that Environmental & Sustainability legislation is breached which impacts negatively on the safety and health of patients, staff and the public and the organisation's reputation.	4 – Likely – Strong possibility this could occur	5 - Extreme	20	High Risk	4 – Likely – Strong possibility this could occur	5 - Extreme	20	High Risk	Estates currently have significant high risks on the E&F risk register; until these have been eradicated this risk will remain. Action plans have been prepared and assuming capital is available these will be reduced in the near future.	Neil McCormick Director of Property & Asset Management	Finance, Performance & Resources (F,P&R). Rona Laing.	*Ongoing actions designed to mitigate the risk including:* 1. Operational Planned Preventative Maintenance (PPM) systems in place 2. Systems in place to comply with NHS Estates 3. Action plans have been prepared for the risks on the estates & facilities risk register. These are reviewed and updated at the monthly risk management meetings. The highest risks are prioritised and allocated the appropriate capital funding. 4. The SCART (Statutory Compliance Audit & Risk Tool) and EAMS (Estates Asset Management System) systems record and track estates & facilities compliance. 5. Sustainability Group manages environmental issues and Carbon Reduction Commitment(CRC) process is audited annually. 6. Externally appointed Authorising Engineers carry out audits for all of the major services i.e. water safety, electrical systems, pressure systems, decontamination and so on.	Nil	1. Capital funding is allocated depending on the E&F risks rating Responsible person: Director of Estates, Facilities & Capital Services Timescale: Ongoing as limited funding available 2. Increase number of site audits Responsible person: Estates Compliance Manager Timescale: Ongoing	1. Capital Investment delivered in line with budgets 2. Sustainability Group minutes. 3. Estates & Facilities risk registers. 4. SCART & EAMS. 5. Adverse Event reports..	1. Internal audits 2. External audits by Authorising Engineers 3. Peer reviews.	None.	High risks still exist until remedial works have been undertaken, but action plans and processes are in place to mitigate these risks.	1 – Remote – Can't believe this event would happen	5 - Extreme	5	Low Risk	All estates & facilities risk can be eradicated with the appropriate resources but there will always be a potential for failure i.e. component failure or human error hence the target figure of 5..

Linked Operational Risk(s)

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

Previously Linked Operational Risk(s)

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

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Workforce Sustainability																											
16	Excellent	1 1 1		There is a risk that failure to ensure the right composition of workforce, with the right skills and competencies will adversely affect the provision of services and quality patient care and impact on organisational capability to implement the new clinical and care models and service delivery set out in the Clinical Strategy and the future population Health & Wellbeing Strategy and the challenges and demands associated with the current COVID-19 pandemic.	5	4	20	High	4	4	16	High	Workforce failures may have consequences for patients' health outcomes. NHS Fife has an ageing workforce, with recruitment challenges in many disciplines. Failure to ensure the right composition of workforce with the right skills and competencies continues to give rise to a number of organisational risks including: reputational and financial risk; a potential adverse impact on the safety and quality of care provision; staff engagement, staff absence, staff attrition and morale. Failure may also adversely impact on the implementation of the current Clinical Strategy and the future NHS Fife Population Health & Wellbeing Strategy. The current scores reflect the existing controls and mitigating actions in place.	Lisa Sta ff Gov		*Ongoing actions designed to mitigate the risk including:* WORKFORCE – GENERAL • Implementation of the Workforce Strategy to support the Clinical Strategy and Strategic Framework; development of Workforce Strategy and Workforce Plans for 2022 to 2025. • Implementation of the Health & Social Care Workforce Strategy to support the Health & Social Care Strategic Plan for 2019 to 2022, the integration agenda and the development of the H&SCP Workforce Strategy and Workforce Plan for 2022 to 2025. • Implementation of the NHS Fife Board Strategic Objectives, particularly the "exemplar employer / employer of choice" and the associated values and behaviours. • Implementation of the NHS Fife / H&SCP Joint Interim Workforce Plan for 2021/2022. WORKFORCE CAPACITY • Current resourcing actions include: active local and international recruitment campaigns and *continued* expansion of bank and supplementary staffing resources, including recruitment of newly qualified nurse practitioners in all disciplines, Band 4 pre-registered nurses, additional Band 2 bank HCSWs, fast track process to support appointable candidates being appointed to other vacancies and admin support roles as part of a commitment to support Senior Charge Nurses and nursing teams. First International Nurse recruits will take up post in February 2022. • Planning and delivery of actions undertaken by respective COVID-19 and Workforce Groups at various levels, including inter alia local workforce groups, workstreams associated with new programmes of work, for example, Community Care and Treatment, Vaccination Transformation and Implementation of the General Medical Services contract. • Planning to meet future service needs, applying workforce planning and forecasting skills in support of service delivery, using the workforce modelling and abstraction techniques learned during the pandemic and managing staff availability to respond to escalation requirements. • Supporting service delivery through implementation and integration of systems and joint working with services. WORKFORCE CAPABILITY • eLearning and training offers aligned to current work modes • Continuation of fast track induction and related activity, including new welcome and orientation package. • Implementation of Practice Development initiatives to support changes in service delivery and preparation for further escalation requirements, for example training resources for non-clinical staff to support clinical service delivery. • Ensuring managers and staff are prepared for the implementation of and compliance with the Health & Care (Staffing) (Scotland) legislation within the clinical workforce. • Develop and deliver Phase 1 of the framework to improve leadership capability and embed talent management and succession planning. • To prioritise staff personal / professional development needs that have been delayed or restricted due to COVID-19 response as restrictions are eased, through Directorate development delivery plans. • To progress actions in support of the employability agenda. WORKFORCE ENGAGEMENT • Working in partnership with staff side and professional organisations across all sectors of NHS Fife to ensure staff engagement opportunities are maximised. • iMatter – supporting action planning and Board actions arising from the 2021 cycle of feedback and reporting. • Supporting staff through changes in ways of working and providing access to new and different career opportunities. • Realising the benefits of the Internal (Staff) Communication Strategy and ensuring that StaffLink and other mediums for example the weekly Team and Chief Executive Briefings, joint managerial / partnership walkabouts support organisational objectives. • Scoping a Staff Experience and Engagement Framework that sets out our key ambitions and commitments for improving staff experience, which will help to develop a culture that values and supports our workforce. WORKFORCE SUPPORT & WELLBEING • Provision of support and wellbeing initiatives which contribute to staff maintaining and enhancing their personal health and wellbeing at work and creating a great place to work. • Access to OH, H&S, Peer Support, Psychology, Spiritual Care and Staff Listening Services. • Integration of Mindfulness, Good Conversations and Our Space support and Outdoor sessions	Nil	WORKFORCE – GENERAL • Implementation and review of workforce plans and strategies to ensure that these support service delivery and the provision of appropriate and safe care to the population of Fife. • Ensuring workforce preparedness for any further COVID-19 escalation requirements, working in partnership through the respective Workforce Groups and command structure. • Support for capacity building within and across the organisation to make sure we make the best use of the skills of all of our workforce and to foster an environment for staff development. WORKFORCE CAPACITY • Consideration of redesign of roles and services, for example: expansion of Health Care Support Worker and Nursing Associate roles, Advanced Practitioners, Pharmacy Technicians and Physicians Associates, combined with targetted ward administrative support, to enable clinical time to be released. • Consideration of alternative ways to attract and recruit staff, or redesign of job roles to support service delivery models and the future supply pool. • Realising the benefits of implementation of the regional recruitment model. • Harnessing the benefits of digital technology and automation. • Create a pathway for young people with barriers to employment to gain paid work experience with us, with the aim of securing future employment via the Kickstanrt and Long Term Unemployed Programme. WORKFORCE CAPABILITY • Consideration of and implementation of learning and development activities in support of skill mix and associated actions. • Contributing to NHS Scotland developments in Learning and Development. • Realising benefits from the implementation of and compliance with the Health & Care (Staffing) (Scotland) legislation within the clinical workforce. • Supporting managers to harness the benefits of Tableau, TURAS and other systems integration aligned to workforce planning. • Provision of workforce planning training and support for managers. • Develop and deliver further phases of the framework to improve leadership capability and embed talent management and succession planning. • Consideration of the functionality of TURAS Learn to support capture and to facilitate reporting and analysis of training and development data. WORKFORCE ENGAGEMENT • Continuation of active partnership working through APF and LPFs, with staff side colleagues key stakeholders in the development of the next Workforce Strategies and Action Plans. • Continue to promote NHS Fife as an employer to enhance our ability to recruit and retain staff, utilising positive Communication support and social media. • To develop mechanisms which enable everyone to feel more valued and involved on a collaborative basis throughout health and social care. WORKFORCE SUPPORT & WELLBEING • Review of Staff Health & Wellbeing Strategy to take account of COVID-19 lessons learned and evaluation of activities to establish which are most appreciated by staff. • Provision of additional staff support and wellbeing initiatives which contribute to staff health and wellbeing, staff resilience and staff retention, showcasing NHS Fife as an exemplar employer in the local labour market. • Continue to hold Gold HWL Award status and deliver on HPHS commitments.	1. Regular performance monitoring and reports to Executive Directors Group, Area Partnership Forum, Local Partnership Fora and Staff Governance Committee 2. Staff Governance activities are reported to EDG, APF, LPFs and Staff Governance Committee	1. Use of national data for comparative purposes 2. Internal Audit reports 3. Audit Scotland reports 4. Bench - marking against other NHS Boards	Full implementation and utilisation of eESS, Job Train, Tableau and TURAS will provide integrated workforce systems which, alongside access to national data via the NES Portal will capture and facilitate reporting, including all learning and development activity.	Overall NHS Fife has robust workforce planning, learning and development, governance and risk systems and processes in place. Continuation of the current controls and full implementation of mitigating actions, in particular the Workforce Strategy supporting the Clinical Strategy and the future Population Health and Wellbeing Strategy for Fife and full implementation and use of eESS, should provide appropriate levels of control.	2	4	8	Med	Continuing improvements in current controls, ongoing review and full implementation of mitigating actions will reduce both the likelihood and consequence of the risk to moderate, taking account of current and potential future workforce challenges.

	o	for staff as part of Going Beyond Gold Programme, contributing to a culture of kindness and staff recovery. • Consistent application of NHS Fife and Once for Scotland employment policies • Provision of a healthy and safe working environment, including access to refreshments in the workplace and ongoing development of Staff Hubs, Pause Pods and rest areas. Management of leave and encouraging rest and recuperation.		• Consideration of support for the ageing workforce and opportunities for job redesign. Responsible Person/s: Director of Workforce			

Linked Operational Risk(s)

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

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
1042	Staffing Levels	Active Risk	Moderate Risk	12	Nolan, Karen
1324	Medical staff recruitment and retention	Active Risk	Moderate Risk	12	Kennedy, John
1375	Breast Radiology Service	Active Risk	Moderate Risk	12	Cross, Murray
1420	Loss of consultants	Active Risk	Moderate Risk	12	Bett, Heather
1652	Medical Capacity in Community Paediatric Service	Active Risk	Moderate Risk	12	Dobson, Claire
1846	Test and Protect/Covid Vaccination	Active Risk	Moderate Risk	12	Connor, Nicky
503	Diabetes	Closed Risk	Moderate Risk	9	CHE
1349	Service Provision - GP locums may no longer wish to work for NHS Fife Salaried Practices	Closed Risk	Moderate Risk	8	Dobson, Claire
1353	Service Provision - Shortfall in GP Cover will limit service provision	Closed Risk	Moderate Risk	9	Dobson, Claire
1858	workload resulting from deterioration in mental health	Closed Risk	Moderate Risk	10	Torrens, Jillian

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Quality & Safety																											
1674	Clinically Excellent, Person Centred	03/11/2021	10 March 2022	There is a risk that due to failure of clinical governance, performance and management systems (including information & information systems), NHS Fife may be unable to provide safe, effective, person centred care.	4 – Likely – Strong possibility this could occur	5 - Extreme	20	High Risk	3 – Possible – May occur occasionally – reasonable chance	5 - Extreme	15	High Risk	Failure in this area could have a direct impact on patients' health, organisational reputation and exposure to legal action. While it is recognised that several adverse events ranging from minor to extreme harm can occur daily, the proportion of these in relation to overall patient activity is very small.	Christopher McKenna Medical Director	Clinical Governance Christina Cooper	*Ongoing actions designed to mitigate the risk including:* Oversight and monitoring of strategy / framework / policy and procedure implementation and impact including: 1. Strategic Framework 2. Clinical Strategy 3. Clinical Governance Structures and operational governance arrangements 4. Clinical & Care Governance Strategy 5. Participation & Engagement Strategy 6. Risk Management Framework 7. Governance arrangements established to support delivery of the UK Coronavirus (COVID-19) action plan 8. Processes established for reporting and escalation of COVID-19 related incidents & risks 9. Remobilisation plan 3 These are supported by the following: 10. Risk Registers 11. Integrated Performance and Quality Report (IPQR), Performance reports dashboard data 12. Performance Reviews 13. Adverse Events Policy 14. Scottish Patient Safety Programme 15. Implementation of SIGN and other evidence based guidance 16. Staff Learning & Development 17. System of governance arrangements for all clinical policies and procedures 18. Participation in relevant national and local audit 19. Complaints handling process 20. Using data to enhance quality control 21. HIS Quality of Care Approach & Framework, Sept 2018 22. Implementing Organisational Duty of Candour legislation 23. Adverse event management process 24. Sharing of learning summaries from adverse event reviews 25. Implementing Excellence in Care 26. Using Patient Opinion feedback 27. Acting on recommendations from internal & external agencies 28. Revalidation programmes for professional staff 29. Electronic dissemination of safety alerts	1.Reviewing together of patient experience, complaints, adverse events and risk information to provide an overview of good practice, themes, trends, and exceptions to the norm 2.Weaknesses in the process for recording completion of actions from adverse event reviews including evidence of steps taken to implement and share learning from actions 3.Weaknesses in related oversight and monitoring processes at operational level 4. Risk Management Framework requires review, update & plan for implementation	1. Give due consideration to how to balance the remobilisation of clinical services and manage staff and public expectations, while dealing with the ongoing COVID-19 pandemic 2. Continually review the Integrated Performance and Quality (IPQR) to ensure it provides an accurate, current picture of clinical quality / performance in priority areas 3. Refresh the extant Clinical Governance structures and arrangements to ensure these are current and fit for purpose 4..Review the coverage of mortality & morbidity meetings in line with national developments and HIS guidance 5. Review and refresh the current content and delivery models for key areas of training and development e.g. corporate induction, in house core, quality improvement, leadership development, clinical skills, interspecialty programmes, risk management, clinical effectiveness 6. Review annually, all technology & Digital & Information systems that support clinical governance e.g. Datix / Formic Fusion Pro./ Labs systems 7. Review our position against the Quality of Care Framework and understand our state of readiness for a review 8. Further develop the culture of a person centred approach to care 9. Executive commissioning of reviews as appropriate e.g. internal audit, external peer and 'deep dives' 10. Align the developing Clinical Governance Framework with the NHS Fife Corporate Objectives and the developing Population Health & Wellbeing Strategy 11.Identify improvements within the adverse events process taking into consideration communication, roles, use of DATIX and lines of reporting 12. Build a risk culture which ensures that there is engaged risk leadership and proactive measures with focus in place to address risks 13 .Build risk culture which links the identification of risk to organisational objectives and strategic priorities 14.Identify and implement an electronic system/ quality management system for managing policy and procedures to improve efficiency and assurance of document management 15. Use the Essentials of Safe Care framework as the basis of an organisational self assessment to understand status quo and support development of CG Framework 16..Ensure linkages with Patient Relations Team to allow for shared learning and identification of organisational themes 17. Further develop and monitor implementation of NHS Fife governance and reporting structure for the review of deaths and young people ensuring a pan organisational approach with clear reporting lines taking into consideration existing review groups e.g. groups for suicide and peri-natal deaths	1. Assurance statements from clinical & clinical & care governance groups and committees 2. Assurances obtained from all groups and committees that: i. they have a workplan ii. all elements of the work plan are addressed in year 3. Annual Assurance Statement 4. Annual NHS Fife CGC Self assessment 5. Reporting bi annually on adequacy of systems & processes to Audit & Risk Committee 6. External accreditation systems e.g.. Unicef - Accredited Baby Friendly Gold. UKAS Inspection for Labs 7. External agency reports e.g. GMC 8. Quality of Care review 9. Compliance and monitoring of policies & procedures to ensure these are up to date 9. Locally designed subject specific audits 10. National audits	1. Internal Audit reviews and reports on controls and process; including annual assurance and governance review / departmental reviews 2. External Audit reviews 3. HIS visits and reviews 4. Healthcare Environment Inspectorate (HEI) visits and reports 5. Health Protection Scotland (HPS) support and feedback 6. Health & Safety Executive visits and reports 7. Scottish Patient Safety Programme (SPSP) visits and reviews 8. Scottish Govt Organisational DoC Annual Report 9. Scottish Public Service Ombudsman (SPSO) reports 10. Patient Opinion 11. Specific National reporting 12. Mental Welfare Commission (MWC) reviews	1. Key performance indicators relating to corporate objectives e.g. person centred, clinically excellent, exemplar employer & sustainable 2. We require additional assurances that there is a system in place for oversight and monitoring of actions from a variety of sources e.g. audit, adverse events, SPSO, MWC reviews 3. We require additional assurances that there are systems in place for oversight of operational and strategic risks	Overall, NHS Fife has in place sound systems of clinical governance and risk management as evidenced by Internal Audit and External Audit reports and the Statement of Annual Assurance to the Board.	2 – Unlikely – Not expected to happen – potential exists	5 - Extreme	10	Moderate Risk	The organisation can identify the actions required to strengthen the systems and processes to reduce the risk level.

Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
43	Vascular access for haematology/Oncology	Active Risk	High Risk	16	Savage, Shirley-Anne
1365	Cancer Waiting Times Access Standards	Active Risk	High Risk	15	Couser, Gemma
1296	Emergency Evacuation, VHK Phase 2 Tower Block	Active Risk	High Risk	15	McCormick, Neil

Previously Linked Operational Risk(s)

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

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Strategic Planning																											
1675	Clinically Excellent, Exemplar Employer, Person Centred, Sustainable	15/02/2022	15/03/2022	There is a risk that the development and the delivery of the new NHS Fife Population Health and Wellbeing strategy is not adequately supported by the required planning and programme management capacity, capability and governance arrangements. Key Risks from previous BAFs will remain until committees are content they are covered in renewed PHW Strategy. 1. Community/Mental Health redesign is the responsibility of the H&SCP/IJB which hold the operational plans, delivery measures and timescales 2. Governance of the transformation programmes remains between IJB and NHS Fife. 3. Regional Planning - risks around alignment with regional plans are currently reduced as regional work is focussed on specific workstreams 4. Clinical Strategy does not reflect that the strategic direction of the organisation following the COVID-19 pandemic.	4 – Likely – Strong possibility this could occur	4 – Major	16	High Risk	3 – Possible – May occur occasionally – reasonable chance	4 – Major	12	Moderate Risk	Following period of COVID-19, portfolio management is being put in place. Programme management approach being refreshed through Strategic Planning Resource Allocation (SPRA) process.	Margo McGurk Director of Finance	Clinical Governance. Christina Cooper.	*Ongoing actions designed to mitigate the risk including:* **1. PHW Portfolio Board established** **2. Public and Staff Survey, developed in relation to PHW Strategy, released in November 21 with results received in February 22.** **3. SPRA 22/23 returns analysed, to inform Corporate Objectives for 22/23, to be finalised**	EDG Strategy meetings will provide the required leadership and executive support to enable strategy development.	**PHW Portfolio Board is established and will meet monthly. TOR signed off. Governance route will be Public Health and Wellbeing Committee** **Time period for Strategy has been amended to start from 23/24 rather than 22/23. Operational Delivery Plan for 22/23 providing interim strategic direction. Work will continue during 2022 to ensure delivery of Strategy for 23/24.** Responsible Person: Director of Finance Timescale: 31/03/2022	1. Minutes of meetings record attendance, agenda and outcomes. 2. Reporting of key priorities to governance groups from the SPRA process.	1. Internal Audit Report on Strategic Planning (no. B10/17) 2. Governance committee scrutiny and reporting.	Governance of new arrangements will be agreed to deliver the required assurance.	Corporate Objectives agreed for 21/22. **SPRA process 22/23 commenced in October 21, results analysed and will inform the Operational Delivery Plan and corporate objectives for 22/23.** **RMP4 submitted on 30 September 21 with Q3 update on deliverables on 9 February 22.**	3 – Possible – May occur occasionally – reasonable chance	4 – Major	12	Moderate Risk	Once governance and monitoring is in place and transformation programmes are being realised, the risk level should reduce.

Linked Operational Risk(s)

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

Previously Linked Operational Risk(s)

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

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Integration Joint Board																											
16	S1 4	14		There is a risk that the Fife Integration Scheme does not clearly define operational responsibilities of the Health Board, Council and Integration Joint Board (IJB) resulting in a lack of clarity on ownership for risk management, governance and assurance.	L i	M a	16 H i	P o	M a	12 M o		In view of the fact there is ongoing dialogue with Scottish Government and a commitment with partners to conclude by September, the risk remains at a moderate level	N i	NHS Fife Board	Ongoing actions designed to mitigate the risk including: 1. The partner bodies, NHS Fife and Fife Council, developed the Fife IJB Integration Scheme in 2015 and it received Scottish Ministers' approval in October of that year. 2. The Integration Scheme was reviewed in March 2018 to reflect the implementation of the Carers (Scotland) Act 2016 as required by the Scottish Government. 3. The Audit Scotland report, Health and Social Care Integration – Update on Progress, published on 15 November 2018, was the second in a series of three national performance audits following the introduction of the Public Bodies (Joint Working) (Scotland) Act, 2014. It examined the impact public bodies are having as they integrate health and social care services. The report set out six areas which needed to be addressed if integration is to make a meaningful difference to Scotland. 4. This report was followed by the Ministerial Strategic Group for Health and Community Care's report – Review of Progress with Integration of Health and Social Care published in February 2019 which set out a number of proposals in each of the six key areas and allocated a timescale for completion of these. These were reviewed by Fife IJB and its partners to ensure they were incorporated into the work that was ongoing within Fife and an action plan was produced to drive forward changes. This was submitted to the Scottish Government in August 2019. The action plan set out actions to improve governance arrangements including the need to provide further clarity on the Integration Scheme. 5. All Integration Schemes are scheduled to be reviewed every five years, however, Scottish Government have allowed additional time for the review to take cognisance of the disruption caused by the coronavirus outbreak. 6. The review of the Fife Integration Scheme concluded through NHS Fife and Fife Council governance structures in September 2021. Thereafter it was submitted to Scottish Government for approval. Comment has been received from Scottish Government and this is currently being considered. Legal advice and comment is being sought via Fife Council's Head of Legal Services Until the revised scheme is approved the current Scheme will remain in place. 7. Following the approval of the revised Integration Scheme work will be required to ensure governance arrangements for NHS	Nil	Nothing more to be done than the ongoing actions set out. Responsible Person: Director of Health & Social Care	1. Through regular updates to SLT and EDG about the progress of the reviews. 2. Updates to Audit & Risk Committees, the Integration Joint Board (IJB) and NHS Fife. .	1. • The views of auditors will be the key independent assurance mechanism around this risk. We will involve them in the work to clarify governance arrangements as it progresses. 2. • Scottish Government will also provide useful advice and an independent perspective on the work to be carried out.	None.	The problem should be largely resolved with the action taken.	R e M a 4			L o	Once resolved and given effect to in IJB integration scheme and NHS Fife corporate governance arrangements, the issue should largely be resolved. But given maturity of relationships and dynamics around regional approaches a remaining risk will remain..

													Fife, Fife Council and the IJB clearly reflect the position set out in the Integration Scheme. Work has begun on review of the IJB Governance Manual and review of risk management arrangements within NHS Fife and the IJB is being progressed												

Linked Operational Risk(s)

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

Previously Linked Operational Risk(s)

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

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Digital & Information																											
1677	Clinically Excellent, Exemplar Employer, Person Centred, Sustainable	07/01/2022	25 February 2022	There is a risk that the organisation will fail to recognise and afford the financial investment necessary to deliver its D&I Strategy and current operational lifecycle commitment to enable transformation across Health and Social care to deliver sustainable and integrated services that are safe, secure and compliant with governance frameworks and associated legislation.	4 – Likely – Strong possibility this could occur	5 - Extreme	20	High Risk	3 – Possible – May occur occasionally – reasonable chance	5 - Extreme	15	High Risk	Failure in this area could have a direct impact on patients care, organisational reputation and exposure to legal action. While it is recognised that several adverse events ranging from minor to extreme can occur daily, the proportion of these in relation to overall activity is very small and reporting to competent authorities is minimal.	CMK Medical Director	Clinical Governance, Finance Performance & Resources (FP&R) Christina Cooper (CGC), Rona Laing (FP&R)	*Ongoing actions designed to mitigate the risk including:* 1. Consistent alignment of the D&I Strategy with the NHS Fife Corporate Objectives and developing Health & Wellbeing Strategy 2. Digital & Information Board Governance improvement with ongoing review 3. Information Governance & Security Governance improvement with assurance activity plans reviewed by Steering Group and Improvement measures agreed 4. Caldicott - register maintained and reviewed 5. Review of financial impact of D&I Strategy as part of annual deliver planning and areas of exposure quantified and presented via SPRA process 6. Operational governance lead through SLT focusing on operation controls (finance & resource), lifecycle management, policy/procedure implementation a workforce development 7. Risk management arrangements underpinned by: Policy & Process, Adverse event management, Asset Management Controls, Monitoring and Detection, Defence in Depth security measures and technology; all of which are receiving a higher percentage of budget allocation. 8. Directive on security of network and information systems (NIS) & Cyber Essentials Compliance – Action Plan developed prioritising a series of Cyber workshops informing technical controls and organisational response to Cyber attacks 9. Additional resilience planning and disaster recovery work underway to update alignment to current operating priorities 10. FOI, records management, DPA improvements being lead through IG&S Steering and Operational Groups 11. Senior Management Team consideration of policy and procedure impact and associated implementation 12. Monthly risk reviews with Operational Leads and escalation/reporting to Governance Groups as necessary 13. Performance Review 14. Participation in national and local audit e.g. NISD Audit 15. Commitment to ensure appropriate implementation of Cyber Defence Measures, including support of national centralised cyber incident reporting and coordination protocols. 16. Staff Learning & Development, both Digital staff and the wider organisation including leadership skills. 17. Business Case development to include costed resilience by design and ongoing support activities. 18. Enhancing monitoring of our digital systems.	Lack of formal quantification of the financial impact of the Digital Strategy, inline with the current baseline of D&I Operating Costs Lack of long term financial, lifecycle and workforce planning. Lack of evidence of assurance now that systems to maintain ongoing monitoring of compliance and control are established: GDPR/DPA 2018 - Improvements noted in IG&S Assurance Report (Target March 2022) Lack of consideration and commitment to unification of business process on strategic applications and the associated remove of duplicate or legacy systems Lack of training and education resource to ensure our staff and patients are digitally ready - Business Case in consideration Lack of resilience of key digital systems and technical recovery procedures and regular failover (DR) testing. - Plan to address agreed with EDG - April 2021- project now in initiation – Oct 2021 Governance and procedures do not fully follow ITIL professional standards - Internal Audit Findings responded to	1. Improving and maintaining strong governance, risk management and operating procedures following Information Technology Infrastructure Library (ITIL) professional standards within early adoption of continuous improvement assessment. (ITIL implementation - Phase 1 Agreed - Phase 2 underway) 2. Organisation to consider the gaps in current operating financial commitments and assessment of financial implementation of Digital Strategy presented through SPRA process. 3. Develop long term financial, lifecycle and workforce planning - plan to address is in development (Completed - October 2021) 4. Work to become fully compliant with GDPR, DPA 2018, NIS Directive, Information Security Policy Framework and thereafter maintain compliance. (Target completion February 2022)	Second line of Assurance: 1. Reporting to D&I SLT, D&I Board, Information Governance & Security Steering Group (IG&SG), EDG & Clinical Governance groups and committees. 2. Annual Assurance Statements for the D&I Board and IG&S Steering Group. 3. Locally designed subject specific audits. 4. Compliance and monitoring of policies & procedures to ensure these are up to date via D&I Senior Management Team. 5. Reporting bi annually on adequacy of risk management systems and processes to Audit & Risk Committee. 6. Monthly SIRO report 7. SGHSCD Annual review 8. SG Resilience Group Annual report on NIS & Cyber compliance 9. Quarterly performance report. 10. External Assurance on Delivery Plan by Scottish Government 12. Update to Assessment following June 2019- Digital Maturity Assessment 13 Periodic Benchmarking for areas of focus	Third line of Assurance : 1. Internal Audit reviews and reports on controls and process; including annual assurance and governance review / departmental reviews. 2. External Audit reviews. 3. Formal resilience testing / DR testing using an approved scope and measured success and mechanism for lessons learned and action plans. 4. Cyber Essentials/Plus Assessments. 5. NISD Audit Commissioned by the Competent Authority for Health. 6. Benchmarking with NHS Scotland's Boards	1. The D&I Strategy has not undergone a financial assessment against delivery. This work is now complete (October 2021) Findings presented via SPRA 2. Continual development of data assured performance is ongoing across all D&I Domains. Development of workplans aligned to risk continue to be developed. 3. Assurance reports are consistently provided to D&I SLT monthly and development of data/KPI reports to Governance Groups continue to be developed. These reports will ensure trend and analysis to highlight potential vulnerabilities and provide assurances (including assurances that confirm compliance with GDPR, DPA 2018, NIS Directive, the Information Security Policy Framework is being maintained). 4. Implementation of improvements as recommended in Internal and external Audit ongoing. Adverse Events review to be included 5. Improvements to SLA's (in line with 'affordable performance')is that output still awaited from 4 to provide assurance or otherwise 6. Assurance on patients' readiness/equality impact in the adopt ion of digital care provision 6. Assurance on organisational readiness for further Digital Adoption	Overall, NHS Fife Digital has in place a sound systems of 1. Governance - agreed ToR and reporting 2. Improving security defences and risk management as evidenced by Internal Audit and External Audit reports 3. Attainment of the ISO27001 standard in the recent past and the Statement of Annual Assurance to the Board. 4. Investment has been made to support NIS, GDPR and Cyber resilience and some tools which will improve visibility of the Network. 5. Clear articulation of digital aspiration via the Digital Strategy 2019-2024 5. Extended corporate governance including EDG attendance 6. Meeting visibility through provision of minutes and delivery plans to EDG/CGC	2 – Unlikely – Not expected to happen – potential exists	5 - Extreme	10	Moderate Risk	1. Difficulty in securing investment in people, tools and maintaining systems that are resilient and always within support cycles. 2. Fully implementing resistance to attack through 'resilience by design', well practised response plans and recovery procedures. 3. Reduce the 'human factor' through ongoing 'user base education' and improving organisational digital readiness. 4. Enhanced controls and continuing improvements to systems and processes for improved usage, monitoring, reporting and learning are continually being put in place. Aim for Moderate Risk as target rather than Low Risk is due to the fact that likelihood whilst unlikely may still happen and consequence will be extreme due to level of fines that may be imposed, reputational damage and patient harm.

Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
885	Digital & Information Financial Position	Active Risk	High Risk	20	Graham, Alistair
1338	NHS Fife at increased cyber attack risk due to legacy systems / application versions	Active Risk	High Risk	20	Graham, Alistair
2192	Risk that Digital & Information Service Management activities are not aligned to ITIL	Active Risk	High Risk	20	Graham, Alistair
1422	Unable to meet NIS & Cyber Essentials compliance	Active Risk	High Risk	16	Graham, Alistair
1934	Loss of Cloud based Email & Collaboration Services	Active Risk	High Risk	16	Young, Allan
1996	Office 365 - Unknown Financial Consequence and so risk to licence availability	Active Risk	High Risk	16	Graham, Alistair
537	Failure of the Network causing widespread loss of access to IT systems	Active Risk	High Risk	15	Young, Allan

Previously Linked Operational Risk(s)

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

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**17 March 2022**
Title:	**Internal Audit Progress Report**
Responsible Executive/Non-Executive:	**M McGurk, Director of Finance & Strategy**
Report Author:	**B Hudson – Regional Audit Manager**

1 Purpose

This is presented to the Audit and Risk Committee for:

- Assurance
- Discussion

This report relates to a:

- Local policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this report is to:

- Provide the Audit and Risk Committee with comprehensive assurance on the progress of the 2021/22 Internal Audit Plan.
- Ask the Audit and Risk Committee to approve proposed amendments to the Annual Internal Audit Plan 2021/22

2.2 Background

The Internal Audit year runs from May to April. The Internal Audit team is progressing the 2021/22 Annual Internal Audit Plan under the supervision of the Chief Internal Auditor. Audit work completed allows the Chief Internal Auditor to provide the necessary assurances prior to the signing of the annual accounts.

A large element of our year-end assurance has already been provided through the Internal Control Evaluation report presented to the last Audit and Risk Committee.

The work of Internal Audit and the assurances provided by the Chief Internal Auditor in relation to internal control are key assurance sources taken into account when the Chief Executive undertakes the annual review of internal controls, and forms part of the

consideration of the Audit and Risk Committee and the Board prior to finalising the Governance Statement which is included and published in the Board's Annual Accounts.

2.3 Assessment

Annual Internal Audit Plan 2021/22

The following audits have not yet commenced, and will be risk assessed for possible inclusion in the Internal Audit Plan for 2022/23.

Audit	Original scope	Rationale for including in Risk Assessment for 2022/23 Internal Audit Plan
B14/22 Operational Planning	Review of the Strategic Planning and Resource Allocation (SPRA) process, including savings and related risks.	Internal Audit have undertaken work on the SPRA process as part of B08/22 ICE and will consider again as part of the Annual Report for 2021/22. For 2022/23 Internal Audit will consider the SPRA and its alignment with the development of the Population Health and Wellbeing Strategy.
B21/22 Digital and Information (eHealth) governance	-	Internal Audit have undertaken work on Digital and Information Governance as part of B08/22 ICE and will further consider as part of the Annual Report for 2021/22. Internal Audit have also attended and provided input to IG meetings throughout 2021/22, but this will not cover the entirety of the original scope for this work. For 2022/23 Internal Audit will consider progress of NISR and Digital Governance arrangements.

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:

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

Improvement Activities

Development of the FTF website is complete and members will be provided with the link, when operational.

The FTF self assessment against the Public Sector Internal Audit Standards has been completed and following approval by the FTF Partnership Board it will be presented to the May 2022 Audit and Risk Committee.

Advice and input

In addition to formal audit reviews which result in a report to the Audit and Risk Committee, Internal Audit have continued to provide advice and assistance to officers and Board members since the last Audit and Risk Committee meeting.

Internal Audit have facilitated the work of the Assurance Mapping group and liaised with the Board Secretary to consider how the agreed principles can be adapted to the specific needs of NHS Fife. Originally, Internal Audit were to provide input into the review and update of the Quality and Safety BAF. NHSF are currently developing a new approach to Risk Management which will involve fundamental review of the structure and content of the high level risk register. Internal audit will provide comment on both the process and output, ensuring that Assurance mapping principles are embedded throughout.

2.3.1 Quality/ Patient Care

The Triple Aim is a core consideration in planning all internal audit reviews.

2.3.2 Workforce

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

2.3.3 Financial

Financial Governance is a key pillar of the Annual Internal Audit Plan and value for money is a core consideration in planning all internal audit reviews.

2.3.4 Risk Assessment/Management

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

2.3.5 Equality and Diversity, including health inequalities

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

2.3.6 Other impacts

N/A

2.3.7 Communication, involvement, engagement and consultation

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

2.3.8 Route to the Meeting

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

2.4 Recommendation

The Audit and Risk Committee is asked to:

- **DISCUSS** and **NOTE** the progress on the delivery of the Internal Audit Plan
- **NOTE** the audits from the 2021/22 plan which are to be risk assessed as part of the development of the 2022/23 audit plan

3 List of appendices

The following appendices are included with this report:

- Appendix A – Internal Audit Progress Report

Internal Audit Progress Report

Introduction

This report presents the progress of internal audit activity up to 4 March 2022.

Internal Audit Activity

NHS Fife Audit Work

The following audit products have progressed since the previous Audit and Risk Committee meeting, where a progress report was considered, on 9 December 2021. .

NHS Fife Draft Reports Issued

Audit 2021/22	Draft Issued
B16/22 Prescription Stationery Security	11 March 2022
B18/22 Procurement	11 March 2022
B20/22 Financial Process Compliance	10 March 2022
B23/22 Resilience – Interim Report	9 March 2022

NHS Fife Work in Progress and Planned:

Audit 2021/22		Status	Target Audit and Risk Committee
B10/22	Attendance at Committees and Groups	Fieldwork	May 2022
B11/22	Assurance Mapping	Fieldwork	May 2022
B12/22	Risk Management Strategy, Standards and Operations	Fieldwork	May 2022
B13/22	Strategic Planning	Fieldwork	May 2022
B17/22	Workforce Planning	Fieldwork	May 2022

Summary of Audit Findings

There have been no reviews finalised since the 9 December 2021 Audit and Risk Committee.

Key Performance Indicators 2020/21

Performance against service specification as at 28 February 2022:

	Planning	Target	9 December 2021	17 March 2022
1	Audit assignment plans for planned audits issued to the responsible Director at least 2 weeks before commencement of audit	75%	100%	100%
2	Draft reports issued by target date	75%	67%	60%
3	Responses received from client within timescale defined in reporting protocol	75%	100%	100%
4	Final reports presented to target Audit Committee	75%	100%	75%
5	Number of days delivered against plan	100% at year-end	-	349 days – 77%
6	Number of audits delivered to planned number of days (within 10%)	75%	-	67%

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**17 March 2022**
Title:	**Internal Audit – Follow Up Report on Audit Recommendations (as at 28 February 2022)**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Report Author:	**Barry Hudson, Regional Audit Manager**

1 Purpose

This is presented to the Audit & Risk Committee for:

- Assurance
- Discussion

This report relates to the:

- Audit Follow up Protocol

This aligns to the following NHSScotland quality ambition:

- Effective

2 Report summary

2.1 Situation

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

2.2 Background

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

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

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

2.3 Assessment

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

The table below shows the status of all remaining internal audit recommendations as at 28 February 2022, with comparable figures from the last Audit Follow-Up (AFU) report in November 2021.

	February 2022	**November 2021**
Remaining Recommendations	**37**	47
Extended with revised dates (agreed by Responding Officer) *(Appendix C)*	34	34
Outstanding – Date passed *(Appendix D)*	0	0
Not yet due	3	13

Progress summary

The following reports, featured in our November 2021 report, but have either been completed and validated or superseded by recommendations in more recent reports:

Report	**Remaining Actions Status**
B11/19 Mandatory Training	Completed and Validated
B22/19 Losses & Compensations	Completed and Validated
B25/19 Financial Management	Completed and Validated and 1 recommendation superseded by: B20/22 Financial Process Compliance
B14/20 Staff & Patient Environment	Completed and Validated
B21/20 Transportation of Medicines	Last remaining action will be reviewed in the 22/23 Transportation of Medicine Audit
B27/20 Financial Process Compliance	Completed and Validated
B26/21 Financial Process Compliance	Completed and Validated

The status of actions to address recommendations arising from the Internal Audit Annual Report and Internal Control Evaluation Report will be reported to the May Audit and Risk Committee.

The role of Internal Audit in the follow-up process is to maintain a record of responses received by management and to assess and validate responses. Appendix F records

where we have concluded evidence provided was insufficient to allow us to validate that action as complete, and where further information has been requested.

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

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

2.3.1 Quality/ Patient Care

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

2.3.2 Workforce

There are no workforce implications arising from this report

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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:-

- **note** and consider the current status of Internal Audit recommendations recorded within the AFU system.

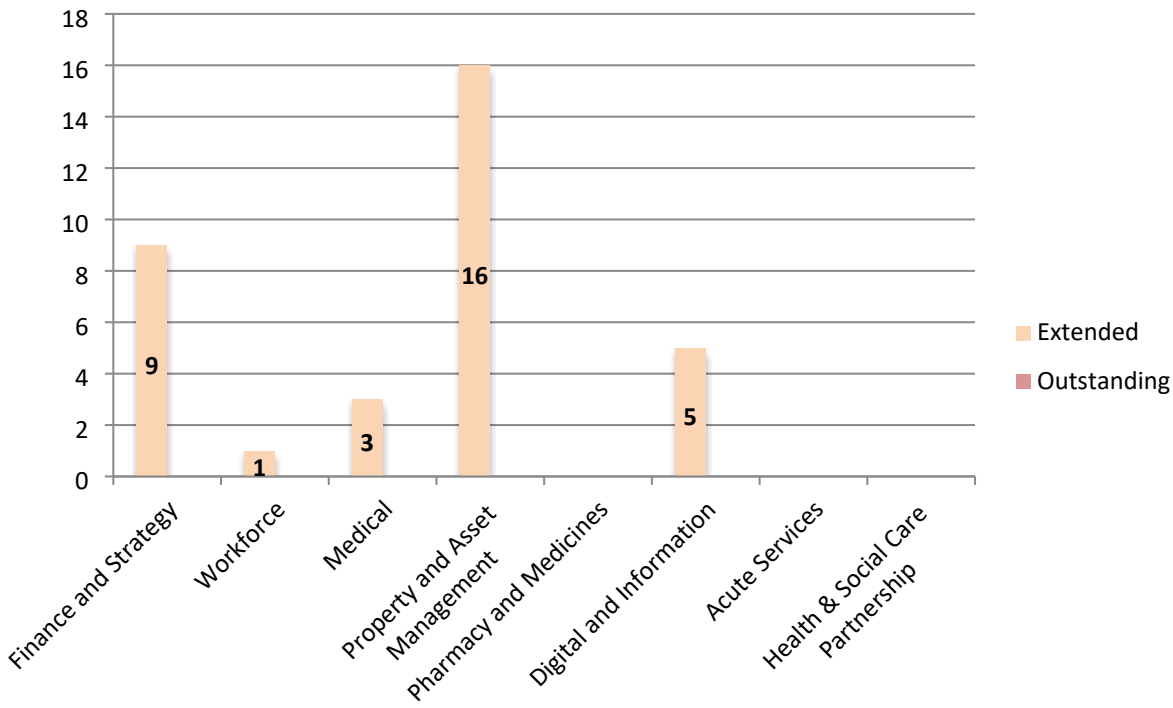
3. List of appendices

The following appendices are included with this report:

Report Contact

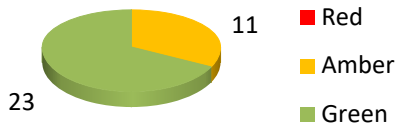
Barry Hudson, Regional Audit Manager, Email: barry.hudson@nhs.scot

Outstanding and Extended by Directorate

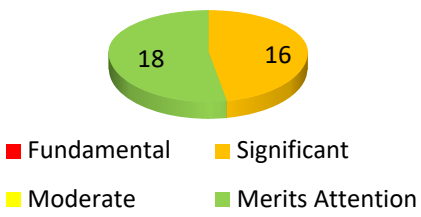


Extended Recommendations RAG Status and Priority

RAG Status



Priority



	Date of Issue	Total Recs.	Complete	Superseded	Remaining		Extended	Outstanding	Not Yet Due		Not Validated
Appendix							*C*	*D*			*E*
2019/20											
B17/20 Organisational Performance Management	Oct-20	6	1	0	5		5	0	0		-
B23A/20 Workforce Planning	Jan -20	4	3	0	1		1	0	0		-
2019/20 Totals		**10**	**4**	**0**	**6**		**6**	**0**	**0**		**-**
2020/21											
B13/21 Risk Management Strategy	Sep 21	5	0	0	5		4	0	1		-
B14/21 Sharps Management	Dec-21	14	9	0	5		5	0	0		-
B19/21 Clinical Governance Strategy and Assurance	Sep-21	2	0	0	2		1	0	1		-
B20/21 Adverse Events Management	Mar-21	1	0	0	1		1	0	0		-
B21/21 Medical Equipment and Devices	Nov-21	4	0	0	4		4	0	0		-
B22/21 Manual Handling Training	Jun-21	7	0	0	7		7	0	0		-
B23/21 ITIL Processes	Jul-21	6	2	0	4		4	0	0		-
B28/21 Digital & Information Governance Arrangements	Jul-21	3	1	0	2		1	0	1		-
2020/21 Totals		**42**	**12**	**0**	**30**		**27**	**0**	**3**		**-**
2021/22											
B19/22 Post Transaction Monitoring	Aug-21	2	1	0	1		1	0	0		-
2021/22 Totals		**2**	**1**	**0**	**1**		**1**	**0**	**0**		**-**
Overall Totals **(Actions from reports where recommendations remain unaddressed)**		**54**	**17**	**0**	**37**		**34**	**0**	**3**		**-**

	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
2019/20							
B17/20 Organisational Performance Management	1	M A	A revised schedule for the Performance and Accountability Review Framework (P&ARFF) meetings and the submission of a timetable for key documents should be agreed at the Executive Directors Group	Director of Finance & Strategy **Chief Executive**	01 Apr 21 30 Apr 22		NHS Fife is still under emergency planning measures and this will be ongoing until March 2022. The P&ARFF meetings have been paused during this time, we will however utilise the remaining months of 2021/22 to review the current process and embed that (with any agreed revisions) into the overall strategic planning and performance management arrangements for the Board. We expect to resume this process by 31 March 2022 at the latest and will route reporting on this through the recently reconfigured EDG meeting profile arrangements
	3	M A	The KSF/TURAS/appraisal performance completion rate should be included within the Workforce section of the report used for the P&ARFF.	Director of Finance & Strategy **Chief Executive**	30 Apr 21 30 Apr 22		NHS Fife is in emergency planning measures until March 2022 and the P&ARF have been paused during this time. Discussions are ongoing with the Workforce directorate about the KPIs includes in the IPQR for Workforce. The revised KPIs would be included from April 2022 forward.
	4	M A	Directorates and Departments should be reminded to include the links to strategic objectives and corporate objectives within the reports used for submission to the P&ARFF.	Director of Finance & Strategy **Chief Executive**	01 Apr 21 30 Apr 22		NHS Fife is in emergency planning measures until March 2022 and the P&ARF have been paused during this time. Links to corporate objectives are already in place to key programmes
	5	M A	Officers should be reminded to include the responsible officer and completion dates on action trackers. The action tracker should be amended to monitor attendance at the P&ARFF meetings.	Director of Finance & Strategy **Chief Executive**	01 Apr 21 30 Apr 22		NHS Fife is in emergency planning measures until March 2022 and the P&ARF have been paused during this time.

	6	M A	The P&ARFF should be further enhanced by including risk management	Director of Finance & Strategy **Chief Executive**	26 Feb 21 30 Apr 22		NHS Fife is in emergency planning measures until March 2022 and the P&ARF have been paused during this time. All aspects of strategic and performance work will include identification of risks and mitigations
B23a/20 Workforce Planning - Attendance Management	4	M A	A review should be undertaken to identify any gaps or duplication with the Attendance Management groups and ensure that there is a clear framework of all the groups, their purpose (strategic or operational) and how they interrelate to ensure that themes, reporting and escalation are defined and reported.	Director of Workforce **Chief Executive**	31-Mar-20 31-May-21 31-Mar-22		COVID-19 Pandemic and associated work pressures - While the content of the audit report has been shared with the NHS Fife Promoting Attendance Group and the associated local Promoting Attendance Groups and initial discussions have taken place with the Director of Workforce and Head of Human Resources on this recommendation, due to business as usual being interrupted by the COVID-19 Pandemic, we have been unable to have the fulsome discussion required on the framework for of all the groups, their purpose (strategic or operational) and how they interrelate, to ensure that themes, reporting and escalation are defined and reported. Update – November 2021. A draft Staff Health & Wellbeing Framework detailing the framework for all of the groups and their interrelationships has been drafted and will progress through the relevant approval routes for implementation in April 2022.
19/20 Sub Total	**6**						

	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
2020/21							
B13/21 Risk Management Strategy	1	S	The number and nature of the BAFs should be reassessed as part of the new process to ensure that there is clear alignment with the Board's overall and supporting strategies and to allow appropriate scrutiny and accountability.	**Director of Finance and Strategy**	31 Dec 21 30 Jun 22		The EDG, Audit & Risk Committee and the NHS Board have been engaged in a review of the current processes. On 21 December, later than planned but necessary as a result of the ongoing Covid impact, the Board was presented with and approved the proposal to develop dashboard reporting to replace the current BAF process. The Board agreed that the new process should be in place and operating by the end of Q1 2022/23. A plan will now be developed to ensure the delivery of this work.
	2	S	A project plan should be developed and produced which details the key aspects of work which need to be undertaken to complete the RMF. The project plan should include reference to the workplan, remaining actions required, realistic key dates and milestones to enable the monitoring of the plan and ensure a timely completion.	**Director of Finance and Strategy**	31 Dec 21 30 Jun 22		
	4	S	KPI performance should be reviewed with departments and Directorates to ascertain the reasons for the current performance and to identify where KPIs can be improved. A Risk Management Training Needs analysis should be undertaken as a priority. Assurance reports on individual BAFs should overtly address the Risk and Assurance questions to allow better scrutiny and accountability.	**Director of Finance and Strategy**	31 Dec 21 30 Jun 22		
	5	S	The Risk Appetite should be clearly understood by all involved and should have real consequences in relation to assurance required, allocation of resources and officers accountability. The Board should consider including the achievement of the Board's risk appetite within Directors' individual objectives.	**Director of Finance and Strategy**	31 Dec 21 30 Jun 22		

B14/21 Sharps Management	2f	M A	Update the Adverse Events Policy to: • clearly outline processes for review and analysis of Health and Safety Incidents related to staff • refer to lessons learned needing to be applied across the organisations to all departments and wards that they are applicable to.	Associate Director of Quality and Clinical Governance **Medical Director**	26 Mar 21 30 Apr 22		An extension is requested to do the time taken for the Lead for Adverse Events to commence in post. Preparatory work has commenced however due to the system pressures there has been a delay to proceeding.
	3a 3b 3c 3d	S	Action plan to address issues raised in report (section 3 - Control 2) and appendix 1 to be developed and implementation progress to be reported to the Sharps Strategy Group and the Health and Safety Sub-Committee. The Health and Safety Sub-Committee to be reminded of their responsibility to escalate issues to the Clinical Governance Committee when required.	H&S Manager **Director of Property and Asset Management**	a. 3-Feb-21 b. 3-Feb-21 c. 10-Feb-21 d. 30-Dec-20 a to d: 30-Jun-21 28-Feb-22 31-Jul-22		The pandemic and senior staff being seconded to other roles has delayed progress in addressing these actions. A new Health and Safety Manager has been recruited and will commence working for NHS Fife shortly.
B19/21 Clinical Governance Strategy and Assassurance	1	S	Revision of Clinical and Care Governance Strategy addressing recommendations made in Internal Audit report B15/17 & B18/18 – Clinical Governance Strategy & Assurance.	Associate Director of Quality and Clinical Governance **Medical Director**	31 Jan 22 31 May 22		To allow for the Clinical Governance Framework and Delivery Plan to be approved by CGC and for related Terms of Reference to be updated and approved by the relevant groups and committees. The Clinical Governance Framework to be presented to CGC in April 2022 for endorsement.

B20/21 Adverse Events Management	1	M A	Address concerns of DATIX Action Module users expressed by the comments made in this review regarding unfamiliarity with the DATIX Action Module and the lack of a full understanding of users' individual responsibilities Based on the findings of the initial review in B19/20 – Adverse Event Management, plus the additional comments made by users in this review, consideration should be given to a review of the framework and processes currently in place, to determine if any system changes could result in benefits and improvements, which would reduce the number of actions actually outstanding and those incorrectly recorded as outstanding.	Associate Director of Quality and Clinical Governance **Medical Director**	31-May-21 30-Apr-22		An extension has been is requested due to do the time taken for the Lead for Adverse Events to commence in start post (commenced 15 November 2021). Preparatory work has commenced, including preparing an action plan to address issues raised in this report and previously in B19/20, however due to the system pressures there has been a delay to proceeding encountered.
B21/21 Medical Equipment and Devices	1	M A	Updates required to both the GP/E4 – Medical Equipment Management Policy (including related appendices) and E14.1 - Equipment Procurement Operational Policy and these require to be authorised by the Capital Equipment Management Group.	Head of Estates **Director of Property and Asset Management**	31 Jan 22 31 Jul 22		Changes within department have delayed implementation of these actions. Extension required to allow policies to be updated and approved.
	2	M A	Equipment Request Form (ERF) requires updating to include prompts for sufficient detail to be recorded regarding consultation, training requirements, maintenance costs and needs assessment.	Head of Estates **Director of Property and Asset Management**	31 Jan 22 31 Jul 22		Changes within department have delayed implementation of these actions. Extension required to allow ERF to be updated and approved.
	3	M A	As per 2 above.	Head of Estates **Director of Property and Asset Management**	31 Jan 22 31 Jul 22		As per 2 above.
	4	M A	The CEMG should review the KPIs within Annex 2 of CEL 35 (2010) and consider whether receipt of these would benefit its decision making process and arrange for the receipt of such information in future. In addition it terms of reference (currently being reviewed) should be updated to note the monitoring of such KPIs.	Head of Estates **Director of Property and Asset Management**	31 Jan 22 31 Jul 22		Changes within department have delayed implementation of these actions. Extension required to allow consideration of KPIs by CEMG.

B22/21 Manual Handling Training	1	S	An annual manual handling training plan should be put in place to ensure that NHS Fife can effectively deliver manual handling training to all the necessary staff in line with government requirements.	H&S Manager **Director of Property and Asset Management**	27-Aug-21 31-Mar-22		Sickness absence in MH Team and other changes in H&S management structure have not allowed for action plans to be implemented as originally envisioned. Focus has necessarily been on what training can be delivered given restrictions on personnel. Whilst some initial progress was made realistically the action plans for this audit are effectively on hold whilst the team rebuilds.
	2	S	A training needs exercise should be undertaken to determine manual handling training requirement.	H&S Manager **Director of Property and Asset Management**	27-Aug-21 31-Mar-22		As per recommendation 1 above.
	3	S	Routine manual handling training management reports should be prepared detailing the number of courses held in comparison with the planned number, with explanations being provided for significant variations. High level reporting on this should be reported to the Clinical Governance Committee.	H&S Manager **Director of Property and Asset Management**	30-Sep-21 31-Mar-22		As per recommendation 1 above.
	4	M A	Consideration should be given to changing the way courses are advertised, so that availability is more accessible and potentially a greater uptake in attendance.	H&S Manager **Director of Property and Asset Management**	30-Jul-21 31-Mar-22		As per recommendation 1 above.
	5	M A	The introduction of the self-accreditation scheme should be revisited.	H&S Manager **Director of Property and Asset Management**	30-Aug-21 31-Mar-22		As per recommendation 1 above.
	6	M A	Lesson plans should be created for all areas of manual handling training to ensure the content and suitability of each is considered.	H&S Manager **Director of Property and Asset Management**	30-Jul-21 31-Mar-22		As per recommendation 1 above.
	7	M A	The risk assessment for manual handling training should be finalised to ensure that correct actions are in place to deal with the associated risks.	H&S Manager **Director of Property and Asset Management**	30-Jun-21 31-Mar-22		As per recommendation 1 above.

B23/21 ITIL Processes	3	S	Digital and Information should engage with other services undertaking IT service management roles to assess their ITIL compliance and to offer assistance in introducing further ITIL processes to improve the efficiency of IT Service management in these areas. The timing of these actions will need to follow the cost benefit analysis and outcome referred to in action plan point 1 above and will also need to be sensitive to the impact the pandemic continues to have on the operation of other services.	Head of Digital Operations **Associate Director - Digital and Information**	31-Aug-21 31-Mar-22		Cost / Benefit paper presented to D&I Board 19/10/21. Time to allow for engagement with other services regarding introducing ITIL practices
	4	S	The NHS Fife Policy and Procedure for Change Management should be reviewed prior to the forthcoming change of IT Service Management software from Cherwell to ServiceNow. Part of this review should include determination of mandatory fields to be completed for all changes. Recording of risks related to changes should be undertaken in a consistent manner and should always include scoring of the risks based on impact and likelihood. The relevant staff should be reminded of the need to complete and attach the appropriate checklist for changes associated with server decommissioning.	Service Delivery Manager **Associate Director - Digital and Information**	30-Sep-21 31-Dec-21 31-Mar-22		Delays incurred regarding staffing the Transition Specialist post.
	5	S	The setting of required approvals should not be undertaken by the change requester. This should be automated as far as possible based on the type of change and its impacts and where the change is exceptional the approval requirements should be set by another member of the Digital and Information Team (eg the Change Manager). The move from Cherwell to ServiceNow should include determination of how approvals for changes are recorded so that this is clear and does not result in any doubt over whether the change has been appropriately authorised. Brief minutes of each Change Advisory Board meeting held should be recorded including listing	Service Delivery Manager **Associate Director - Digital and Information**	31-Aug-21 31-Mar-22		Delays incurred going live with Service Now ITSM (Information Technology Security Management).

			those in attendance and decisions made.				
	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		Delays incurred going live with Service Now ITSM.
B28/21 Digital & Information Governance Arrangements	3	M A	The new business case template for Digital and Information projects should be presented to the next Digital and Information Board for endorsement and to the next Finance, Performance and Resources Committee for approval. The SBAR supporting the new template should explain the reasons for changes made.	Head of Strategy and Programmes – Digital & Information **Associate Director – Digital & Information**	30-Nov-21 31-Mar-22		The Business Case has been endorsed by EDG and is to be presented to FP&RC for approval.
20/21 Sub Total	**27**						

	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
2021/22							
B19/22 Post Transaction Monitoring	2	M A	Checklists for each property transaction type to be agreed to allow these to be used to ensure evidence of compliance with the Property Transactions Handbook as each transaction progresses.	**Director of Property and Asset Management**	31-Jan-22 31-May-22		To allow for agreement of checklists prior to issuing them for use. A meeting has been scheduled for early April 2022 to facilitate this.
21/22 Sub Total	**1**						
Total	**34**						

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

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

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

Recommendation Priority	
Term	**Definition**
Fundamental (F)	Non-Compliance with key controls or evidence of material loss or error. Action is imperative to ensure that the objectives for the area under review are met.
Significant (S)	Weaknesses in control or design in some areas of established controls. Requires action to avoid exposure to significant risks in achieving the objectives for area under review.
Moderate (M)	Weaknesses in design or implementation of controls which contribute to risk mitigation. Requires action to avoid exposure to moderate risks to achieving the objectives for area under review.
Merits Attention (MA)	There are generally areas of good practice. Action may be advised to enhance control or improve operational efficiency.

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

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**17 March 2022**
Title:	**Internal Audit Framework**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Kevin Booth, Head of Financial Services & Procurement**

1 Purpose

This is presented to the Audit & Risk Committee for:

- Decision

This report relates to a:

- Legal requirement
- Local policy

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

- Safe
- Effective

2 Report summary

2.1 Situation

Public Sector Internal Audit Standards require each organisation to agree an Audit Charter, that defines Internal Audits purpose authority and responsibility. Whilst also clarifying the functional reporting relationships and accessibility provisions. This Charter, part of the Internal Audit Framework is to be annually reviewed and updated following approval by the Board, in this case through the Audit and Risk Committee.

The Charter is complementary to the relevant provisions included in the Board's Standing Orders and Standing Financial Instructions and the Shared Service Agreement and Service Specification with FTF Audit.

2.2 Background

Internal Audit is an independent, objective assurance and consulting function designed to add value and improve the operations of NHS Fife. Internal Audit supports NHS Fife to

accomplish its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of governance, risk management and control processes.

Internal Audit is responsible for providing an independent and objective assurance opinion to the Accountable Officer, the Board and the Audit and Risk Committee on the overall adequacy and effectiveness of NHS Fife's framework of governance, risk management and control. In addition, internal audits findings and recommendations are beneficial to management in securing improvement in the audited areas.

FTF Audit provides the internal audit service as part of a shared service which is hosted by NHS Fife. A partnership Board comprising of the Directors of Finance for NHS Fife, Forth Valley and Tayside is chaired by the Director of Finance of NHS Tayside. The FTF Partnership board have the responsibility to approve the draft Internal Audit Framework prior to the presentation to the respective boards Audit and Risk committees for their final approval.

2.3 Assessment

The attached internal audit framework sets out the Audit Charter, Service Specification and Reporting Protocol that have been reviewed and provided to NHS Fife for 2022/23. The revised framework follows on from the 2021/22 internal audit framework which was previously approved at the meeting of the Audit and Risk Committee on 19th January 2021. There are no material changes but it is important that the Audit and Risk Committee is assured that the document has been reviewed and has the opportunity to comment..

The Internal Audit Framework has been approved by the FTF Partnership Board members and is now presented to the Audit & Risk Committee for its formal approval.

2.3.1 Quality/ Patient Care

Internal Audit's Mission statement provides that 'Internal Audit is an independent, objective assurance and consulting activity designed to add value and improve the organisations operations'.

2.3.2 Workforce

Due consideration is given to the appropriate staff skill mix and is provided in the service specification.

2.3.3 Financial

Any identified Financial Implications will be highlighted to the appropriate responsible individual within NHS Fife.

2.3.4 Risk Assessment/Management

Internal Audit assignments identify the key risks at the planning stage and the work is designed to evaluate whether appropriate control systems are in place and are operating effectively to mitigate the risks identified at the onset.

2.3.5 Equality and Diversity, including health inequalities

Any Internal Audit assignments which involve the review of policies and procedures will consider the way in which equality and diversity is incorporated into the Boards documentation.

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

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

2.3.8 Route to the Meeting

This framework has been produced by the Chief Internal Auditor and Regional Audit Manager.
The Internal Audit Framework was approved by the FTF Partnership Board on 4th January 2022.

2.4 Recommendation

The Audit and Risk Committee is asked to:

- **Decision** – Approve the Internal Audit Framework for 2022/23

3 List of appendices

The following appendices are included with this report:

- Appendix No 1 – FTF Audit Charter and Specification for Internal Audit Services

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

Introduction

Public Sector Internal Audit Standards require each organisation to agree an Audit Charter which is regularly updated following approval by the Board, in this case through the Audit and Risk Committee. This Charter is complementary to the relevant provisions included in the organisation's own Standing Orders (SOs) and Standing Financial Instructions (SFIs) and the Shared Service Agreement and Service Specification with FTF Audit (SSA).

The terms 'Board' and 'senior management' are required to be defined under the Standards and therefore have the following meaning in this Charter:

- Board means the Board of NHS xxx with responsibility to direct and oversee the activities and management of the organisation. The Board has delegated authority to the Audit and Risk Committee in terms of providing a reporting interface with internal audit activity; and
- Senior Management means the Chief Executive as being the designated Accountable Officer for NHS xxx. The Chief Executive has made arrangements within this Charter for an operational interface with internal audit activity through the Director of Finance.
- FTF are the Internal Auditors for NHS xxx

Purpose and responsibility

"Internal audit is an independent, objective assurance and consulting function designed to add value and improve the operations of NHS xxx. Internal audit helps the organisation accomplish its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of governance, risk management and control processes." Its mission is to enhance and protect organisational value by providing risk-based and objective assurance, advice and insight. (See Appendix 1 for FTF Mission Statement).

Internal Audit is responsible for providing an independent and objective assurance opinion to the Accountable Officer, the Board and the Audit and Risk Committee on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. In addition, internal audit's findings and recommendations are beneficial to management in securing improvement in the audited areas.

The Shared Services Agreement and associated Service Specification with FTF set out their specific responsibilities as internal auditors to NHS xxx.

Independence and Objectivity

Independence as described in the Public Sector Internal Audit Standards is the freedom from conditions that threaten the ability of the internal audit activity to carry out internal audit responsibilities in an unbiased manner. To achieve the degree of independence necessary to effectively carry out the responsibilities of the internal audit activity, the Chief Internal Auditor will have direct and unrestricted access to the Board and Senior Management, in particular the Chair of the Audit and Risk Committee and Accountable Officer.

Organisational independence is effectively achieved when the auditor reports functionally to the Audit and Risk Committee on behalf of the Board. Such functional reporting includes the Audit and Risk Committee:

- approving the internal audit charter;
- approving the risk based internal audit plan;
- receiving outcomes of all internal audit work together with the assurance rating; and
- reporting on internal audit activity's performance relative to its plan.

Whilst maintaining effective liaison and communication with the organisation, as provided in this Charter, all internal audit activities shall remain free of untoward influence by any element in the organisation, including matters of audit selection, scope, procedures, frequency, timing, or report content to permit maintenance of an independent and objective attitude necessary in rendering reports.

Internal Auditors shall have no executive or direct operational responsibility or authority over any of the activities they review. Accordingly, they shall not develop nor install systems or procedures, prepare records, or engage in any other activity which would normally be subject to Internal Audit.

This Charter makes appropriate arrangements to secure the objectivity and independence of internal audit as required under the standards. In addition, the shared service model of provision across FTF provides further organisational independence.

The Shared Services Agreement sets out the operational independence of FTF as internal auditors to NHS xxx. In particular it states '*FTF may be called upon to provide advice on controls and related matters, subject to the need to maintain objectivity and to consider resource constraints. Normally FTF will have no executive role nor will it have any responsibility for the development, implementation or operation of systems. Any internal audit input to systems development work will be undertaken as specific assignments. In order to preserve independence and objectivity, any such involvement in systems development activities will be restricted to the provision of advice and ensuring key areas in respect of control are addressed*.'

FTF have controls in place to ensure compliance with the relevant aspects of the Public Sector Internal Audit Standards and the wider requirement to conform with NHSScotland standards of conduct regulations.

Appointment of CIA and Internal Audit Staff, Professionalism, Skills & Experience

Under s5.1 of the Specification NHS Fife, as the host body, is responsible for appointing a CIA who (Spec s12.6) is a member of CCAB Institute or CMIIA with experience equivalent to at least five years post-qualification experience and at least three years of audit.

The Specification also sets out the required qualified skill-mix and the proportion of the Audit Plan to be delivered by the Chief Internal Auditor, Regional Audit Managers and other qualified staff as well as specifying the responsibility of FTF to ensure staff are suitably trained with appropriate skills with a formal requirement for preparation and maintenance of Personal Development Plans for all audit staff.

Authority and Accountability

Internal Audit derives its authority from the NHS Board, the Accountable Officer and Audit and Risk Committee. These authorities are established in Standing Orders and Standing Financial Instructions adopted by the Board.

The Chief Internal Auditor leads FTF and assigns a named contact to NHS xxx. For line management (e.g. individual performance) and professional quality purposes (e.g. compliance with the Public sector Internal Audit Standards), the Regional Audit Managers report to the Chief Internal Auditor.

The Chief Internal Auditor reports on a functional basis to the Accountable Officer and to the Audit and Risk Committee on behalf of the Board. Accordingly the Chief Internal Auditor has a direct right of access to the Accountable Officer, the Chair of the Audit and Risk Committee and the Chair of the Health Board if deemed necessary.

The Audit and Risk Committee approves all Internal Audit plans and may review any aspect of its work. The Audit and Risk Committee also has regular private meetings with the Chief Internal Auditor and its remit requires it to '*To ensure that there is direct contact between the Audit and Risk Committee and Internal Audit and to meet with the Chief Internal Auditor at least once per year and as required, without the presence of Executive Directors'.*

In order to facilitate its assessment of governance within the organisation, Internal Audit is granted access to attend any committee or sub-committee of the Board charged with aspects of governance

Relationships

The Chief Internal Auditor will maintain functional liaison to the Director of Finance who has been nominated by the Accountable Officer as executive lead for internal audit. The Director of Finance is supported in this role by the Head of Finance – Capital & Resources.

In order to maximise its contribution to the Board's overall system of assurance, Internal Audit will work closely with NHS xxx Executive Leadership Team in planning its work programme. Co-operative relationships with management enhance the ability of internal audit to achieve its objectives effectively. Audit work will be planned in conjunction with management, particularly in respect of the timing of audit work.

Internal Audit will meet regularly with the external auditor to consult on audit plans, discuss matters of mutual interest, discuss common understanding of audit techniques, method and terminology, and to seek opportunities for co-operation in the conduct of audit work. In particular, internal audit will make available their working files to the external auditor for them to place reliance upon the work of Internal Audit where appropriate.

Internal Audit strives to add value to the organisation's processes and help improve its systems and services. To support this Internal Audit will obtain an understanding of the organisation and its activities, encourage two way communications between internal audit and operational staff, discuss the audit approach and seek feedback on work undertaken.

The Audit and Risk Committee may determine that another Committee of the organisation is a more appropriate forum to receive and action individual audit reports. However, the Audit and Risk Committee will remain the final reporting line for all reports.

Standards, Ethics, and Performance

Internal Audit must comply with the Core Principles for the Professional Practice of Internal Auditing, the Code of Ethics, the Standards and the Definition of Internal Auditing. The CIA will discuss the Mission of Internal Audit and the mandatory elements of the International Professional Practices Framework with senior management and the Board.

Internal Audit will operate in accordance with the Shared Services Agreement (updated 2019) and associated performance standards agreed with the Audit and Risk Committee. The Shared Services Agreement includes a number of Key Performance Indicators and we have agreed with the Audit and Risk Committee that these will be reported to each Audit and Risk Committee meeting as part of the Internal Audit Progress report.

Scope

The scope of Internal Audit encompasses the examination and evaluation of the adequacy and effectiveness of the organisation's governance, risk management arrangements, system of internal control, and the quality of performance in carrying out assigned responsibilities to achieve the organisation's stated goals and objectives. It includes but is not limited to:

- Reviewing the reliability and integrity of financial and operating information and the means used to identify measure, classify, and report such information;
- Reviewing the systems established to ensure compliance with those policies, plans, procedures, laws, and regulations which could have a significant impact on operations, and reports on whether the organisation is in compliance;
- Reviewing the means of safeguarding assets and, as appropriate, verifying the existence of such assets;
- Reviewing and appraising the economy and efficiency with which resources are employed, this may include benchmarking and sharing of best practice;

- Reviewing operations or programmes to ascertain whether results are consistent with the organisation's objectives and goals and whether the operations or programmes are being carried out as planned;
- Reviewing specific operations at the request of the Audit and Risk Committee or management, this may include areas of concern identified in the corporate risk register;
- Monitoring and evaluating the effectiveness of the organisation's risk management arrangements and the overall system of assurance (see below);
- Ensuring effective co-ordination, as appropriate, with external auditors; and
- Reviewing Annual Governance Statement prepared by senior management.

Internal Audit will devote particular attention to any aspects of the risk management, internal control and governance arrangements affected by material changes to the organisation's risk environment.

If the Chief Internal Auditor or the Audit and Risk Committee consider that the level of audit resources or the Charter in any way limit the scope of internal audit, or prejudice the ability of internal audit to deliver a services consistent with the definition of internal auditing, they will advise the Accountable Officer and Board accordingly.

Risk Management

Internal Audit will liaise with both the Audit and Risk Committee and senior management (including the chair of Strategic Risk Management Group) to discuss the alignment of audit priorities to strategic and emerging risks. This will include the strategic risks not being audited in-year to enable a discussion about coverage and the level of audit resource.

Each year an annual overview of risk management arrangements will be undertaken by FTF through the Internal Control Evaluation and Annual Report.

An overall review of risk management has been included within the annual internal audit plan. This review will encompass validation of strategic risk management group assurances, risk management self-assessments and KPI reporting.

We will also review the risk management systems, associated controls, assurance processes and functions, and test the operation of controls beyond the risk register within NHS xxx. This will be achieved through specifics audits and by incorporation within standard audit processes as part of every relevant audit undertaken. Significant findings will be communicated to allow immediate action to be taken by NHS xxx.

Appropriate communication is in place with the risk management function which includes provision of all audit reports and regular meetings with risk management managers.

Reporting arrangements including Key Performance Indicators

Arrangements for reporting and following up individual assignments are contained within the reporting and follow-up protocols approved by the Audit and Risk Committee. The Specification states that '*The principal report to be produced by Internal Audit will be the Annual Audit Report for each audit year. This needs be prepared in time for submission to the Audit and Risk Committee not later than the target date specified in Appendix I in order to provide the assurance required in considering the Board's Annual Accounts.*

The Annual Audit Report should contain:

- *An opinion on whether:*
    - ✧ *Based on the work undertaken, there were adequate and effective internal controls in place throughout the year;*
    - ✧ *The Accountable Officer has implemented a governance framework in line with required guidance sufficient to discharge the responsibilities of this role;*
    - ✧ *The Internal Audit plan has been delivered in line with PSIAS*

- *analysis of any changes in control requirements during the year*
- *comment on the key elements of the control environment*
- *summary of performance against this service specification*
- *progress in delivering the Quality Assurance Improvement Programme.*

The Specification sets out the key performance indicators to be used by Internal Audit and requires that they be reported in full within the Annual Internal Audit Report and the Audit and Risk Committee also wanting these reported to each meeting as part the Internal Audit Progress report.

Assurances provided to parties outside the organisation;

Internal Audit will not provide assurance on activities undertaken by NHS xxx to outside parties without specific instruction from NHS xxx or as per the approved output sharing protocol.

Approach

To ensure delivery of its scope and objectives in accordance with the Charter, Internal Audit has produced suite of working practice documents. This suite includes arrangements for annual and strategic planning, individual audit assignment planning, fieldwork and reporting.

Access and Confidentiality

Internal Audit shall have the authority to access all the organisation's information, documents, records, assets, personnel and premises that it considers necessary to fulfil its role. This shall extend to the resources of the third parties that provide services on behalf of the organisation. NHS xxx's Standing Financial Instructions state that '*The Chief Internal Auditor is entitled without necessarily giving prior notice to require and receive:*

a) *Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature (in which case he shall have a duty to safeguard that confidentiality), within the confines of the data protection act.*
b) *Access at all reasonable times to any land, premises or employees of the Board;*
c) *The production or identification by any employee of any cash, stores or other property of the Board under an employee's control; and*
d) *Explanations concerning any matter under investigation.*

All information obtained during the course of a review will be regarded as strictly confidential to the organisation and shall not be divulged to any third party without the prior permission of the Accountable Officer. S6.6 of the SSA sets out those circumstances in which reports and working papers will be shared with the statutory External Auditors and the application of the Freedom of Information (Scotland) Act 2002.

Where there is a request to share information amongst the NHS bodies, for example to promote good practice and learning, then permission will be sought from the Accountable Officer/Lead Officer before any information is shared.

Irregularities, Fraud & Corruption

It is the responsibility of management to maintain systems that ensure the organisation's resources are utilised in the manner and on activities intended. This includes the responsibility for the prevention and detection of fraud and other illegal acts.

Internal Audit shall not be relied upon to detect fraud or other irregularities. However, Internal Audit will give due regard to the possibility of fraud and other irregularities in work undertaken. Additionally, Internal Audit shall seek to identify weaknesses in control that could permit fraud or irregularity.

If Internal Audit discovers suspicion or evidence of fraud or irregularity, this will immediately be reported to the organisation's Fraud Liaison Officer in accordance with the organisation's Counter Fraud Policy & Fraud Response Plan and with S10 of the SSA.

Quality Assurance

S7 of the Specification requires that '*the Chief Internal Auditor shall be responsible for the preparation and maintenance of quality processes which maintain and record the operational procedures and quality standards of the Service, and which are compliant with PSIAS*.'

The Chief Internal Auditor has establish a quality assurance programme designed to give assurance through internal and external review that the work of Internal Audit is compliant with the Public Sector Internal Audit Standards and to achieve its objectives. A commentary on compliance against PSIAS and against agreed KPIs will be provided in the Annual Internal Audit Report. KPIs will also be reported to each Audit and Risk Committee meeting as part of the Internal audit Progress report.

Resolving Concerns

S5.2 of the Specification states that '*The Chief Internal Auditor will also be responsible for monitoring the contract and will therefore be the Agreement Control Officer performing the additional quality, performance measurement and liaison activities. The Chief Internal Auditor shall be available to meet with the Director of Finance whenever required and at least bi-annually to discuss the service*.' S7 of the SSA states that '*The Chief Internal Auditor shall be available to meet with the Client Director of Finance or nominated representative whenever required and at least bi-annually to discuss the services. Any issues should be raised with the Chief Internal Auditor in the first instance.*

If the matter is not resolved to the satisfaction of the Client, then it shall be presented to the next available meeting of the Partnership Board for resolution by majority vote.'

Review of the Internal Audit Charter

This Internal Audit Charter shall be reviewed annually and approved by the Audit and Risk Committee.

Date: November 2021

Date of next November 2022

Appendix 1

Mission and values

The purpose of the internal audit function has been defined within the Public Sector Internal Audit Standards (PSIAS). FTF, following discussion with staff and the Partnership Board has developed a mission and vision statement which incorporates this definition as well as additional elements reflecting our way of delivering the audit function as follows:

WORKING TOGETHER TO PROVIDE ASSURANCE AND ADD VALUE

We achieve this by following the Public Sector Internal Audit Standards:

*"Internal Audit is an independent, objective **assurance** and consulting activity designed to **add value** and **improve** an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes".*

We work with our clients to provide an excellent service by understanding their values, their objectives and risks and the environment in which they operate. We value and listen to our staff and ensure that they have the skills and knowledge they require to help us to succeed, continuously assessing and improving the service we provide.

APPENDIX 2

Specification for Internal Audit Services

APPENDIX 2

CONTENTS

Page

1. Introduction

This document sets out a specification for the Internal Audit requirements of the Client. The specification is for a total Internal Audit Service to the Client organisation over the period 1 April 2019 to 31 March 2024.

Wherever reference is made to Audit and Risk Committee, Director of Finance etc. it shall refer to that of the Client unless otherwise specified.

1.1 FTF will undertake to perform the Internal Audit Service in accordance with the provisions set out in this specification.

1.2 Either party shall be entitled to terminate the Agreement for the Internal Audit Service. Prior to the termination of the Agreement both parties must follow any agreed management arrangements relating to termination. These arrangements will be agreed prior to the start of the Agreement and will include the period of notice to be given.

1.3 In addition to the obligations imposed within this specification, it is the duty of FTF to provide the Internal Audit Service to a standard that is in all respects acceptable to the Director of Finance and the Audit and Risk Committee and consistent with professional standards and complies with the Internal Audit Charter approved by Audit & Risk Committee annually.

1.4 FTF and its staff must respect all medical and managerial confidences and shall regard as confidential and shall not disclose, except as required by law, to any person other than a person authorised by the Client, any information acquired by FTF or its staff in connection with the provision of the Internal Audit Service concerning:

- ✧ the organisation or its directors and officers;
- ✧ patient identity;
- ✧ medical condition of/treatment received by patients

1.5 Subject to the availability of resources, FTF and its staff shall co-operate and respond to reasonable requests or give support in situations, whether or not they are detailed in the specification.

1.6 FTF shall comply with any relevant directives issued by the Scottish Government Health and Social Care Directorates, including the Public Sector Internal Audit Standards.

2. Internal Audit Responsibilities

2.1 Within the organisation, responsibility for internal control rests fully with management to ensure that appropriate and adequate arrangements are established. FTF will be responsible for conducting an independent appraisal and giving assurance to the Audit and Risk Committee on all internal control arrangements.

2.2 FTF will be responsible for obtaining relevant, reliable and sufficient audit evidence in order to provide an opinion to the client on the adequacy and effectiveness of internal controls. FTF will also assist management by evaluating and reporting to them on the effectiveness of the controls for which management are responsible.

2.3 FTF will consider the adequacy of controls necessary to secure propriety, economy, efficiency and effectiveness in all areas and will seek to confirm that management have taken the necessary steps to achieve these objectives.

2.4 In order to provide the required assurance, FTF will evaluate the controls that management have established to ensure that:

- ✧ the organisation's objectives are achieved
- ✧ there is economical and efficient use of resources
- ✧ risks are adequately and effectively identified, recorded and managed

- there is compliance with established policies, procedures, laws and regulations
- assets belonging or entrusted to the organisation are properly controlled and safeguarded from losses of all kinds, including those arising from fraud, irregularity or corruption
- there is integrity and reliability of information and data provided to management including that used in decision making
- the organisation's interests are protected with regard to any contractual arrangements entered into
- the controls over information technology applications and installations are sufficient in quality and comply with recommended standards

2.5 FTF may be called upon to provide advice on controls and related matters, subject to the need to maintain objectivity and to consider resource constraints. Normally FTF will have no executive role nor will it have any responsibility for the development, implementation or operation of systems. Any internal audit input to systems development work will be undertaken as specific assignments. In order to preserve independence and objectivity, any such involvement in systems development activities will be restricted to the provision of advice and ensuring key areas in respect of control and risk are addressed.

2.6 It will not be within FTF's remit to question the appropriateness of policy decisions. However, FTF may draw to the attention of the Audit & Risk Committee instances where there are illegal acts or contraventions of Standing Orders, Standing Financial Instructions or Statutory Powers and Regulations. FTF may also examine the management arrangements for making, monitoring and reviewing all such policy decisions.

3. Internal Audit Standards

3.1 Public Sector Internal Audit Standards (PSIAS)

3.2 FTF shall comply with PSIAS and report on its compliance to the Audit and Risk Committee as part of the Annual Internal Audit Report. FTF shall maintain a system to ensure compliance with Public Sector Internal Audit Standards and shall adhere to an agreed timetable for external quality assessments and reporting on a formal mid-point self-assessment against the Standards.

4. Planning

4.1 At the start of the calendar year, the Audit and Risk Committee and senior management team shall consider the findings of the Internal Audit Internal Control Evaluation together with the Strategic Risk Register and advise Internal Audit of key topics they wish to be considered for inclusion in the Internal Audit Plan for the following financial year.

4.2 Internal Audit shall then prepare a strategic and operational audit plan based on the Strategic Risk Register and independent assurances available from other sources. In order to ensure coverage of all key controls, the plan also takes into account the Internal Audit risk assessment, which shall be reviewed annually and updated for changes in systems, in organisation and in the NHS control framework.

4.3 Audit plans based on these factors will then be prepared by FTF, agreed with the Director of Finance and discussed with the external auditors prior to submission to the Senior Management Team and then the Audit and Risk Committee. They will comprise a Strategic Audit Plan and an Annual Audit Plan in a format agreed with the Audit and Risk Committee.

4.4 The Strategic Audit Plan and Annual Audit Plan should separately identify any special investigations and should also include a provision for contingencies.

Strategic Audit Plan

4.5 The Strategic Audit Plan should cover the period of appointment during which all major risks, systems and key areas of activity, identified by the planning process, will be audited. The plan should usually incorporate a rotation of audit emphasis to form a cyclical approach.

There are a number of areas within the audit universe which, because of their nature, need to be planned for outwith the Risk Assessment process. These may include:

- ✧ Core Financial systems where assurance is required by External Audit
- ✧ Reviews targeting high risk fraud/probity areas through proactive CFS liaison
- ✧ Management of significant projects
- ✧ Post-transaction Monitoring

The Strategic Plan should set out the audit areas categorised by type of activity, risk rating, frequency of audit, and an assessment of resources to be applied. It should be prepared in conjunction with Audit and Risk Committee members and management, and be presented by the Chief Internal Auditor for formal approval by the Audit and Risk Committee by 30 June. The Strategic Plan should be updated annually in order to inform the Annual Audit Plan.

Annual Audit Plan

4.6 The Chief Internal Auditor in each year of the Agreement shall submit to the Audit and Risk Committee an Annual Audit Plan, which should reflect the audit coverage identified in the Strategic Audit Plan. Each Annual Audit Plan should cover the next twelve month period (May-April) and should be submitted to the Senior Management team and Audit and Risk Committee by no later than 30 June, subject to timely receipt of the appropriate risk assessment scoring template from the Client or by agreement with the Client. The Annual Audit Plan should set out the planned scope of audit work and should identify the critical areas to be covered and resources required in each project.

Audit Assignment Plans

4.7 An audit work schedule should be produced for each audit project undertaken and agreed with the relevant Director and Director of Finance. The assignment plans will identify the following:

- ✧ Job number and title
- ✧ Relevant Corporate/operational risks
- ✧ Relevant Director and responding officer
- ✧ Audit staff
- ✧ Start date and planned number of audit days required
- ✧ Scope, control objectives and other instructions
- ✧ Target draft report date and target Audit & Risk Committee

5. Managing Audit Work

5.1 Fife NHS Board shall appoint a person to be the Chief Internal Auditor. The Chief Internal Auditor will be responsible for managing and undertaking specified audit tasks to appropriate quality and other work standards. This includes management of internal audit staff and resources. The tasks will be based on the Annual Audit Plan approved by the Client Audit and Risk Committee along with any additional items covered by the contingency provision. That Committee will consider any significant changes to the scope or duration of assignments.

5.2 The Chief Internal Auditor will also be responsible for monitoring the contract and will therefore be the Agreement Control Officer performing the additional quality, performance measurement and liaison activities. The Chief Internal Auditor shall be available to meet with the Director of Finance whenever required and at least bi-annually to discuss the service.

5.3 The Regional Audit Manager will be expected to be available to attend meetings with the Director of Finance at least monthly and as required, to discuss the progress of individual projects. The Regional Audit Manager will be the Internal Audit point of contact for any other bodies, internal or external, such as the external auditor.

5.4 The Audit and Risk Committee and Director of Finance must endeavour to ensure management's perspective of internal audit is positive and that a participative approach is adopted. Therefore FTF will be expected to actively involve and keep auditees informed during all stages of audit assignments. This is particularly crucial during the testing and evaluation stages when it would be more appropriate to inform management of the emerging findings where these are significant rather than wait and produce the findings in a report at a later date. The circumstances where this approach would be appropriate would be:

- ✧ where there may be a material loss to the organisation unless action is taken quickly
- ✧ where there is a serious breach of law/regulations

There will be occasions when this approach is not however appropriate (i.e. where fraud or irregularities are suspected) and involvement of the Director of Finance must be sought (see s11).

5.5 The Chief Internal Auditor is responsible for delivering an economic and efficient quality audit and ensuring that the internal audit service is delivered according to the terms of this specification. The Chief Internal Auditor also has a responsibility to the Audit and Risk Committee, Chief Executive and Director of Finance. Broadly this encompasses the following areas:

- ✧ Planning logical and comprehensive coverage that reflects the agreed degree of risk associated with each system
- ✧ Identifying and selecting resources and funding
- ✧ Determining standards
- ✧ Monitoring delivery and quality assuring the products including compliance with Public Sector Internal Audit Standards
- ✧ Effecting appropriate changes
- ✧ Promoting the work of internal audit and the Audit & Risk Committee as a contribution to the control environment within the organisation
- ✧ Audit reporting
- ✧ Attendance at Audit and Risk Committees as appropriate and to present the Strategic Plan, Interim review and Annual report
- ✧ Promoting the Internal Audit Service to members and officers
- ✧ Managing requests for unplanned work

5.6 In addition the Chief Internal Auditor will have managerial and personnel responsibilities for internal audit staff.

6. Reporting

6.1 The main purpose of Internal Audit reports is to provide management and the Audit and Risk Committee with information on significant audit findings, conclusions and recommendations. For full Internal Audit reviews of systems carried out as part of the identified Annual Audit Plan, Internal Audit will provide an opinion on the adequacy of internal controls within the system, except where specified within the reporting protocol e.g. Financial Process Compliance, or reviews of known areas of weakness as requested by management etc.

6.2 The aim of every internal report should be to:

- ✧ define the scope and objectives of the work carried out
- ✧ provide a formal record of issues and recommendations arising from the internal audit assignments and, where appropriate, of agreements reached with management
- ✧ instigate management action to improve performance and control

6.3 In addition, Internal Audit should provide the Director of Finance and Audit and Risk Committee with regular reports on progress (see 0 below)

6.4 The Audit and Risk Committee should approve a formal follow-up protocol for ensuring that agreed Internal Audit recommendations have been actioned. This is incorporated as Appendix III to this Specification.

6.5 The Chief Internal Auditor should ensure that reports are sent to managers who have a direct responsibility for the activity being audited and who have the authority to take action on the subsequent internal audit recommendations.

6.6 The distribution of reports by Internal Audit should be restricted to those individuals who need the information including members of the Audit and Risk Committee and the appointed external auditors. Except as required by law or as agreed within an approved output sharing protocol with IJB partners, documents should not be divulged to any other third party without the written express permission of the Director of Finance and/or Audit and Risk Committee.

Individual Audit Project Reporting

6.7 For each audit project, the Internal Auditor shall prepare and submit a draft report of findings in a form agreed by the Audit and Risk Committee and Director of Finance. The reporting protocol shall be approved by the Audit and Risk Committee and incorporated as Appendix II to this document and shall include target timescales for issue and responding to Internal Audit reports.

It is expected that where it is necessary to alert management to the need to take immediate action to correct a serious weakness in performance or control or where material errors or irregularities are identified, these will immediately be brought to the attention of the Director of Finance and if appropriate the Chair of the Audit and Risk Committee.

Annual Audit Reporting

6.8 The principal reports to be produced by Internal Audit will be the Internal Control Evaluation (ICE) and the Annual Internal Audit Report for each audit year. The ICE is normally presented to the January Audit and Risk Committee and the Annual Internal Audit Report needs be prepared in time for submission to the Audit and Risk Committee not later than the target date specified in Appendix I following the end of the audit period. The Annual Internal Audit Report should contain:

- ✧ An opinion on whether:
  - ✧ Based on the work undertaken, there were adequate and effective internal controls in place throughout the year

- ✧ The Accountable Officer has implemented a governance framework in line with required guidance sufficient to discharge the responsibilities of this role
- ✧ The Internal Audit plan has been delivered in line with PSIAS
- ✧ analysis of any changes in control requirements during the year
- ✧ comment on the key elements of the control environment
- ✧ summary of performance against this service specification
- ✧ progress in delivering the Quality Assurance Improvement Programme.

The summary of performance will include details of staffing and skill mix in addition to the other performance measures outlined in Appendix I

In addition to the Annual Internal Audit Report, other reports may require to be made to the Audit and Risk Committee as requested by the Director of Finance.

Progress reporting

6.9 The Director of Finance will receive regular reports, together with the FTF Balanced Scorecard specific to the client, on dates specified by the Client, detailing progress against the agreed Annual Audit Plan together with notification of any significant breaches of the timescales within the approved reporting protocol.

For each individual assignment within the plan the following will be reported:

- ✧ Planned days
- ✧ Actual days to date
- ✧ Planned start date
- ✧ Date of each milestone
- ✧ Audit opinion (where applicable)

Progress reports will also be presented to each Audit & Risk Committee in a format agreed with the Client.

7. Quality Control and Quality Measurements

7.1 The Chief Internal Auditor will be held accountable by the Audit and Risk Committee for performance and is therefore responsible for ensuring quality standards are defined, agreed, monitored and reported. These aspects of quality should be enshrined in the Performance Measures, shown in Appendix I and reported within the Annual Internal Audit Report.

7.2 The Chief Internal Auditor shall continuously review the performance of each region and use this review to inform the bi-annual discussion with the Client Director of Finance.

7.3 The Chief Internal Auditor shall be responsible for the preparation and maintenance of quality processes which maintain and record the operational procedures and quality standards of the Service and which are compliant with PSIAS.

7.4 FTF shall report compliance with the PSIAS within the Annual Internal Audit Report, including the outcomes of any External Quality Assessments and progress in implementing any required actions. See also the provisions in 3.1 above.

Client Satisfaction Survey

7.5 A questionnaire will be issued to key contacts at the end of each audit review in a format agreed with the Director of Finance. The Chief Internal Auditor shall review these surveys, investigate any matters of concern and take appropriate remedial action where required. The results of the surveys should be reported annually to the Audit & Risk Committee within the Annual Internal Audit Report.

7.6 In addition, the Chief Internal Auditor will seek to ascertain the views of the Audit and Risk Committee and Board Members in relation to the quality of the service. This will be achieved through discussion with the Director of Finance, and through the offer of availability for meetings with the Audit and Risk Committee Chair and Board Chair.

8. Liaison with External Audit

8.1 The Public Finance and Accountability (Scotland) Act, provides for the accounts of Health Bodies to be audited by auditors appointed by Audit Scotland.

8.2 FTF will be expected to maintain a close working relationship with the Statutory Auditors on matters of mutual interest and to provide them with copies of all formal internal audit reports. The Statutory Auditor will be allowed access on request to all internal audit working papers and Final and Draft Final reports.

9. Best Value Reviews

9.1 It is the responsibility of the Internal Auditor, as part of the general review of systems of internal control, to review, appraise and report to management the extent to which the organisation's assets and interests are accounted for and safeguarded against losses of all kinds arising from fraud and other offences, waste, extravagance and inefficient administration, poor value for money or other cause.

9.2 This shall be achieved by the inclusion within the audit universe, and therefore the Strategic Audit Plan, of those systems of service monitoring and performance measurement that are critical for the attainment of value for money including the framework for providing overt assurance to the Accountable Officer on Best Value.

10. Suspected Criminal Offences

10.1 CEL (2013)11, an update of CEL (2008) 03 “Strategy to Combat Financial Crime in NHS Scotland” sets out further requirements on Boards and the requirements of the Bribery Act (2010) need to be met. Whilst the key messages from CEL 11 (2013) remain relevant, the annual list of activities required by NHS Boards was revised in a Dear Colleague letter of 1 July 2015 from the Director of Finance, eHealth and Analytics in the Scottish Government Health and Social Care Directorate (SGHSCD) which places an increased emphasis on delivering agreed outcomes and putting the customer at the heart of NHS Scotland Counter Fraud Services (CFS) work.

10.2 Where the Client wishes to nominate the Internal Audit Service to fulfil the Fraud Liaison Officer responsibilities as set out in the Fraud Action Plan and Partnership agreement, the contingency reserve shall be adjusted accordingly to reflect this increased responsibility.

10.3The audit universe shall include the arrangements for complying with relevant HDL/CELs, for responding to suspected criminal offences and for liaising with the CFS as appropriate.

11. Freedom of Information

11.1 Fife NHS Board is subject to the Freedom of Information (Scotland) Act 2002 (the Act).

11.2 As part of our duties under the Act, the Board may publish some of the information clients provide to us in its Freedom of Information publication scheme. The Board may disclose information to anyone who makes a request.

11.3 In all cases, wherever a request for information is received, the Client's nominated Freedom of Information contact point shall be notified in sufficient time to allow an informed decision to be reached without compromising our ability to comply with the timescales set out in the Act.

11.4 If the Client considers that any of the information supplied to us should not be disclosed due to its sensitivity then this should be stated giving reasons for withholding it. FTF will consult with the Client and have regard to its comments or stated reasons for withholding information.

12. Staffing

12.1 The anticipated total number of audit days required per annum to carry out the Internal Audit Service for each client is set out in the Shared Service Agreement.

12.2 FTF shall allocate a sufficient number of employees, sufficiently qualified and experienced to ensure the Internal Audit Service is provided at all times and in all respects to this specification.

12.3 FTF shall ensure that every person employed or contracted by FTF is at all times properly and sufficiently trained and instructed with regard to:

- ✧ the task or tasks that person has to perform
- ✧ all relevant provisions of this specification
- ✧ all relevant rules, procedures and standards of the organisation
- ✧ security
- ✧ patient confidentiality and relevant aspects of Information Governance

12.4 Training and development should be a planned and continuing process. The Chief Internal Auditor should co-ordinate and keep under review the training requirements of all staff engaged on the contract in compliance with national guidance and report on these as part of the Balanced Scorecard.

12.5 The Director of Finance may instruct FTF to remove from work in or about the provision of the service, any person employed by FTF if, in the opinion of the Director of Finance, such person is not providing the service or part thereof to a satisfactory level or is not conforming with client expectations of behaviour or professionalism. FTF shall immediately comply with such instructions and as soon as reasonably practical thereafter provide a replacement individual.

12.6 For the purposes of this paragraph, staff are categorised as follows:

Chief Internal Auditor: member of CCAB Institute or CMIIA with experience equivalent to at least five years post-qualification experience and three years audit experience

Qualified: member of a CCAB Institute, the Institute of Internal Auditors or an alternative qualification agreed with the Director of Finance including specialist support e.g. computer audit (ITAC etc.) and Risk Management.

Non-Qualified Auditors: appropriately skilled staff including those training towards CCAB or IIA or an appropriate alternative qualification.

During each successive twelve month period of the Agreement, FTF shall maintain, in the performance of the services, the skill mix of staff outlined in Appendix IV. Actual performance against this specified skill mix should be reported within the Annual Internal Audit Report.

12.7 FTF shall be expected to limit the number of staff employed on the contract to ensure sufficient experience and continuity is gained. With regard to this limit FTF should comply with the parameters specified in Appendix IV.

12.8 FTF shall be required to keep detailed time ledger records detailing actual time spent on each audit and the name and qualification of staff. Only time spent working exclusively on the performance of the services and associated chargeable travelling time shall be chargeable. The Director of Finance will have the right to make random spot checks of detailed time ledgers to verify the accuracy of time records.

12.9 NHS Fife shall be entirely responsible for the employment and conditions of service of FTF staff and FTF will be responsible for ensuring that:

- ✧ there are sufficient staff employed at the appropriate levels to fulfil the terms of the Shared Service Agreement
- ✧ staff do not smoke while on the organisation's premises
- ✧ staff do not introduce or consume any drug (including alcohol) on the organisation's premises
- ✧ staff who are under the influence of any drug (including alcohol) do not work or attempt to work on the organisation's premises
- ✧ staff are properly and presentably dressed while on the organisation's premises

Appendix I

INTERNAL AUDIT SPECIFICATION

PERFORMANCE MEASURES

The following performance measures shall be monitored by FTF, reported to the client Director of Finance bi-annually and included within the Annual Internal Audit Report, with comparative figures for the previous year.

	Planning		**Target**
1	Strategic/Annual Plan presented to Audit & Risk Committee by June 30	Yes/No	Yes
2	Annual Internal Audit Report presented to Audit & Risk Committee by June 30	Yes/No	Yes
3	Audit assignment plans for planned audits issued to the responsible Director before commencement of audit fieldwork.	%	75%
	Delivery		
4	Draft reports issued within 2 weeks of fieldwork completion / exit meeting	%	75%
5	Draft reports issued by target date	%	75%
6	Responses received from client within timescale defined in reporting protocol	%	75%
7	Final reports presented to target Audit & Risk Committee	%	75%
8	Number of days delivered against plan	%	100% at year-end
9	Number of audits delivered to planned number of days (within 10%)	%	75%
10	Number of products delivered against plan at year end	%	75%
11	Percentage of audits that directly relate to a strategic risk	%	75%
12	Skill mix	%	50%
13	Staff provision by category	Pie chart	As per SSA/Spec
	Effectiveness		
14	Client satisfaction surveys	Bar chart	Average score of 3

Appendix II

INTERNAL AUDIT SPECIFICATION

INTERNAL AUDIT REPORTING PROTOCOL & FLOWCHART

To be approved at

1. Executive Directors (the Responsible Directors) are designated as being responsible for liaising with Internal Audit within specified areas, consistent with the Scheme of Delegation.

2. Internal Audit contact the Responsible Director to request that they review and approve the Assignment Plan and to ascertain if the Responsible Director or a nominated operational manager within the directorate (the Responding Officer) will clear the draft report.

3. The Responsible Director confirms agreement of the assignment plan by e-mail prior to the commencement of the audit, and it is copied to the Director of Finance as Lead Officer for the Audit and Risk Committee.

4. At the end of audit fieldwork, the summary of findings is discussed and agreed with the appropriate staff, including the Responding Officer. If the audit findings relate to the work of any other department or have an impact on any other departments, an appropriate senior officer from within that area will be consulted on the summary of findings. For example, where the report narrative or recommendations have a financial implication or comment on the work of the Finance Department, the Director of Finance or Assistant Director of Finance will be consulted and included in the distribution of the first draft of the report.

5. Following Regional Audit Manager and/or Chief Internal Auditor review, a draft report is issued to the officer nominated to clear the draft report i.e. the Responsible Director or Responding Officer identified at step 2. In the covering e-mail the nominated officer is asked to confirm the factual accuracy of the report and provide formal management responses to the recommendations within the report.

6. Following discussions with the Responding Officer/Responsible Director, management responses are recorded and line management responsibilities determined together with a timeframe for action. It is the responsibility of the Responding Officer/Responsible Director to ensure that the response reflects the official position of the Directorate and to obtain responses from any other relevant officers.

7. Within one week of the Directorate response the draft report is then issued to the Director of Finance for clearance and copied to the Responding Officer and Responsible Director so that they can confirm that their response has been recorded accurately.
8. Following clearance by the Director of Finance, within two weeks of receipt, the final report is formally issued by Internal Audit to all officers on the distribution list, including External Audit.
9. Audit and Risk Committee members receive the Internal Audit reports as they are finalised by the Office Manager and a summary is provided as an appendix to the progress report issued by the Regional Audit Manager for the next Audit and Risk Committee.
10. The recommendations will be added to the Audit Follow Up System by Internal Audit and progress reported to the Audit and Risk Committee.

11. All final audit reports are presented to the Senior Leadership Team, relevant Standing Committee and, where appropriate, the Health & Social Care Partnership Audit and Risk Committee.

Dispute resolution

12. In the event of a failure to receive a timely response from the Responsible Director in relation to a draft report or assignment plan, or to reach agreement on a fundamental recommendation, the matter will be referred to the Director of Finance and, if necessary, to the Chief Executive.

Assignment Milestone	Stage	Processes involved	Responsibilities	Response time
	Annual Audit Plan agreed	Formulated from Strategic Audit Plan for agreement by Audit & Risk Committee	Regional Audit Manager/ Chief Internal Auditor with Director of Finance	
1	Assignment Plan agreed	Terms of reference for the assignment agreed with Responsible Director and / or Responding Officer.	Regional Audit Manager with Responding Officer/ Responsible Director.	within 2 weeks of issue
2	Fieldwork commenced	Audit team conduct audit assignment in accordance with Assignment Plan	Principal/Auditor with co-operation of operational staff	
3	Fieldwork completed	Audit findings evaluated and summary of findings discussed and agreed with appropriate staff, including the Responding Officer. If the audit findings relate to the work of any other department or have an impact on any other departments, an appropriate senior officer from within that area will be consulted on the summary of findings. Draft report prepared for review.	Principal/Auditor in discussion with operational staff prior to Audit Manager review	Within 1 week of fieldwork end
4	Draft report issued to Directorate	Audit report issued to Directorate in draft for review and consideration of action plans. If audit findings relate to the work of any other department or have an impact on any other departments, an appropriate senior officer from within that area should be consulted on the report content.	Regional Audit Manager with Principal/ Auditor to Responding Officer/ Responsible Director.	within 2 weeks of fieldwork end
5	Directorate response	Formal response required from Directorate to include completed time bound action plan matrix.	Responding Officer with agreement of Responsible Director	within 2 weeks of draft report release

Assignment Milestone	Stage	Processes involved	Responsibilities	Response time
6	Report issued to Director of Finance	Audit report reviewed for clearance.	Regional Audit Manager	within 1 week of Directorate response
			Director of Finance/ Responding Officer/ Responsible Director	within 1 week of receiving report
7	Final Report released	Report issued in full to relevant officers and External Auditor.	Regional Audit Manager/Office Manager to Director of Finance, Responding Officer & Chief Executive	within 1 week of Director of Finance clearance

Flowchart

Stage	Explanation	Timeframe
Assignment Plan	Assignment Plan issued to relevant Client Director by Principal Auditor/Auditor. When agreed, the assignment plan is issued to the Director of Finance.	For return within 2 weeks
Fieldwork	Fieldwork carried out by Principal Auditor/Auditor according to the Annual Internal Audit Plan. On completion of fieldwork the summary of findings is discussed and agreed with the appropriate staff. A draft report will be prepared and file review undertaken.	File Review for completion within 1 week
Issue of Draft Report to Directorate	The draft report will be issued to the Responding Officer for factual accuracy check and management responses.	For return within 2 weeks
Directorate Response	Management responses are received and incorporated within the report.	Within 1 Week
Report to CE and Director of Finance	Report is issued to Director of Finance for review, comment and approval.	For return within 1 Week
CE / Director of Finance Responses	The responses from the Director of Finance will be incorporated into the report.	Within 1 Week
Report finalised and issued	The Office Manager will finalise and issue the report to the relevant Client Director and Officers.	By the end of the next day
Recom-mendations added to AFU	The recommendations will be added to the AFU System by the AFU Coordinator and progress reported to the Audit & Risk Committee.	On receipt of report

The final report will be presented to the Executive Leadership Team, Audit & Risk Committee, the relevant Standing Committee, and the Health & Social Care Partnership

Appendix III

INTERNAL AUDIT SPECIFICATION

FOLLOW-UP OF AGREED INTERNAL AUDIT RECOMMENDATIONS

Protocol agreed by Client Audit & Risk Committee:

For approval at

Appendix IV

INTERNAL AUDIT SPECIFICATION
AUDIT SERVICE

STAFFING SKILL MIX

For the purpose of paragraph 12.6, FTF shall maintain at least the following skill mix of staff in the performance of the service. Any variation of these shall require the express approval of the Client.

Chief Internal Auditor	2.5 per cent
Regional Audit Manager	10 per cent
Other Qualified	37 per cent
Auditor	50 per cent

For the purpose of paragraph 12.7, it is expected that at least 50% of the internal audit work shall be undertaken by qualified staff and furthermore that 50% of all IT audit work shall be undertaken by staff with the relevant qualification.

Appendix V

INTERNAL AUDIT SPECIFICATION
AUDIT SERVICE

PUBLIC SECTOR INTERNAL AUDIT STANDARDS

https://www.gov.uk/government/publications/public-sector-internal-audit-standards

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**17 March 2022**
Title:	**Internal Control Evaluation – Final Report**
Responsible Executive/Non-Executive:	**M McGurk, Director of Finance & Strategy**
Report Author:	**T Gaskin – Chief Internal Auditor**

1 Purpose

This is presented to the Audit and Risk Committee for:

- 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 Internal Control Evaluation (ICE) is undertaken each year by Internal Audit to provide assurance on the overall systems of internal control that support the achievement of the Boards objectives.

The Chief Internal Auditor presented the draft ICE report to the 9 December 2021 Audit & Risk Committee. Although initial management responses had been provided, further discussions took place and these clarified responses are now reflected within the final report, which is attached as Appendix 1.

2.2 Background

As Accountable Officers, Chief Executives are responsible for maintaining a sound system of internal control and managing and controlling all the available resources used in his/her organisation. This review aims to provide early warning of any significant issues that may affect the Governance Statement.

2.3 Assessment

Following discussions with the responsible Executive Director(s), the management responses were enhanced to ensure clarity and to ensure actions will mitigate the audit finding in full. The changes to the report presented to the December Audit and Risk Committee related to:

- Audit Recommendation 3 – Organisational Duty of Candour
- Audit Recommendation 12 – Digital and Information Risk Management

All changes were agreed with the responsible Executive Director and the Director of Finance and Strategy.

2.3.1 Quality/ Patient Care

The Triple Aim is a core consideration in planning all internal audit reviews.

2.3.2 Workforce

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

2.3.3 Financial

Financial Governance is a key pillar of the Annual Internal Audit Plan and value for money is a core consideration in planning all internal audit reviews.

2.3.4 Risk Assessment/Management

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

2.3.5 Equality and Diversity, including health inequalities

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

2.3.6 Other impacts

N/A

2.3.7 Communication, involvement, engagement and consultation

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

2.3.8 Route to the Meeting

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

2.4 Recommendation

The Audit and Risk Committee is asked to:

- **NOTE** the finalised Internal Control Evaluation, with updated management responses to the audit recommendations.

3 List of appendices

The following appendices are included with this report:

- Appendix A – Internal Control Evaluation B08/22

FTF Internal Audit Service

Internal Control Evaluation 2021/22

Report No. B08/22

Issued To: **C Potter, Chief Executive**
M McGurk, Director of Finance and Strategy

G MacIntosh, Head of Corporate Governance/Board Secretary
Executive Directors Group
H Thomson, Board Committee Support Officer

Audit Follow-Up Co-ordinator

Audit and Risk Committee
External Audit

Contents

Draft Report Issued	29 November 2021
Management Responses Received	07 February 2022
Target Audit & Risk Committee Date	9 December 2021
Final Report Issued	**21 February 2022**

EXECUTIVE SUMMARY

1. As Accountable Officers, Chief Executives are responsible for maintaining a sound system of internal control and to manage and control all the available resources used in the organisation. This review aims to provide early warning of any significant issues that may affect the Governance Statement.

OBJECTIVE

2. The principal objective of this review is to provide assurance to the Chief Executive, as Accountable Officer, that there is a sound system of internal control that supports the achievement of the Board's objectives.

3. This year's Internal Control Evaluation (ICE) was designed to coordinate with fieldwork to be undertaken within B13/22 Strategic Planning and B17/22 Workforce Planning, both of which will be carried out in two phases, with the initial work focussing on the adequacy of the arrangements in place to develop the Health and Wellbeing Strategy and the Workforce Plan. The second phases of both reviews will consider the effectiveness of these arrangements.

4. This ICE also provides a detailed assessment of action taken to address previous internal audit recommendations from the 2020/21 ICE and Annual Report, and assess the adequacy and effectiveness of internal controls, giving time for remedial actions to be taken before year-end, thereby allowing the year-end process to be focused on year-end assurances and confirmation that the required actions have been implemented.

5. This evaluation assessed the design and operation of the controls in place and specifically considered whether:

   - Governance arrangements are sufficient, either in design or in execution, to control and direct the organisation to ensure delivery of sound strategic objectives.

6. Whilst there was no overarching corporate/strategic risk relevant to this review, our audit specifically considered whether governance arrangements are sufficient, either in design or in execution, to control and direct the organisation to ensure delivery of sound strategic objectives.

AUDIT OPINION

7. Ongoing and required developments and recommended actions are included at Section 2.

8. The Annual Internal Audit Report issued 9 September 2021, was informed by detailed review of formal evidence sources including Board, Standing Committee, Executive Leadership Group (ELG), and other papers. 6 recommendations from the 2020/21 ICE remained outstanding at that point with all reported as being on track, and 2 of these now reported as completed.

9. As well as identifying key themes, the Annual Internal Audit Report made one specific recommendation on:

   - Increased risk of harm - a specific risk should be recorded, delegated to the CGC, to capture the clinical implications of Covid19 on waiting times and the associated impact on patient safety, clinical effectiveness and strategic prioritisation.

10. Completed actions from previous ICE and Annual Report recommendations are included under each strand of governance and ongoing recommendations from the 2020/21 ICE are detailed in table 1.

11. In this report, we have provided an update on progress to date and, where appropriate, built on and consolidated previous recommendations to allow refreshed action and completion dates to be agreed. This has culminated in 12 recommendations for which management have agreed

actions to progress by year end. Whilst this appears to be a large number given the overall positive conclusions within the report, these recommendations are primarily suggestions to enhance governance improvement activities already underway within NHS Fife.

12. We recommend that this report is presented to each Standing Committee so that key themes can be discussed and progress against the recommendations can be monitored.

KEY THEMES

13. Our 2020/21 Annual Report noted that a number of the issues highlighted within that year's ICE were being addressed as part of a wide range of governance and strategic initiatives. This continues at pace and we were pleased to see good progress in:

    - Development of an overall Health and Wellbeing Strategy and associated governance arrangements
    - Continuing development of Risk Management arrangements
    - Reflection on Active Governance and adoption of governance and assurance principles within working practises
    - Update of Clinical and Care Governance framework and associated BAF
    - Preparation for development of a workforce strategy
    - Ongoing development of the SPRA process to link with and support the overall and financial strategies
    - Addressing known issues in Information Governance and assurance
    - Agreeing a revised Integration Scheme for submission to the Scottish Government

14. Many of these areas are subject to ongoing Internal Audit review and will not be complete until year-end, when we will be able to provide a final opinion. We are, however, pleased to note the significant progress made to date and the robust processes and principles adopted, as well as the very positive engagement with Internal Audit where we have provided input and advice on a wide range of issues at the outset. It is particularly encouraging that these developments have continued despite the enormous ongoing pressures created by Covid.

15. This report contains a number of recommendations, intended to enhance the processes referred to above, to embed good governance principles and to ensure coherence between Governance Structures, Performance Management, Risk Management and Assurance.

KEY DEVELOPMENTS SINCE THE ISSUE OF THE ANNUAL REPORT INCLUDED:

16. The introduction of the Public Health and Wellbeing Committee, which has developed Terms of Reference and a workplan and has met twice. The Committee will oversee the development of the new Health and Wellbeing Strategy, which will supersede the current Clinical Strategy, and is due to be presented to the Board for approval in March 2022.

17. The fourth iteration of the Remobilisation Plan RMP4 was considered by the Board in September2021, with Scottish G approval received November 2021.

18. An Active Governance Board Development Session was held on 2 November 2021 and an action plan developed.

19. A Risk Management maturity assessment has been undertaken with further risk management development planned including revision of the risk appetite.

20. Overall, there has been good progress on recommendations from the ICE from last year and the Annual Report for 2020/21. Where action is still to be concluded, the Board has been informed of the planned approach and timescales, as well as associated improvement plans.

ACTION

21. The action plan has been agreed with management to address the identified weaknesses. A follow-up of implementation of the agreed actions will be undertaken in accordance with the audit reporting protocol.

ACKNOWLEDGEMENT

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

A Gaskin, Bsc. ACA
Chief Internal Auditor

TABLE 1 - ICE 2020/21 (B08/21) - Update of Progress Against Ongoing Actions since Annual Report		
Agreed Management Actions with Dates	**Management Actions Updates with Dates**	**Assurance Against Progress**
ICE Report 2020/21 – B08/21		
1. Long term Strategy • The EDG should jointly agree how the various strands of work to inform and deliver the long term strategy for NHS Fife will be analysed and translated into a co-ordinated programme, building on the progress already made through the Strategic Planning and Resource Allocation (SPRA) as well as remobilisation planning, considering how best use can be made of existing expertise and data and understanding constraints on resources. • This review should also consider how best to ensure effective governance and oversight of this key area in advance of the Board Development Session • A timetable for development of the new Strategy and supporting strategies should be reported to the NHS Board. Reporting on progress should be clearly assigned to an Assurance Committee or the NHS Board and should include a broad overview of whether Recovery, Remobilisation and strategy development is on track, key achievements, challenges and risks and any significant implications for strategy and priorities. ***Action Owner: Chief Executive***	Not due until 31 March 2022 • Establishment of the Population Health and Wellbeing Portfolio Board to deliver strategic coordination of the emerging strategy, the first meeting was held in November 2021. This Board will report to the Public Health and Wellbeing Committee. • Public Health and Wellbeing Committee has been established to oversee the implementation of the Population Health and Wellbeing Strategy and oversee a number of related areas and held its introductory meeting on 15 October 2021. Wide-ranging Terms of Reference (ToR) and a comprehensive annual workplan have been approved.	 **On track**

2. Governance and Year end Assurances Coordination of the year-end governance reports and statements of assurance is well underway. This will conclude in the normal timeframes – **June 2021,** specifically • Adoption of Assurance Mapping principles **– June 2021** ***Action Owner: Director of Finance and Strategy***	Assurance Mapping Principles were adopted at the September 2021 Audit and Risk Committee and year-end governance reports and statements of assurance were concluded in the required year end timescales. Assurance mapping work continues, and the Board Secretary and Chief Internal Auditor are working together to ensure that local developments are congruent with national initiatives.	 **Completed**
3. Clinical Governance Framework Development of the Clinical Governance Strategy and Clinical Governance Assurance Framework with a focus on risk, informed by Committee Assurance and Integration Principles. ***Action Owner: Medical Director***	• As per internal audit report B19/21 the Clinical Governance Strategy and Framework are being revised. A revised strategy is scheduled to be presented to the Clinical Governance Committee (CGC) and Fife NHS Board towards the end of 2021/22. • The approach to presentation of the BAFs and corporate risks are currently being reviewed by the Director of Finance & Strategy (Executive Lead for RM) with full involvement of EDG. The content of the three BAFs presented to CGC is being reviewed and updated.	 **On track**
4. Whistle Blowing • An annual report from the Whistleblowing Champion (WBC) cannot be provided until a WBC is appointed to NHS Fife. In the absence of a WBC a report is being presented to the Board which includes whistleblowing data. The Staff Governance Committee (SGC) action plan 2021/22 will include the reporting requirement from the Whistleblowing Champion – **March 2021** ***Action Owner: Director of Human Resources***	An update report on NHS Fife's whistleblowing arrangements was presented to the March 2021 Board meeting, detailing NHS Fife's readiness for adopting the new standards from 1 April 2021. A new Non-Executive Director has been appointed whistleblowing champion. They attended the July 2021 SGC meeting and provided an update on their responsibilities to the September 2021 SGC meeting. The 2021/22 SGC workplan includes a report on whistleblowing incidents being presented to the SGC in March 2022. Arrangements are in place to present quarterly whistleblowing reports to the SGC, detailing the number of such incidents occurring within NHS Fife.	 **Completed**

5. Property Management Strategy • Property and Asset Management Strategy (PAMS) is on the Agenda for the NHS Board in March 2021. • We anticipate that there will be a requirement for an East Regional PAMS report in the near future. The data in this document represents NHS Fife position as at 1 April 2020. • The 2020 PAMS document is largely retrospective and represents the pre-Covid19 landscape, the Impact of Covid19 will be further considered as part of the 2021 full PAMS which will be compiled between April and July 2021 by NHS Fife and likely submitted as part of an East Regional PAMS report – August 2021 ***Action Owner: Director of Property and Asset Management***	The PAMs was approved by the FPRC at its November 2021 meeting and emphasises the need for the NHS Fife Property & Asset Management over the next few years to be revised to support the development and deliver the objectives of the Health & Wellbeing Strategy.	 **On Track**
6. Information Governance and Security • Establishment of IG&S Operational Group and Steering Group ToR • Digital and Information (D&I) Board to provide additional support and assurance to IG&S and its alignment to strategy and operational performance **– April 2021** • IG&S Assurance Report and Framework – **March 2021** • Assurance report will be made available for consideration at the next Clinical Governance Meeting, following the IG&S Steering Group meeting on 23 March 2021. • Risk associated with resources and requirement for business cases when delivering the Digital and	The IG&S Operational Group and Steering Group have approved Terms of Reference. Assurance reporting is evolving and the D&I BAF was updated to reflect resources risk regarding implementation of the NHS Fife D&I Strategy 2019-2024.	 **On track**

Information Strategy will be documented within the related BAF – **April 2021** ***Action Owner: Associate Director of Digital***		
Internal Audit Annual Report 2020/21 – B06/22		
6. Increased Risk of Harm • A specific risk should be recorded, delegated to the CGC, to capture the clinical implications of Covid19 on waiting times and the associated impact on patient safety, clinical effectiveness and strategic prioritisation. The risk should include clear controls and assurance sources looking at reducing avoidable harm caused by delays in diagnoses and treatment and should reflect: • The key priorities and aims for 2021/22 within the current remobilisation plan. • Other relevant controls, such as implementation of Royal College of Surgeons guidelines • A description of controls to address the current pressure on scheduled care as a result of imbalance in demand and capacity; additional pressures due to Covid19; possible pent up demand due to reduction in referral rates. • Identified requirements to redesign services.	The CGC agreed that the Quality and Safety BAF Risk should be reworded to reflect short, medium and long term impact of the pandemic on clinical services waiting times and the associated impact on patient safety, clinical effectiveness and strategic prioritisation as well as including new linked risks, related to pandemic impact (Paper 6.1 to 3 November 2021 CGC). Internal Audit have been asked to contribute to this process as part of their Board Assurance work.	 **On Track**

CORPORATE GOVERNANCE

BAF Risks:

- **Risk 1675 - Strategic Planning - There is a risk that the development and the delivery of the new NHS Fife Population Health and Wellbeing strategy is not adequately supported by the required planning and programme management capacity, capability and governance arrangements.**
- **Risk 1676 – Integration Joint Board - There is a risk that the Fife Integration Scheme does not clearly define operational responsibilities of the Health Board, Council and Integration Joint Board (IJB) resulting in a lack of clarity on ownership for risk management, governance and assurance.**

Strategy

Progress with the development of the Population and Wellbeing Strategy (PWS) is positive. The Public Health and Wellbeing Committee has been established to oversee the implementation of the PWS, with an initial meeting held on 15 October 2021. We commend the progress of the establishment of the Population Health and Wellbeing Portfolio Board to deliver strategic coordination of the emerging strategy, with the first meeting taken place in November 2021. Initial work is underway as follows:

- the Public Health and Wellbeing Assessment has been drafted;
- a public survey has been developed as part of the Communication Plan to engage with the citizens of Fife to direct and shape the strategy, this is planned for presentation to the November 2021 Board meeting and thereafter will be released online. The survey is aligned to NHS Fife 4 strategic priorities: Health and Wellbeing; Quality of Clinical Services; Staff experience and Wellbeing and Value and Sustainability, and,
- a review of the existing Clinical Strategy, where the initial meeting has been held on 24 November 2021.

A critical path plan with monthly timelines has been developed for the work on these workstreams. The planned completion date of 31 March 2022, will be challenging, especially given the pressures of Covid. We will review the development of the Strategy in detail within B13/22 - Strategic Planning.

Remobilisation Plans

The draft Remobilisation Plan 4 (RMP4) was considered and approved by the NHS Fife Board in Private session on 28 September 2021 prior to submission to the Scottish Government. The SBAR presented to the November 2021 Board meeting states that the RMP4 is aligned to the strategic planning in Fife and going forward, Annual Delivery Plans will reflect strategic developments including:

- Strategic Planning and Resource Allocation (SPRA) which has commenced for 2022/23, and will align with the development of the Population Health and Wellbeing Strategy;
- The development of NHS Fife's 5-year Population Health and Wellbeing Strategy.

Covid19 & Governance

NHS Fife has continued to monitor the governance arrangements whilst taking account of the pressures on management.
Regular Flu and Covid19 reporting to the Board has continued, the latest update to the November 2021 Board meeting included Covid19 testing, Covid19 cases, Vaccinations and Covid19 deaths.

Committee Assurance

NHS Fife has implemented the NHS Scotland Model Meeting Paper Template for all standing Committee and Board papers, enhanced to include papers for assurance. In particular we noted the comprehensive and informative narrative within the NHS Fife Annual report highlighting 'Key Issues and Risks that could affect the delivery of objectives'.

Standing Committee papers and workplans, demonstrate that Committees receive regular assurances in accordance with their remit and in line with the Committee Assurance Principles, although we noted that the workplans could better highlight and changes or delays to scheduled items and any potential impact on the Committee's ability to provide appropriate assurance.

A Board Development session was held on 2 November 2021 on Active Governance which focussed on improving how data presented to the Board and Standing Committees and explored how insights from intelligence can be used to assure quality and performance. An action plan was agreed following the session and includes a number of actions to improve reporting to Fife NHS Board and its committees, which link well with other developments within the Board.

Assurance Mapping

Internal Audit continue to facilitate the work of the Assurance Mapping group and to liaise with the Board Secretary to consider how the agreed principles can be adapted to the specific needs of NHS Fife and in particular, the actions arising from the November 2021 Active Governance Board Development Event. In addition, we are assisting Board Officers in their review and update of the Quality and Safety BAF and looking at how assurance mapping can be used to provide assurance on Best Value and on assurances required from Directors in accordance with the Scottish Public Finance Manual, as well as ensuring that all work is congruent with national governance initiatives. Whilst Best Value arrangements are in place with assurance statements received from all Standing Committees, there is scope for further improvement by increasing the focus on outcomes and through overt linkage to assurance mapping to avoid duplication.

Integration

The revised Integration Scheme was approved by NHS Fife Board on 28 September 2021 and has been submitted to the Scottish Government (SG) for approval. The revised Integration Scheme, which included input from FTF as the Internal Auditors of both the Health Board and IJB, has much greater clarity around the role of the IJB and that of its partners and now reflects national guidance received.

We previously noted that the Integration BAF was significantly out of date and needed to be reviewed. This has not yet taken place.

Performance

The Integrated Performance Quality Report (IPQR) Executive Summary report informs each meeting of the Board of performance against a range of key measures (Scottish Government and local targets) as well as RMP3 activity. The Board, the Finance, Performance and Resources Committee, the Staff Governance Committee and the Clinical Governance Committee have received regular performance reports to every meeting this year, the latest report presented with the (ESIPQR) at the November 2021 Board meeting highlights:

Cancer 31-Day Diagnostic Decision to first Treatment (DTT) and Antenatal are meeting target, with five indicators not achieving target but performing well above the Scotland average: 4- Hour Emergency Access; Cancer 62 Day RTT; Patient TTG; New Outpatients; Diagnostics. A further four areas are neither meeting the target nor the Scotland average: Smoking Cessation; Detect Cancer early; 18 week RTT; Cancer 62 Day RTT; Delayed Discharge (% bed days lost). However, we recognise that this is a time of exceptional pressure and all Health Boards are facing considerable challenges.

NHS Fife are successfully delivering against the remobilisation plan for New Outpatient Activity; Elective Imaging Activity; Urgent Suspicion of Cancer; CAMHS and Psychological Therapies.

The Board has been less successful with activity against projected activity for TTG Inpatient /Daycase Activity; Elective Scope Activity; A&E Attendance, Emergency Admissions and 31 Day Cancer – First Treatment and the challenges are likely to increase given the ambitions around elective activity and the likely backlog of unrecognised need and higher case mix in relation to both targets.

The SBAR presented with the ESIPQR advised that the activity templates data for RMP4 will be incorporated for governance purposes in future versions of the IPQR.

Actions to improve data reporting to Fife NHS Board and its committees were identified as part of the Active Governance Board Development session on 2 November 2021. These included revising the IPQR to bring in other ways of presenting data and changes are to be made to the format of the IPQR going forward and this is an opportune time to link the corresponding risks to performance to provide a triangulation of assurance.

Risk Management

A review of overall Risk Management arrangements is underway as reported to the Audit and Risk Committee in September 2021 incorporating an externally facilitated risk maturity assessment including a presentation and self-assessment undertaken by the Executive Directors and other EDG members in September 2021. This will inform the development of a risk management improvement plan including revision of the Risk Management Key Performance Indicators reported to the Audit and Risk Committee. We would recommend that the action plan should be presented to the Audit and Risk Committee for approval and monitoring.

We welcome that the newly established Public Health and Strategy Committee is giving consideration to creating a stand-alone BAF, for the areas associated with the work of this Committee.

Committee papers reflected good discussion on the BAFs although this could be further improved. We did note that the risk section of many SBARs was not well completed, often did not reference BAFs or operational risk and did not facilitate discussion of the accuracy of the description and scoring of risks, nor the adequacy and effectiveness of key controls and actions. Some papers did not evidence a serious consideration of risk implications and this area could be improved overall.

B08/21 Internal Control Evaluation report highlighted that whilst a number of BAFs have been updated for Covid19, the Board has not received an overall Covid19 risk, nor have they been informed of how and when Covid19 risks will be incorporated into the BAF. Although we have seen detailed scrutiny of Covid risks at Gold Command, this has still not translated into full revision of the BAFs to reflect the impact of Covid.

Action Point Reference 1 – Board Assurance Framework (BAF)

Finding:

a) Committee papers evidenced discussion on the BAFs and there is further scope to improve the process by overt scrutiny of the accuracy of scoring of risks and the adequacy and effectiveness of key controls and actions which should be mitigating and reducing the risk.

b) In addition, B08/21 Internal Control Evaluation report highlighted that whilst a number of BAFs have been updated for Covid19, the Board has not received an overall Covid19 risk, nor have they been informed of how and when Covid19 risks will be incorporated into the BAF.

c) We have previously recommended the need for the Integration Joint Board BAF to be reviewed and revised once the Integration Scheme has been approved by SG and we reiterate this as a priority, to ensure the NHS Fife Board is apprised and updated of the current risks.

Audit Recommendation:

a) The inclusion of appropriate analysis in each SBAR supporting the BAFs regarding the adequacy and effectiveness of key controls and actions would promote/aid further scrutiny by committee members.

b) The Board Assurance Framework should encompass and link Covid19 risks, to ensure the NHS Board has appropriate oversight and transparency over these risks.

c) Once the revised Integration Scheme has been approved by the Scottish Government, the IJB BAF should be revised to ensure that it adequately describes the risk the mitigating controls and appropriately scored.

Assessment of Risk:

Significant		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.

Management Response/Action:

The Board is currently reviewing the BAF process and the approach to risk management more generally. There is a planned session of the Audit and Risk Committee and the NHS Fife Board in December to consider this which will include responding to the audit points noted above. From this an action plan will be developed to support a range of improvement activitity which will inform our arrangements in this area.

Action by:	Date of expected completion:
Director of Finance and Strategy	**31 March 2022**

Action Point Reference 2 – Performance Reporting

Finding:

Actions to improve data reporting to Fife NHS Board and its committees were identified as part of the Active Governance Board Development session on 2 November 2021. These included revising the IPQR to bring in other ways of presenting data and changes are to be made to the format of the IPQR going forward.

Our review of Board and Committee papers highlighted that, whilst Board and Committee members are keen to discuss risk, many papers lack adequate, or sometimes any, detail on the associated risks. Where narrative is provided it does not overtly link to BAF or operational risks and does not overtly provide assurance on narrative, scores or the adequacy and effectiveness of key controls and actions.

Audit Recommendation:

As part of this Active Governance action plan, consideration should be given to how Performance Reports can provide overt assurance on the accuracy of the narrative and scores for related strategic (BAF) risks as well as the adequacy and effectiveness of key controls.

The risk section of Board and Committee papers should be given higher priority than at present and should contain basic information to facilitate a focused discussion on the risk implications, be overtly linked to any operational or BAF risks and contain enough information for members to be able to form a conclusion on whether the score narrative and other elements of the related risk are adequately described.

Assessment of Risk:

Merits Attention		There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**

Management Response/Action:

Following discussion at EDG on 2 December 2021, the IPQR will undergo development in a range of areas.

- **Creation of a "System-Wide Summary - Dashboard"/ "Balanced Scorecard" showing the overall position across health and social care**
- **Proposed alternative presentation of aspects of data**
- **Proposed additional content in some areas**
    a. **Workforce**
    b. **Patient Feedback**
    c. **Information Governance**

Proposed section of the IPQR to report on Public Health and Prevention

As agreed with EDG, a review group will be created to lead the IPQR development process.

As a first priority the group will develop a working version of the System-Wide Summary/Balanced Scorecard for the opening section of the report to be used in January 2022.

This will include risk profiling aligned to our performance reporting. The final narrative supporting this will be approved in advance by the Chief Executive. This and all other changes proposed will be reported in an iterative way to EDG by the review group during the final quarter of 2021/22. Progress on the review will also be reported to the governance committees in January and March 2022. **The IPQR reports on the quality of patient care through a number of core targets, the targets are reported individually. The proposal to develop the System-Wide Summary/Balanced Scorecard will draw out the interdependencies across the system which impact on the effectiveness of patient pathways and flow.**	
Action by:	**Date of expected completion:**
Director of Finance and Strategy	**31 March 2022**

CLINICAL GOVERNANCE

BAF Risks:

Risk 1674 – Quality and Safety – High Risk (15)

There is a risk that due to failure of clinical governance, performance and management systems (including information & information systems), NHS Fife may be unable to provide safe, effective, person centred care.

Risk 1675 – Strategic Planning – High Risk (16)

There is a risk that the development and the delivery of the new NHS Fife Population Health and Wellbeing strategy is not adequately supported by the required planning and programme management capacity, capability and governance arrangements.

Clinical Governance Framework

A Clinical Governance Framework, to replace the Clinical and Care Governance Strategy, is currently in development and will be presented to EDG in January 2022 and then the CGC in March 2022 for approval. An associated delivery plan will be developed and its implementation monitored by the Clinical Governance Oversight Group (CGOG) with reports being provided to CGC.

The development of the framework is taking into account previous internal audit recommendations summarised in internal audit report B19/21 - Clinical Governance Strategy and Assurance including: clinical governance reporting routes, services delegated to the IJB, committee assurance principles and integration governance principles. Programmes of work in progress which support the development of the framework include reviews of the Risk Management Framework and Adverse Events Policy and Procedures.

Internal Audit have been consulted in a number of these developments and, we are extremely positive about the direction of travel, the process being adopted, and principles being applied to the development of the Framework.

Our IJB internal audit plan includes a review of Clinical and Care Governance arrangements for the services delegated to the IJB, which is intended to compliment the work undertaken in B19/21 and ensure that whole service assurances are in place with no omissions and no unnecessary duplication.

Clinical Governance Committee

No changes have been made to the CGC Terms of Reference since the period covered by the Internal Audit Annual Report (B06/22) and the CGC Workplan continues to be presented to each meeting of the CGC.

Clinical Risk Management

Following a review of the Quality and Safety (Q&S) BAF by Senior Management CGC were asked to consider proposals to improve the BAF including:

- work to improve the quality of Controls, Gaps in Control and Assurances recorded and to strengthen the assurances provided
- recommendations regarding risks currently linked to the BAF (whether these should continue to be linked or be managed in another way)
- linking new risks, associated with the impacts of the pandemic on the quality and safety of patient care and service delivery to the BAF
- revising the high level risk description for the BAF to reflect the impact of the pandemic on

clinical services (thereby addressing recommendation 1 from our annual report B06/22)

- reviewing all existing high risks related to Clinical Governance to consider which risks should be linked to the Q&S BAF
- engaging with Operational Directors and Senior Leadership Teams to identify key risks to operational delivery and ensure these are reflected on the appropriate risk registers and linked as appropriate to the BAF.

The CGC supported these recommendations and an updated Q&S BAF, will be presented to its January 2022 meeting. We commend this approach and are liaising with management on the revision of the Q&S risk as part of our Assurance Mapping work for 2021/22.

Clinical Performance Reporting

The IPQR was presented to both CGC meetings held since our annual report (September and November 2021). The latest report highlights that 7 of the 10 Clinical Governance targets measured are not currently being achieved and 5 of the 12 activity areas measures relating to NHS Fife's remobilisation plan are worse than predicted. The committee raised concerns regarding these areas and were reassured by the Director of Nursing that work is ongoing to achieve the targets, that the challenges inhibiting progress were recognised and the remobilisation plan will provide more context going forward. We highlight performance against the 4 hour wait target for A&E as an area of potential clinical risk, whilst recognising that Fife is out-performing the Scottish average.

The CGC has also received reports on Health Associated Infection, Complaints, Excellence in Care, Covid19 Testing, Remobilisation and the Covid19 and seasonal flu vaccination programmes.

External Review

An Organisational Learning Group has been established to share learning from incidents, adverse events and positive feedback so that all parts of NHS Fife benefit from lessons learned. This group is in its infancy but has the remit to consider issues identified from external reports to establish why these were not identified by existing internal control mechanisms and to recommend improvements to address issues identified and its terms of reference support this approach.

An unannounced inspection was undertaken by Healthcare Improvement Scotland at Victoria Hospital between 4 & 6 May 2021. The inspection considered compliance with existing Healthcare Associated Infection standards across a sample of wards and departments and found 7 areas of good practice and 2 requirements for improvement. The inspection report was presented to CGOLG in its activity tracker then to CGC on 17 September 2021 when the committee were informed that the 2 requirements for improvement had been addressed.

Significant Adverse Events

The new Adverse Events Lead is undertaking a full review of the Adverse Events Policy and Procedures which will incorporate the recommendations made in internal audit reports on Adverse Events Management (B19/20 and B20/21). We noted that although the CGC receives data on the number and nature of major and extreme adverse events it does not receive KPIs on the Board's performance in resolving these within required timescales.

Duty of Candour

In the Clinical Governance section of our Annual Report B06/22 we stated that due to the unavoidable delay in finalising duty of candour figures the Organisational Duty of Candour report could not be presented to CGC before that Committee's annual assurance statement/report was approved and we recommended that '*In future a short summary report should be provided to the CGC at year-end for consideration when concluding on its Annual Assurance Report and Statement*'. However, no such update on Organisational Duty of Candour has been scheduled for the CGC.

An interim Organisational Duty of Candour Annual Report for 2020/21 was presented to CGC on 3 November 2021 and indicated that between 1 April 2020 and 31 March 2021 there were 15 adverse events where the duty of candour applied with the most common related outcome being an increase to the person's treatment. The report was provided on an interim basis due to the backlog of adverse events reviews as a result of the pandemic meaning that the number is likely to increase. An updated report for 2020/21 is to be provided to the March 2022 CGC, but not, as noted above, a 2021/22 report.

Action Point Reference 3 – Organisational Duty of Candour

Finding:

In the Clinical Governance section of our Annual Report B06/22 we stated that due to the unavoidable delay in finalising duty of candour figures the Organisational Duty of Candour report could not be presented to CGC before that Committee's annual assurance statement/report was approved and we recommended that '*In future a short summary report should be provided to the CGC at year-end for consideration when concluding on its Annual Assurance Report and Statement*'. However, no such update on Organisational Duty of Candour has been scheduled for the CGC.

Audit Recommendation:

An update on the number of instances Organisational Duty of Candour has been applied in NHS Fife in 2021/22 should be scheduled for presentation to CGC prior to it concluding on its Annual Assurance Report and Statement, which should highlight any issues experienced and be sufficient allow it to conclude whether there were adequate and effective Duty of Candour arrangements throughout 2021/22.

The Committee should be informed when it can expect the final report on the year's activity and how arrangements will be developed in future to allow more timely reporting.

Assessment of Risk:

Merits attention		There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**

Management Response/Action:

An interim Duty of Candour Report was presented to the Clinical Governance Committee (CGC) in November 2021 with a further report presentedin January 2022. The report was issued on an interim basis due to delays resulting from the impact of the pandemic. The report presented included information on 2020/21 activity and also includes a look back at previous years (2018/2019 and 2019/2020). Previous years have been included for completeness as Duty of Candour applied to cases which concluded review after submission of respective annual reports. The review of the Adverse Event Policy and Proceedure will identify actions to improve timely reporting.

The processes involved in collating and finalising the duty of candour compliance information takes time and the report on Duty of Candour for activity in 2021/22 is scheduled for presentation to CGC in November 2022. A statement providing assurance on Duty of Candour, including assurance on 2021/22 activity understood at this time, will be included in the Clinical Governance Committee's Annual Assurance Statement which is due to be considered by CGC at their March 2022 meeting.

Action by:	Date of expected completion:
Medical Director	**31 March 2022**

Action Point Reference 4 – Adverse Events KPIs	
Finding:	
Although the CGC receives data on the number and nature of major and extreme adverse events it does not receive KPIs on the Board's performance in resolving these within required timescales.	
Audit Recommendation:	
The revised approach for Adverse Events should include regular reporting of KPIs to CGC on the completion of adverse events within agreed timescales.	
Assessment of Risk:	
Merits attention  There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**	
Management Response/Action:	
A review of the Adverse Events Policy and Procedure has been initated. The improvement plan to support this review will include action to address visibility of KPIs.	
Action by:	**Date of expected completion:**
Medical Director	**30 April 2022**

STAFF GOVERNANCE

BAF Risk:

Risk 1673 – Workforce Sustainability – High Risk (16)

There is a risk that failure to ensure the right composition of workforce, with the right skills and competencies will adversely affect the provision of services and quality patient care and impact on organisational capability to implement the new clinical and care models and service delivery set out in the Clinical Strategy and the future population Health & Wellbeing Strategy and the challenges and demands associated with the current Covid19 pandemic

Governance Arrangements

The March 2021 meeting of the Staff Governance Committee (SGC) approved a revised Terms of Reference and the changes therein have been formally reflected in the Code of Corporate Governance annual update, which was approved by the Board at its May 2021 meeting. As with other Committees, completion of the 2021/22 SGC workplan is not reported to each SGC meeting.

Covid19

During 2021/22, regular reports on NHS Fife's staff governance arrangements have included information on the impact of the Covid19 pandemic and providing assurance to the SGC on the measures being taken to ensure NHS Fife's workforce is being supported during the pandemic. Examples of this include reports on staff appraisals, health & wellbeing (including attendance management and support for staff shielding and working from home), all of which made specific reference to the impact of Covid19.

Workforce Strategy/Planning

An Interim Joint NHS Fife and Fife Health & Social Care Partnership Workforce Plan for 2021/22 was presented to the April 2021 SGC meeting prior to submission to the Scottish Government (SG). Arrangements are now in place to re-introduce a 3 yearly planning cycle across NHS Scotland with an NHS Fife Workforce Plan 2022-25 currently due to be completed by 31 March 2022. It is being prepared in consultation with the Health & Social Care Partnership and in conjunction with the NHS Fife Population Health & Wellbeing Strategy and its preparation is to take due regard of comments made by the SG on the 2021/22 Interim Joint NHS Fife and Fife Health & Social Care Partnership Workforce Plan. An audit review by Internal Audit of the arrangements for completing the Workforce Plan 2022-25 is ongoing.

Risk Management

The SGC has been presented with an update on the BAF Workforce Sustainability risk at each of its meetings. As part of an overall review of risks being completed by the Executive Directors Group, the SGC approved a number of revisions to the BAF Workforce Sustainability risk at its October 2021 meeting, which, in our view, have improved the quality of the BAF and better reflect workforce challenges and the impact of Covid19. The current risk rating remains high.

The BAF Workforce Sustainability risk is to be further reviewed by management for any workforce pressures identified during the preparation of the Workforce Strategy 2022-25. This risk will be specifically considered by Internal Audit, in our review of the Workforce Strategy 2022-25. Currently, no updates are provided to either the SGC or RC on NHS Fife's succession planning arrangements. There would be benefit in recording and monitoring the Board's approach to mitigating the risks associated with recruiting to key positions.

Staff Governance Action Plan

Guidance is still awaited from the SG review of staff governance standard monitoring arrangements and there is no requirement to prepare a SGAP for 2021/22.

The SGC workplan includes a mid-year and year end review of monitoring compliance with the Staff Governance Standards (SGS). At the September 2021 SGC meeting the Staff Governance Annual Monitoring Return on the application of SGSs was discussed and approved by the committee, with an update on the work underway to locally implement the SGSs provided by the Workforce Leadership team. Further updates on the SGSs are scheduled to be considered at the January and March 2022 SGC meetings to enable the committee to conclude on the implementation of the standards during 2021/22. To enable the SGC to fully ascertain the initiatives introduced during 2021/22 and provide a measure of their success in meeting the requirements of the SGSs, the assurances given at those meetings should give an equivalent level of detail to that previously provided by theStaff Governance Action Plan (SGAP), detailing the measures still to be introduced and the reasons for any delays in doing so.

Staff Experience

The SGC has received regular reports on staff health and wellbeing to highlight the impact of the Covid19 pandemic on staff and provide assurance on the action being taken to support staff. The September 2021 and October 2021 SGC meetings were provided with updates on the Joint Remobilisation Plan (RMP3/RMP4), which has workforce implications. As part of the continuous improvement process relating to staff experience, the results of the recently completed iMatters survey is in the process of being discussed by individual teams and management, with an update due to be given to the January 2022 SGC meeting.

Whistle Blowing

An update on the role of the whistle blowing champion was provided to the September 2021 SGC meeting, along with the a copy of the first quarter's Whistleblowing Quarterly Data Report for 2021/22 (April 2021 – June 2021). No instances of whistleblowing were reported during this period and the Committee discussed the potential reasons for this. The report for the second quarter (July 2021 to September 2021) and is being prepared and will be considered by the relevant fora, before presentation to the SGC. The current arrangements for returns to be considered by different groups is causing timescale issues and these arrangements will be reviewed after this cycle of reports has completed. A review of NHS Fife's whistleblowing arrangements is to be currently scheduled for the draft 2022/23 Annual Internal Audit Plan.

Remuneration Committee

In accordance with the 'Once for Scotland' approach the RC is now a full standing committee of NHS Fife Board. The Remuneration Comittee (RC) terms of reference are now formally reflected in the Code of Corporate Governance and as with other standing committees they will be standardised after the Once for Scotland team issue a new template.

Appraisals

The SGC was advised at its September 2021 meeting that all Executive and Senior Manager appraisals for 2019/20 and 2020/21 had been completed.

To reflect the impact of the Covid19 pandemic, the target for AfC appraisals was reduced from 80% to 55% and as at mid-November 2021, completed KSF/PDP appraisals stood at a 33%.

The Annual Report on Medical Consultant and GP appraisals for 2020/21 was presented to the SGC at its October 2021 meeting. It shows that although, as expected, the Covid19 pandemic did impact the number of appraisals that were completed; 94% of Medical Consultants and 99% of General Practitioners were either appraised or exempt from an appraisal. Apart from the impact of the

Covid19 pandemic, recruiting and retaining NES trained assessors is currently the greatest difficulty faced in completing appraisals, with the number of NHS Fife appraisers having to be supplemented by the use of bank appraisers.

Core Skills Training

Core Skills refers to those common training subject areas which organisations are required to deliver to their workforce, in order to meet either legal training requirements or to comply with key quality standards in accordance with organisational policy and regulatory requirements. The current overall completion rate for mandatory training is 70%. The Workforce Sustainability BAF recognises Core Skills Training as an area requiring improvement. An update on the completion of statutory/mandatory training for 2021/22 will be provided to the March 2022 SGC meeting.

Sickness Reporting

The rate most recently reported to the October 2021 SGC was 6.42% as at 30 September 2021 (5.69% at 30 September 2020,) with Covid19 contributing an additional 1.13% to absence levels, reflecting the trend for Scotland. The Health & Wellbeing Update report provides the committee with a detailed analysis of the causes of absenteeism, along with a summary of the actions being taken to reduce it and the other health and wellbeing initiatives being used. The Workforce Sustainability BAF also recognises sickness absence as an area for improvement and our Internal Audit recommendation in this area is currently outstanding due to the impact of Covid.

Action Point Reference 5 – Succession Planning	
Finding:	
Nationally, recruitment to senior posts have been difficult across NHS Scotland and this trend is likely to be exacerbated by workforce demographics and the impact of Covid. However, we could see no consideration of succession planning for NHS Fife within papers presented to the Staff Governance Committee or Remuneration Committee or in the risk registers.	
Audit Recommendation:	
The Staff Governance Committee and Remuneration Committee should be assured on succession planning arrangements within NHS Fife and of the potential risks associated with this area.	
Assessment of Risk:	
Merits attention 	There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**
Management Response/Action:	
NHS Fife is active in talent management and succession planning and has successfully appointed to all Senior posts over the 2021/22 period. Noting that the challenge to manage future turnover of senior staff is a sector wide issue, an overview paper on our talent management and succession planning arrangements will be outlined to Staff Governance Committee as part of our annual meeting cycle in 2022/23. If this became an issue for Executive Senior Managers then the matter would be considered by the Remuneration Committee. Workforce retention is recognised as risk on our current register and as part of our ongoing review of workforce risks, we will update actions and mitigations to specifically address work on succession planning.	
Action by:	**Date of expected completion:**
Director of Workforce	**October 2022**

Action Point Reference 6 – Staff Governance Standards	
Finding:	
The SGC will receive further updates on implementation of the staff governance standards at its January and March 2022 SGC meetings to enable it to conclude on the implementation of the standards during 2021/22. A review of the assurances provided to it so far during 2021/22 indicates that they have not provided the same level of detail or measurement criteria as the previously maintained SGAP did.	
Audit Recommendation:	
To enable the SGC to fully ascertain the SGS initiatives introduced during 2021/22 and provide a measure of their success in meeting the requirements of the SGSs, the assurances given at those meetings should give an equivalent level of assurance to that previous years, setting out actions and assurances still to be provided and the reasons for any delays.	
Assessment of Risk:	
Merits attention 	There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**
Management Response/Action:	
There have been three elements of review against the staff governance standards in 2021/22; Annual Reports from the Acute & Corporate Services and Health & Social Care Local Partnership Forum and the 2021/22 Staff Governance Monitoring return to Scottish Government which will be repeated for current activity during the 2022/23 cycle. Additionally coverage of standards will be considered through the Staff Governance Committee review of the 2021/22 workplan and the proposals for the 2022/23 workplan at the January and March 2022 meetings respectively.	
Action by:	**Date of expected completion:**
Director of Workforce	**March 2022**

FINANCIAL GOVERNANCE

BAF Risk:

Risk 1671 – Financial Sustainability – High Risk (16)

- There is a risk that the funding required to deliver the current and anticipated future service models, particularly in the context of the COVID 19 pandemic, will not match costs incurred.
- There is a risk that the organisation may not fully identify the level of savings required to achieve recurring financial balance.
- Thereafter there is a risk that failure to implement, monitor and review an effective financial planning, management and performance framework would result in the Board being unable to deliver on its required financial targets.

Risk 1672 – Environmental sustainability – High Risk (20)

There is a risk that Environmental & Sustainability legislation is breached which impacts negatively on the safety and health of patients, staff and the public and the organisation's reputation

Financial Planning 2021/22

The Financial Plan for 2021/22 was a key element of RMP3 which also serves as the Annual Operational Plan for 2021/22. Key financial and Covid assumptions were included as part of the overall financial plan. RMP4 which updates RMP3 and replaces the Annual Operational Plan for 2021/22 was considered by the NHSF Board on 28 September 2021 prior to submission to the SG on 30 September 2021.

In line with national guidance and reflecting difficulties in planning caused by Covid19, a one-year financial plan was provided instead of the intended medium term 3-year plan.

Strategic Planning and Resource Allocation

The Strategic Planning and Resource Allocation (SPRA) process was introduced during 2020/21 to support strategic, financial and organisational planning. It has evolved during 2021/22, learning from last year's iteration and will form the basis of a 3 year medium term financial plan.as well as informing and aligning with the development of the NHS Fife 5 year Population Health and Wellbeing Strategy.

Achievement of recurring savings needed for financial balance, will require both investment and disinvestment to support the delivery of the Population Health and Wellbeing Strategy and the SPRA process recognises the need to disinvest with the aim to further develop plans to achieve savings and efficiency opportunities.

The SPRA highlights the need to further develop the Project Management Office (PMO) to support service transformation and NHS Fife is investing in new posts in this department.

The SPRA process for 2022/23 has commenced with the EDG now reviewing returns, prior to a Board Development Session on 21 December 2021.

Budgetary Control

Each year all budget holders have to provide a signed statement as formal agreement and acceptance of the delegated budget. Budget holders have completed the annual financial 'grip and control' checklist which provides a continuing focus to identify savings opportunities and the way services are delivered due to Covid19.

This budget process provides a clear understanding to budget holders of their role and responsibilities for budgetary control.

Financial Reporting

Finance reporting to Board and FP&RC has been transparent with enhancements made to the IPQR in 2021/22. The content remains the same but the way information is presented has been enhanced. The Director of Finance has consistently and clearly articulated financial challenges and improvement actions. Specific challenges are:

- Achievement of savings;
- the financial impact of Covid in both the short and longer-term, and its impact on both service delivery and financial plans;
- Managing the underlying Acute Services core cost overspend;
- Recruiting to the Corporate PMO.

The Financial Sustainability BAF and the IPQR (Financial Performance) are not overtly linked, with the IPQR making no reference to the BAF. Key challenges are highlighted in the IPQR financial section; however there is no direct correlation to the current controls/gaps in control/mitigation actions within the BAF.

Savings

Savings targets were set out in the 2020/21 Financial Plan, as part of the RMP3. The 2021/22 financial plan reflects an overall savings target of £21.7m and assumes £8m is achievable in-year with £4m on a recurring basis and £4m on a nonrecurring basis. Discussions continue with Scottish Government in relation to supporting the remaining £13.7m this financial year.

For the latest reported figures to August 2021, recurring savings of £3.538m have been achieved, alongside £696k non-recurring. Achievement of financial balance for 2021/22 will be dependent on external funding and we note the ongoing work to identify potential recurring cost saving reduction schemes and programmes for both this year and the next 2 financial years.

Savings is an ongoing issue but with the evolving SPRA process and the development of the PMO capacity and capability, this will further support NHSF to achieve its longer term financial goals and drive service transformation.

BAF – Financial Sustainability – High Risk

The Financial Sustainability BAF, as reported to the FP&RC during 2021/22, recognises the ongoing financial challenges facing the Board, in particular Covid19 funding and savings gaps, which are being discussed with the SG.

The BAF has been developed in-year with the rationale and actions now clearer on the steps required to reduce the overall risk score. Clearer linkages to Strategy, PMO savings programme, and External Audit recommendations would further strengthen the BAF along with greater specificity around current controls.

The BAF has a mitigating action of “relentless pursuit of all opportunities identified through the transformation programme in the context of sustainability & value”; an area should be the subject of specific assurance in future.

Best Value

Internal Audit previously recommended application of the Audit Scotland Best Value Tool Kit. However, given the pressures on officers due to the ongoing Covid19 response, we do not consider this a priority for the Board at this time, especially as best value and effective allocation of resources are a key element of the new SPRA process and Assurance Mapping provide es potentially a more efficient way of achieving Best Value assurance.

Other Areas covered by ICE Fieldwork

We also reviewed the following areas, none of which highlighted any issues of note:

- Standing Financial Instructions
- Standards of Business Conduct
- Anti-Fraud and Corruption Policy and Response Plan
- Financial Operating Procedures
- Control over the Acquisition, Use, Disposal and Safeguarding of Assets

Capital Plan and Property Strategy

Following updates on progress, the November 2021 FP&RC received the PAMS report for the year to 31 March 2021, which is good practice although not mandatory. The PAMs itself was largely retrospective but emphasised the need for a revised NHS Fife Property & Asset Management Strategy to support the development and deliver the objectives of the Health & Wellbeing Strategy.

The PAMS also reported changes to the governance of asset management. The appointment of the Director of Finance as the NHSF Asset Champion, charged with promoting and sustaining of good practice in Asset Management, reflects best practice.

We note the ambition for an NHS Fife PAMS Implementation Action Plan to be developed for 2021/22 which will include actions and outcomes. This Action Plan will be used by the Capital Groups to assess progress in achieving outcomes and objectives that reflect the PAMS requirements of NHS Fife.

Although risks to delivery of the Capital Plan are considered by the Fife Capital Investment Group, and the PAMS, which requires further development, will be essential to support the Health and Wellbeing Strategy, these risks are not recorded on the Risk Register and there is currently no BAF which focuses on Property and Capital.

The FP&RC receive regular updates on current major capital projects. The Elective Orthopaedic Project is on track and due for completion in October 2022with progress regularly reported to the FP&RC.

Environmental Reporting

A paper was presented to the September 2021 FP&RC detailing that NHS Fife is seeking to improve the energy efficiency of its buildings within the Estate, as part of the health sector's drive towards 'net zero carbon' with funding available from the SG as part of the Low Carbon Infrastructure Programme.

A Policy For NHS Scotland on the Climate Emergency and Sustainable Development - DL (2021) 38, was issued on 10 November 2021, with its requirements mandatory and with immediate effect. The DL requirements will almost certainly impact on all NHSF Board decision making.

Action Point Reference 7 – IPQR and Financial Sustainability BAF	
Finding:	
The Financial Sustainability BAF and the IPQR (Financial Performance) are not overtly linked, with the IPQR making no reference to the BAF. Key challenges are highlighted in the IPQR financial section; however there is no direct correlation to the current controls/gaps in control/mitigation actions within the BAF. Clearer linkages to Strategy, PMO savings programme, and External Audit recommendations would further strengthen the BAF along with greater specificity around current controls.	
Audit Recommendation:	
Links between the Financial Sustainability BAF and IPQR should be clear and overtly linked so the controls/mitigations of the BAF provide assurance that challenges within the IPQR is being managed. The financial sustainability BAF should be updated to include links to Strategy, PMO Savings Programme and relevant External audit recommendations.	
Assessment of Risk:	
Merits attention 	There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**
Management Response/Action:	
The improvement activity outlined in previous recommendations in relation to the BAF and Performance Management/IPQR will address a number of the points made in this finding. Additionally a Financial Improvement/Sustainability Programme was approved recently by the Portfolio Board which underpins the delivery of the new strategy for NHS Fife.	
Action by:	**Date of expected completion:**
Director of Finance and Strategy	**31 March 2022**

Action Point Reference 8 – PAMs	
Finding:	
The PAMs and Capital Programme is a vital part of supporting the future Health and Wellbeing Strategy and delivering its prioritised outcomes. However there is currently no BAF risk or linked operational risk that covers the Capital Programme and Property Strategy.	
Audit Recommendation:	
The risks around delivery of the PAMs and capital programme would benefit from having a BAF or operational risk which would aid and support the delivery of the future Health and Wellbeing Strategy.	
Assessment of Risk:	
Merits attention 	There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**
Management Response/Action:	
The Board is currently reviewing the BAF process and the approach to risk management more generally. There is a planned session of the Audit and Risk Committee and the NHS Fife Board in December to consider this which will include responding to the audit points noted above. **Following this, an appropriate BAF or operational risk around delivery of the PAMs and capital programme will be developed which would aid and support the delivery of the future Health and Wellbeing Strategy**	
Action by:	**Date of expected completion:**
Director of Property & Asset Management	**31 March 2022**

INFORMATION GOVERNANCE

Information Governance

BAF Risk:

Risk 1677 – Digital and Information – High Risk (15)

There is a risk that the organisation will fail to recognise and afford the financial investment necessary to deliver its D&I Strategy and current operational lifecycle commitment to enable transformation across Health and Social Care to deliver sustainable and integrated services that are safe, secure and compliant with governance frameworks and associated legislation.

Governance

The governance arrangements, including terms of reference and reporting lines, for Digital and Information were agreed at the beginning of 2021/22 with the Digital and Information Board (D&IB) and Information Governance and Security Steering Group (IG&SSG) identified as having responsibility for providing assurance to the Clinical Governance Committee (CGC) on Information Governance arrangements including assurance on delivery of the NHS Fife Digital and Information Strategy.

The CGC received an update from the IG&SSG in July 2021 regarding the assurance to be developed on key areas of Information Governance, including an activity tracker with target assurance measures. As the IG&SSG meeting scheduled for September 2021 was cancelled due to service pressures the CGC has not yet received a further assurance report from IG&SSG on progress.

The Information Governance and Security Steering Group (IG&SOG) has met twice in 2021/22 in October 2021 and November 2021 and now meets monthly. It has considered an Information Governance Assurance Dashboard which aims to provide assurance regarding the key areas of IG&S. We provided detailed comment on required improvements to the quality and scope of this assurance and the need for clarity regarding the reporting from this group to the IG&SSG and thence assurance reporting to CGC. Papers to the December IG&SSG show further improvement although there are still a number of areas to be resolved by year-end.

Assurance regarding the delivery of the NHS Fife Digital and Information Strategy has been provided to CGC in accordance with its 2021/22 workplan.

It is important that provision of regular assurances to the CGC on the key aspects of Information Governance are established to ensure that the CGC is in a position to conclude on the adequacy and effectiveness of these arrangements at year-end. This regular reporting should be scheduled in the CGC's workplan for the remainder of 2021/22 and in future year's workplans.

Risk Management

The processes for recording and managing risks related to Digital and Information continue to evolve and we were pleased to see that related risks are to be split so that the component parts of the risk and corresponding mitigations can be better understood. It is important that these processes are sufficient to provide CGC with assurance regarding these risks at year end on the accuracy of risk ratings, and the adequacy and effectiveness of key controls and actions. The impact of the pandemic on Digital and Information risks should be considered and specific assurance on this should be provided to CGC.

The Digital and Information BAF is regularly presented to the CGC, however as previously reported the minutes of its meetings do not record any discussion or assurance regarding whether mitigations, in place and planned, will be sufficient to reduce the risk to a tolerable level within an acceptable timescale.

The reporting on risk management to the Digital and Information Board is to change following the adoption of a new risk framework introducing new profiles and risk categorisation in line with ITIL standards.

The IG&SSG has not met since the publication of our annual report (B06/22). The risk report it received at its 1 June 2021 meeting advised that a full risk process and management review was underway with the support of Corporate and Clinical Governance teams, and we have been advised that this has been completed and a risk management report based on the new process is to be presented to the December 2021 IG&SSG.

Digital and Information Strategy

A report on the alignment of NHS Fife D&I Strategy key ambitions and deliverables to NHS Fife's overall strategy to CGC on 17 September 21 highlighted that prioritisation will required over the remaining term of the strategy through the SPRA process, as not all deliverables will be affordable.

Information Governance Responsibilities

An NHS Fife Senior Information Risk Owner (SIRO) and Data Protection Officer (DPO) are in place and the SIRO is an Executive member of the Board.

Information Governance Policies and Procedures

Assurance provided regarding Information Governance Policies and Procedures since the publication of our annual report (B06/22) has been limited to a brief update provided to the Information Governance and Security Operational Group. This did not list the policies and procedures and their review dates (as historical assurances had done) but highlighted a risk regarding lack of resources for Information Governance and Security Policy Management.

The key Information Governance and Security policies, NHS Fife Information Security Policy [GP/I5] and NHS Fife Data Protection and Confidentiality Policy [GP/D3] both have lapsed review dates (01 November 2017 and 01 June 2021 respectively). It is imperative that these important policies are reviewed at the earliest opportunity. The review should specifically consider the impact of the pandemic and the increase in fraud risk and remote working implications.

Information Governance Incidents and Reporting

At this stage, we cannot be certain that that the CGC will receive appropriate and proportionate assurance on Information Governance Incidents. The assurance route for these needs to be clarified and streamlined and should, as a minimum, include the number of IG incidents reported to the Competent Authority, whether these were reported within the 72-hour deadline, feedback from the competent authority (No Further Action, Enforcement or Pending) and whether any of these should be considered for disclosure in the Board's Governance statement.

Action Point Reference 9 – IG&S Assurance Reporting to CGC

Finding:

The CGC has not received regular assurance reporting on the key aspects of IG&S in 2021/22 to date. Whilst it is accepted that this assurance was at the forming stage at the outset of 2021/22, and pandemic related service pressures have hindered progress, it is important that this regular reporting is established so that the CGC, in 2021/22 and future years, is in a position to conclude on the adequacy and effectiveness of Information Governance arrangements at year end.

Reporting to the IG&S Operational Group to date has not provided the necessary detail or quality of information to allow appropriate assurance reporting to the IG&S Steering Group and CGC.

Audit Recommendation:

Regular assurance reporting from the IG&SSG to CGC should be scheduled in the workplan of CGC for 2021/22 and future years.

This should include a regular Assurance Report as well as IG&SSG minutes.

The Assurance report should include clear, sufficient and reliable assurance on the key aspects of IG&S so that the CGC can conclude on the adequacy and effectiveness of Information Governance arrangements at year end.

Assessment of Risk:

Significant		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.**

Management Response/Action:

The Information Governance & Security (IG&S) assurance has been considered within the workplan of the CGC for 2021/22. An assurance report was presented to the July 2021 meeting of the committee with agreement that "a further report will come back to the Committee in due course." This additional report has been scheduled within the 2021/22 workplan for presentation in March 2022, in order to provide further assurance.

The minutes from the IG&S Steering group are consistently presented within the CGC's Linked Committee Minutes section of the agenda.

The provision of the next assurance report, linked committee minutes and annual report 2021/22 will allow the CGC to conclude on the adequacy and effectiveness of Information Governance arrangements.

Action by:	Date of expected completion:
Associate Director of Digital and Information	**28 April 2022**

Action Point Reference 10 – Information Governance and Security Policies

Finding:

The key Information Governance and Security policies, NHS Fife Information Security Policy [GP/I5] and NHS Fife Data Protection and Confidentiality Policy [GP/D3] both have lapsed review dates (01 November 2017 and 01 June 2021 respectively). Lack of resources for IG&S Policy Management was highlighted as a risk to the IG&S Operational Group (28 October 2021).

Audit Recommendation:

Assurance provided regarding Information Governance Policies and Procedures should be improved so that a list of all policies and procedures and their review dates is provided to the IG&S Operational Group and percentage compliance, regarding reviewed within scheduled review date, figures are reported to the IG&S Steering Group.

Progress towards mitigating the risk regarding lack of resources for Information Governance and Security Policy Management should also be reported to the IG&S Steering Group.

The NHS Fife Information Security Policy [GP/I5] and NHS Fife Data Protection and Confidentiality Policy [GP/D3] must be reviewed at the earliest opportunity. The review should specifically consider the impact of the pandemic and the increase in fraud risk and remote working implications.

Assessment of Risk:

Significant  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.

Management Response/Action:

The revised list of policies and procedures was reviewed for all Digital and Information items. This work included the identification of all policies and procedures that were presented within NHS Fife, via Stafflink and publicly through the NHS Fife corporate website. Having identified multiple versions of policies and procedures in these two sources a revised process was introduced to identify a single source of truth for policies and procedures and appropriate tracking and remedial actions.

The revised Policy Review group reactivated their work and presented policy GP/I5 – Information Security to the Executive Director Group (EDG) on September 2021, following its review in February 2020. Given the 19 month delay in presenting the policy the Associate Director of Digital and Information requested that the policy be updated to reflect the new management arrangements and change of name within the Digital and Information team.

The Information Security Policy (GP/I5) and the Data Protection & Confidentiality Policy (GP/D3) will be updated and presented to the Policy Review Group.

Action by:	Date of expected completion:
Associate Director of Digital & Information	**14 February 2022**

Action Point Reference 11 – Information Governance Incident Management

Finding:

The agenda of the IG&S Steering Group on 2 June 2021 did not include any reporting on IG related incidents. No further meetings of the IG&S Steering Group have taken place since the publication of our annual report (B06/22). The next meeting is scheduled for 1 Dec 21 and papers for this have just been distributed with the Activity Tracker report recording the latest data on reportable incidents.

The IG&SSG update report presented to CGC on 7 July 2021 did not include any reporting on IG&S incidents. At this stage, we cannot be certain that that the CGC will receive appropriate and proportionate assurance on Information Governance Incidents.

The process of assurance reporting to the IG&S Steering Group is still evolving and we cannot yet fully comment on the appropriateness of the differentiation in roles between this group and the IG&S Operational Group as the IG&S Operational Group only had its first meeting in October 2021.

Audit Recommendation:

The assurance route for reporting of assurances on Information Governance incidents needs to be clarified and streamlined to provide sufficient assurance to CGC. This should, as a minimum, include the number of IG incidents reported to the Competent Authority, whether these were reported within the 72-hour deadline, feedback from the competent authority (No Further Action, Enforcement or Pending) and whether any of these should be considered for disclosure in the Board's Governance statement.

Assessment of Risk:

Significant  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.

Management Response/Action:

The most recent Activity Tracker and associated Quality Control Assurance Measures included a summary set of incidents, per month, for consideration at the December 2021 Information Governance and Security Steering Group. The summary provided, per month:

- **The number of incidents per category**
- **The number of total incidents**
- **The number escalated to SIRO**
- **The number reportable to the competed Authority**
- **The number by service area**

The data items listed will be included as they are contained within the monthly SIRO report.

Action by:	Date of expected completion:
Associate Director of Digital and Information	**31 March 2022**

Action Point Reference 12 – D&I Risk Management

Finding:

The processes for recording and managing risks related to Digital and Information continue to evolve. The Digital and Information BAF is regularly presented to the CGC, however as previously reported the minutes of its meetings do not record any discussion or assurance regarding whether mitigations, in place and planned, would be sufficient to reduce the risk to a tolerable level within an acceptable timescale.

CGC has not been advised regarding whether the impact of the pandemic on Digital and Information risks has been considered.

Audit Recommendation:

It is important that the processes for recording and managing risks related to Digital and Information are sufficient to provide CGC with assurance regarding these risks at year end on the accuracy of risk ratings, and the adequacy and effectiveness of key controls and actions.

The impact of the pandemic on Digital and Information risks should be considered and specific assurance on this should be provided to CGC.

Assessment of Risk:

Significant		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.**

Management Response/Action:

Within D&I, a full risk review and revised risk management process has been implement. This review and process has been aligned to NHS Fife's Corporate Risk Management Framework and developing thinking in this area and has considered the impact of the pandemic on Digital and Information Risks.

In addition presentational improvements have been developed to support groups and assurance committees to understand the risks performance, and mitigations for highest rated and emerging risks. The improved presentation outlines the timescale for the delivery of the management actions and the impact on risk rating (both likelihood and consequence) from the successful completion of these mitigations. This, together with the risk proximity assessment, allows consideration to be given to the timelyness of mitigation.

These reports will continue to be presented to the assurance groups and be referenced in assurance reports for the remainder of the year 2021/22 and onwards.

Action by:	Date of expected completion:
Associate Director of Digital and Information	**Ongoing – 31 May 2022**

Assessment of Risk

To assist management in assessing each audit finding and recommendation, we have assessed the risk of each of the weaknesses identified and categorised each finding according to the following criteria:

Risk Assessment		Definition	Total
Fundamental		Non Compliance with key controls or evidence of material loss or error. **Action is imperative to ensure that the objectives for the area under review are met.**	None
Significant		Weaknesses in 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.**	Five
Merits attention		There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**	Seven

NHS Fife

Annual Audit Plan 2021/22

AUDIT SCOTLAND

Prepared for NHS Fife
4 March 2022

Contents

Introduction

Summary of planned audit work

1. This document summarises the work plan for our 2021/22 external audit of NHS Fife. The main elements of our work include:

- evaluation of the key controls within the main accounting systems
- provision of an Independent Auditor's Report
- an audit opinion on regularity and other statutory information published within the Annual Report and Consolidated Accounts including the Performance Report, the Governance Statement and the audited part of the Remuneration and Staff Report
- consideration of arrangements in relation to the audit dimensions: financial management, financial sustainability, governance and transparency and value for money that frame the wider scope of public sector audit
- consideration of Best Value arrangements
- review NHS Fife's participation in the National Fraud Initiative.

Impact of Covid-19

2. The coronavirus disease (Covid-19) pandemic has had a significant impact on public services and public finances, and the effects will be felt well into the future.

3. The Auditor General for Scotland, the Accounts Commission and Audit Scotland continue to assess the risks to public services and finances from Covid-19 across the full range of our audit work, including annual audits and the programme of performance audits. The well-being of audit teams and the delivery of high-quality audits remain paramount. Changes in our approach may be necessary and where this impacts on annual audits, revisions to this Annual Audit Plan may be required.

Adding value

4. We aim to add value to NHS Fife through our external audit work by being constructive and forward looking, by identifying areas for improvement and by recommending and encouraging good practice. In so doing, we will help NHS Fife promote improved standards of governance, better management and decision making and more effective use of resources. Additionally, we attend meetings of the Audit and Risk Committee and actively participate in discussions.

Respective responsibilities of the auditor and NHS Fife

5. The Code of Audit Practice (2016) sets out in detail the respective responsibilities of the auditor and NHS Fife. Key responsibilities are summarised below.

Auditor responsibilities

6. Our responsibilities as independent auditors are established by the Public Finance and Accountability (Scotland) Act 2000 and the Code of Audit Practice (including supplementary guidance) and guided by the Financial Reporting Council's Ethical Standard.

7. Auditors in the public sector give an independent opinion on the financial statements and other information within the annual report and accounts. We also review and report on the arrangements within NHS Fife to manage its performance, regularity and use of resources. In doing this, we aim to support improvement and accountability.

NHS Fife responsibilities

8. NHS Fife is responsible for maintaining accounting records and preparing financial statements that give a true and fair view.

9. NHS Fife has the primary responsibility for ensuring the proper financial stewardship of public funds, compliance with relevant legislation and establishing effective arrangements for governance, propriety and regularity that enable them to deliver their objectives.

Managing the transition to 2022/23 audits

10. Audit appointments are usually for five years but were extended to six years due to Covid-19. 2021/22 is the final year of the current appointment and we will work closely with our successors to ensure a well-managed transition.

Financial statements audit planning

Materiality

11. Materiality is an expression of the relative significance of a matter in the context of the financial statements as a whole. We are required to plan our audit to determine with reasonable confidence whether the financial statements are free from material misstatement. The assessment of what is material is a matter of professional judgement over both the amount and the nature of the misstatement.

Materiality levels for the 2021/22 audit

12. We assess materiality at different levels as described in Exhibit 1. The materiality values for NHS Fife are set out in Exhibit 1.

Exhibit 1
2021/22 Materiality levels for NHS Fife

Materiality	Amount
Planning materiality – This is the figure we calculate to assess the overall impact of audit adjustments on the financial statements. It has been set at 1% of gross expenditure for the year ended 31 March 2022 based on the latest audited financial statements for 2020/21.	£14 million
Performance materiality – This acts as a trigger point. If the aggregate of errors identified during the financial statements audit exceeds performance materiality, this would indicate that further audit procedures should be considered. Using our professional judgement, we have assessed performance materiality at 60% of planning materiality.	£8.4 million
Reporting threshold (i.e. clearly trivial) – We are required to report to those charged with governance on all unadjusted misstatements more than the 'reporting threshold' amount.	£200,000

Source: Audit Scotland

Significant risks of material misstatement to the financial statements

13. Our risk assessment draws on our cumulative knowledge of NHS Fife, its major transaction streams, key systems of internal control and risk management processes. Also, it is informed by our discussions with management, meetings with internal audit, attendance at committees and a review of supporting information.

14. Based on our risk assessment process, we identified the following significant risks of material misstatement to the financial statements. These are risks which have the greatest impact on our planned audit procedures. Exhibit 2 summarises the nature of the risk, the sources of assurance from management arrangements and the further audit procedures we plan to perform to gain assurance over the risk.

Exhibit 2

2021/22 Significant risks of material misstatement to the financial statements

Significant risk of material misstatement	Sources of assurance	Planned audit response
1. Risk of material misstatement due to fraud caused by the management override of controls. As stated in International Standard on Auditing (UK) 240, management is in a unique position to perpetrate fraud because of management's ability to override controls that otherwise appear to be operating effectively.	Owing to the nature of this risk, assurances from management are not applicable in this instance.	• Test transactions and journals at the year-end and post-closing entries and focus on significant risk areas. • Review of accounting estimates. • Focused testing of accruals and prepayments, including the holiday pay accrual. • Evaluation of significant transactions that are outside the normal course of business.
2. Estimation in the valuation of land and buildings. NHS Fife held land and buildings with a NBV of £450 million as at 31 March 2021, with land and buildings revaluated on a five-year rolling basis. An external valuer	• Valuations of all land and building assets are reassessed under a five-year programme of professional valuations by the District Valuer and	• Evaluate the competence, capabilities, and objectivity of the professional valuer. • Obtain an understanding of the management's involvement in the valuation process to assess if appropriate oversight has occurred. • Review of reports from the District Valuer to confirm overall asset valuation movements. • Sample testing of valuation amounts applied to individual assets.

Significant risk of material misstatement	Sources of assurance	Planned audit response
carries out valuations of land and buildings. There is a significant degree of subjectivity in the valuation of land and buildings. Valuations are based on specialist and management assumptions and changes in these can result in material changes to valuations.	adjusted in intervening years to take account of movements in prices since the latest valuation.	• Engage with the District Valuer to gain an understanding of the valuation process including any changes in assumptions. • Obtain evidence to support indexation. • Sample testing of indexation calculations applied to individual assets.

Source: Audit Scotland

15. As set out in International Standard on Auditing (UK) 240*: The auditor's responsibilities relating to fraud in an audit of financial statement*, there is a presumed risk of fraud in the recognition of revenue We have considered the risk of fraud over income recognition (ISA 240). We also considered the risk of fraud over expenditure, as most public bodies are net spending bodies, and the risk of external fraud (in accordance with Practice Note 10 (Audit of Financial Statements and Regularity of Public Sector Bodies in the UK)).

16. We have rebutted the presumption that a material risk exists, with the exception of management override, as noted above. This is on the basis of

- there are generally no incentives for staff to commit fraudulent financial reporting (although RRL targets are relevant to our assessment of Management Override)
- most income is provided by the Scottish Government and other public bodies and is easily verified
- most expenditure is in low risk areas where individual transactions are well-controlled (for example salaried staff costs in a well-defined grading system) and individual transactions are relatively small in scale, with management or board approval required for material transactions
- evidence of external fraud from counter fraud services and the National Fraud Initiative does not indicate material risks
- experience in the sector and of the audit of NHS Fife, including a review of past misstatements.

17. Our audit testing is directed towards testing significant and unusual transactions and towards assessing accounting estimates to address any residual risk, as part of

our standard fraud procedures. We have not, therefore, incorporated specific work into our audit plan in these areas over and above our standard audit procedures.

Other areas of audit focus

18. As part of our assessment of audit risks, we have identified other areas where we consider there are also risks of material misstatement to the financial statements. Based on our assessment of the likelihood and magnitude of the risk, we do not consider these to represent significant risks. We will keep these areas under review as our audit progresses. If our assessment of risk changes and we consider these risks to be significant, we will communicate this to management and those charged with governance and revise our planned audit approach accordingly.

19. The areas of specific audit focus are:

- CNORIS claims provision: there is a risk of material misstatement due to the level of estimation and judgement in assessing the potential value of clinical negligence claims. These provisions are generally represented by reimbursement amounts too. We will perform verification of the CNORIS process and 'reliance on an expert' audit, and sample testing of CNORIS claims and associated reimbursements.

- FHS - payments to primary care practitioners: there is a risk of material misstatement due to reduced verification checks and uncertainty about the extent of improvement made by NHS NSS in responding to the weaknesses reported by the service auditor in 2020/21, and we await the outcome of the 2021/22 review. We will test the reconciliation of the ledger to NSS output reports and will review the findings of the Service Auditor We may review counter fraud activity and undertake detailed analytical review at individual practitioner level, in areas where the service auditor is unable to confirm the operation of appropriate controls. We will liaise with the external auditor of NSS on any approach to additional substantive testing.

Group Consideration

20. As group auditors, we are required under International Standard on Auditing (UK) 600: *Audits of group financial statements (including the work of component auditors)* to obtain sufficient appropriate audit evidence on which to base our audit opinion on the group financial statements.

21. NHS Fife has a group which comprises component entities, including Fife Health Charity (the endowment fund) and Fife Integration Joint Board. The audits of the financial information of some of the components are performed by other auditors. We plan to place reliance on the work of the component auditors. We will obtain sufficient appropriate audit evidence in relation to the consolidation process and the financial information of the components on which to base our group audit opinion.

Audit risk assessment process

22. Audit risk assessment is an iterative and dynamic process. Our assessment of risks set out in this plan may change as more information and evidence becomes available during the progress of the audit. Where such changes occur, we will advise management and where relevant, report them to those charged with governance.

Audit dimensions and Best Value

Introduction

23. The Code of Audit Practice sets out the four dimensions that frame the wider scope of public sector audit. The Code of Audit Practice requires auditors to consider the adequacy of the arrangements in place for the audit dimensions in audited bodies.

Audit dimensions

24. The four dimensions that frame our audit work are shown in Exhibit 3.

Exhibit 3
Audit dimensions

Source: Code of Audit Practice

25. In summary, the four dimensions cover the following:

- **Financial management** – financial management is concerned with financial capacity, sound budgetary processes and whether the control environment and internal controls are operating effectively.
- **Financial sustainability** – as auditors, we consider the appropriateness of the use of the going concern basis of accounting as part of the annual

audit. We will also comment on financial sustainability in the longer term. We define this as medium term (two to five years) and longer term (longer than five years).

- **Governance and transparency** – governance and transparency is concerned with the effectiveness of scrutiny and governance arrangements, leadership, and decision-making and transparent reporting of financial and performance information.

- **Value for money** – value for money refers to using resources effectively and continually improving services.

26. We have prior year recommendations covering the wider scope of public sector audit and we will follow-up and report on progress.

Duty of Best Value

27. Ministerial Guidance to Accountable Officers for public bodies and the Scottish Public Finance Manual (SPFM) explain that accountable officers have a specific responsibility to ensure that arrangements have been made to secure Best Value. We will be carrying out a high-level review to confirm that such arrangements are in place within NHS Fife.

28. Additionally, as part our Best Value work, we will be considering the Best Value characteristic "fairness and equality" within NHS Fife.

29. We have identified audit risks in the areas set out in Exhibit 4. This exhibit sets out the risks, sources of assurance from management arrangements and the further audit procedures we plan to perform to gain assurances over the risks.

Exhibit 4
2021/22 Audit dimension risks

	Description of risk	Sources of assurance	Planned audit response
3	**Fairness and equality** In accordance with annual planning guidance issued by Audit Scotland, auditors may carry out specific audit work covering the seven BV characteristics set out in the Scottish Public Finance Manual. There is an expectation that equalities will be advanced through the audit process, and auditors have been advised to carry out work on the Fairness and Equality characteristic at		We will review recent NHS Fife activity on Fairness and Equality including a review of biennial reporting and action plans

	Description of risk	Sources of assurance	Planned audit response
	least once during the audit appointment. Auditors should therefore aim to cover that area in 2021/22 if they have not done so in an earlier year.		
4	**Cyber security** NHS Fife recognises the threat to cyber security as high risk due to legacy systems which are now unsupported. Should a cyber attack occur there are associated risks of data breach and a sustained period of system loss.		We will monitor NHS Fife's response to the risk providing comment in our Annual Audit Report.

Source: Audit Scotland

Reporting arrangements, timetable, and audit fee

Reporting arrangements

30. Audit reporting is the visible output for the annual audit. All Annual Audit Plans and the outputs, as detailed in Exhibit 5, and any other outputs on matters of public interest will be published on our website: www.audit-scotland.gov.uk.

31. Matters arising from our audit will be reported on a timely basis and will include agreed action plans. Draft management reports will be issued to the relevant officers to confirm factual accuracy.

32. We will provide an independent auditor's report to NHS Fife, the Scottish Parliament and the Auditor General for Scotland setting out our opinions on the Annual Report and Consolidated Accounts. We will provide NHS Fife and the Auditor General for Scotland with an annual report on the audit containing observations and recommendations on significant matters which have arisen during the audit.

33. Exhibit 5 outlines the target dates for our audit outputs, and we aim to issue the independent auditor's report by 2 August 2022. We acknowledge this will be challenging due to the ongoing pressures and uncertainties caused by Covid-19.

Exhibit 5
2020/21 Audit outputs

Audit Output	Target date	Audit and Risk Committee Date
Annual Audit Plan	28/02/2022	17/03/2022
Signed Independent Auditor's Report	29/07/2022	02/08/2022
Annual Audit Report	29/07/2022	02/08/2022

Source: Audit Scotland

Timetable

34. To support an efficient audit, it is critical that the timetable for producing the annual report and accounts for audit is achieved. We have included a proposed timetable for the audit at Exhibit 6 that has been discussed with management.

Exhibit 6

Key stage	Provisional Date
Latest submission date for the receipt of the unaudited annual report and accounts with complete working papers package.	16 May 2022
Latest date for final clearance meeting with the Director of Finance and other relevant officers	30 June 2022
Issue of draft Letter of Representation, proposed Independent Auditor's Report, draft Annual Audit Report to the Director of Finance	14 July 2022
Issue of Letter of Representation, proposed Independent Auditor's Report, draft Annual Audit Report, and audited unsigned Annual Report and Consolidated Accounts to NHS Fife Audit and Risk Committee	21 July 2022
Issue of Annual Audit Report to those charged with governance (the Board)	21 July 2022
Signed Independent Auditor's Report and issue of final Annual Audit Report	02 August 2022

Source: Audit Scotland

Audit fee

35. The proposed audit fee for the 2021/22 audit of NHS Fife is £164,130 (2020/21: £160,970). In determining the audit fee, we have taken account of the risk exposure of the NHS Fife, the planned management assurances in place and the level of reliance we plan to take from the work of internal audit.

36. Where our audit cannot proceed as planned through, for example, late receipt of unaudited annual report and accounts, the absence of adequate supporting working papers or being unable to take planned reliance from the work of internal audit, a supplementary fee may be levied. An additional fee may also be required in relation to any work or other significant exercises out with our planned audit activity.

Other matters

Internal audit

37. International standards on Auditing (UK) 610: *Considering the work of internal audit r*equires us to:

- consider the activities of internal audit and their effect on external audit procedures;
- obtain an understanding of internal audit activities to inform our planning and develop an effective audit approach that avoids duplication of effort;
- perform a preliminary assessment of the internal audit function when there is scope for relying on internal audit work which is relevant to our financial statements' responsibilities; and
- evaluate and test the work of internal audit, where use is made of that work for our financial statements responsibilities to confirm its adequacy for our purposes.

38. From our initial review of the internal audit plans, we do not plan to place formal reliance on internal audit's work for our financial statements' responsibilities.

Independence and objectivity

39. Auditors appointed by the Auditor General for Scotland or Accounts Commission must comply with the Code of Audit Practice and relevant supporting guidance. When auditing the financial statements, auditors must also comply with professional standards issued by the Financial Reporting Council and those of the professional accountancy bodies. These standards impose stringent rules to ensure the independence and objectivity of auditors. Audit Scotland has robust arrangements in place to ensure compliance with these standards including an annual *'fit and proper'* declaration for all members of staff. The arrangements are overseen by the Director of Audit Services, who serves as Audit Scotland's Ethics Partner.

40. The engagement lead (appointed auditor) for NHS Fife is Brian Howarth, Audit Director. Auditing and ethical standards require the appointed auditor to communicate any relationships that may affect the independence and objectivity of audit staff. We are not aware of any such relationships pertaining to the audit of NHS Fife.

Quality control

41. International Standard on Quality Control (UK) 1 (ISQC1) requires a system of quality control to be established, as part of financial audit procedures, to provide reasonable assurance that professional standards and regulatory and legal requirements are being complied with and that the independent auditor's report or opinion is appropriate in the circumstances.

42. The foundation of our quality framework is our Audit Guide, which incorporates the application of professional auditing, quality and ethical standards and the Code of Audit Practice (and supporting guidance) issued by Audit Scotland and approved by the Auditor General for Scotland. To ensure that we achieve the required quality standards, Audit Scotland conducts peer reviews and internal quality reviews. Additionally, the Institute of Chartered Accountants of Scotland (ICAS) have been commissioned to carry out external quality reviews.

43. As part of our commitment to quality and continuous improvement, Audit Scotland will periodically seek your views on the quality of our service provision. We welcome feedback at any time, and this may be directed to the engagement lead.

NHS Fife

Annual Audit Plan 2021/22

Audit Scotland's published material is available for download on the website in a number of formats. For information on our accessibility principles, please visit:
www.audit-scotland.gov.uk/accessibility

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NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**17 March 2022**
Title:	**Annual Accounts 2020/21– Follow up Report on External Audit Recommendations**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Report Author:	**Kevin Booth, Head of Financial Services**

1 Purpose

This is presented to the Audit & Risk Committee for:

- Assurance

This report relates to a:

- Government policy/directive
- Legal requirement
- Local policy

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

- Effective

2 Report summary

2.1 Situation

This paper provides a progress report against the recommendations from the External Audit Annual Report on the 2020/21 Accounts.

2.2 Background

The table below sets out the recommendations and the latest position in terms of progress.

2020/21 recommendations

	Issue/risk	Recommendation	Agreed management action/timing
1	**Holiday pay accrual** The holiday pay accrual included in the financial statements is £5.2million. This is a significant increase of £3.7million on the prior year, due to COVID-19 and a change of methodology in how the accrual is estimated for Medical & Dental staff. **Risk –The process and coverage of staff still provides significant uncertainty in the estimate.**	NHS Fife should continue to develop the process used to calculate the accrual to ensure the medical and dental estimate is based on returns from a variety of services, reducing the risk that the estimate is subject to significant uncertainty. Exhibit 2	Agreed management action: NHS Fife are finalising the process for 2021/22 as described in the recommendation. Responsible officer: Director of Finance and Strategy Agreed date: 31 March 2022
2	**Discounting of annual medical negligence payments** NHS Fife has correctly applied discount factors to calculate the provisions for ongoing medical negligence payments in accordance with annex c to PES (2020) 12. These estimates are subject to considerable uncertainty. The period over which they will be paid depends on individual life expectancy. However, we consider that the tables used to discount are flawed. **Risk –incorrect discounting understates the long term estimate.**	The duration of the annual cost commitment is subject to significant uncertainty and is reimbursed to NHS Fife via the CNORIS scheme. The application of discount factors to the ongoing payment should be reviewed by 31 March 2022. Exhibit 2	Agreed management action: NHS Fife will review the application of discount factors in relation to the CNORIS scheme. Responsible officer: Director of Finance and Strategy Agreed date: **31 March 2022**
3	Recruitment of payroll staff NHS Fife have been experiencing difficulties in recruiting payroll staff and some payroll officers are due to retire. Staff turnover (19.4%) has placed increased demands on staff. Risk: Increasing demand and payroll workforce issues will impact on the performance of payroll services.	Recruitment issues in payroll services need to be addressed to prevent wider risks to service provision. Paragraph 46.	Agreed management action: NHS Fife recognise ad continue to progress recruitment to payroll services. The Board has recently approved the Business Case to implement the South East Region Payroll Consortium. The payroll service will transition to the consortium arrangement by 31 March 2023. This action will deliver improved resilience for the payroll teams across the region but will take time to implement. Responsible officer:

			Director of Finance and Strategy Agreed date: 31 March 2022
4	**Savings for 2021/22 still need to be identified** The financial plan includes an in-year budget gap of £8.1million for 2021/22, and a total gap of £21.8 million. This includes unachieved legacy savings brought forward of £13.6 million. The plan includes the assumption that the full unachieved legacy savings brought forward will be funded by Scottish Government, however this has not yet been confirmed. Work is underway to develop recurring savings plans and so far NHS Fife has only identified £5 million savings on a recurring basis. Risk: NHS Fife is unable to deliver its budget for 2021/22 and beyond.	**NHS Fife needs to prepare contingency plans if the unachieved legacy gap is not to be funded by the Scottish Government.** Paragraph 57.	Agreed management action: NHS Fife has developed a draft financial plan which includes a plan to deliver £12.7m savings in 2022/23. NHS Fife has also developed and implemented a Financial Improvement and Sustainability Programme to drive financial improvement across the organisation. Responsible officer: Director of Finance and Strategy Agreed date: 31 March 2022
5	**Transformation** Fife's Transformation Programme was at an early stage when the Covid-19 pandemic began. The formal programme was paused in 2020 as the NHS responded to changing priorities directed by Scottish Government. NHS Fife plans to revisit the formal Transformation Programme as part of the new Strategic Planning and Resource Allocation (SPRA) process and the development of a new Health and Wellbeing Strategy for Fife (replacing the Clinical Strategy). **Risk: Delaying the transformation of services presents a risk to future financial sustainability and delivery of performance targets.**	**NHS Fife needs to ensure the transformation agenda is rebooted once priorities are no longer exclusively on responding to the Covid-19 pandemic.** Paragraph 60.	Agreed management action: NHS Fife have developed a range of improvement and change activity areas which will be aligned to the developing Population Health and Wellbeing Strategy and will deliver cash releasing savings and capacity increases over the medium term. The SPRA and PMO infrastructure will support, guide and report formally on this work. Responsible officer: Director of Finance and Strategy Agreed date: 31 March 2022

Follow-up of prior year recommendations

Issue/risk	Recommendation	Agreed management action/timing
4. Financial capacity and working papers 2019/20 AAR	Financial capacity issues should be addressed as a priority. Going forward, NHS Fife should ensure that the agreed timetable for presenting the unaudited annual report and accounts for audit is met, and that working papers are available and provided as required.	**Complete.**
5. Holiday pay accrual 2019/20 AAR	We recommend that a process is put in place to assist management in determining this estimate, which would make it less susceptible to bias.	**In progress** – superseded by Recommendation 1.
6. Savings for 2020/21 still need to be identified 2019/20 AAR	NHS Fife should ensure that detailed savings plans are developed identifying how the remaining £4.3 million of savings in 2019/20 will be made on a recurring basis.	**In progress** – refer to our 2020/21 Management Report. We found that NHS Fife continues to rely on non-recurring savings to deliver against their financial targets. This is linked to Recommendation 7.

7. Medium term financial plans **2019/20 AAR**	The new medium-term financial plan will need to consider the impact of COVID-19, which as well as affecting services, has had a significant impact on finances in 2019/20 and into 2020/21.	**In progress** – refer to our 2020/21 Management Report. We found that work is progressing on developing a Strategic Planning and Resource Allocation process which includes a medium-term financial plan but this is currently in its early stages. **Conclusion** - We recommended that NHS Fife should prioritise development of its medium-term financial plan to ensure savings are

Issue/risk	Recommendation	Agreed management action/timing
		identified, and a balanced budget is achievable on a recurring basis over the three-year planning and performance cycle.

2.3 Assessment

Good progress has been made in-year however a number of recommendations may require to be carried forward to 2022/23 to ensure completeness and that improvements are embedded. The current progress can be summarised as follows:

1 – Holiday Pay Accrual

Whilst the process for calculating and ensuring sufficient coverage remains the same. Management continue to proactively engage with the services to ensure that any known uncertainties are minimised where possible. DL(2021)35 dated November 21 – Annual Leave Buy Back and Carry Over 2021-22 has warranted wider discussions across the service and colleagues in workforce to ascertain the likely effect on the carried forward Annual Leave position.

2 – Discounting of Annual Medical Negligence payments

The PES papers covering the HM Treasuries approved discount rates for 2021/22 were forwarded to NHS Fife on 13/12/21 from Audit Scotland and were shared with appropriate members of the Finance Team ahead of them being applied in the 2021/22 Annual Accounts process. The application of these rates will ensure that any discounting is calculated using the figures approved and provided by HM treasury.

3 – Recruitment of Payroll Staff

The Band 4 payroll officer posts have been advertised four times across the year with limited applications and no appointments. The Payroll Officer Job Description was re-evaluated to Band 5 in February 2022, the higher banding, in line with a number of other NHS Boards, may lead to more interest in the roles at the next round of recruitment. In addition, the Board of NHS Fife has agreed to join the South East Payroll Consortium which will result in the formation of a single payroll team managed by NSS, servicing a number of the boards within the region and the existing payroll team will TUPE to NSS in late summer 2022. It is expected that the formation of the payroll consortium will build greater resilience to the payroll function for NHS Fife.

4 – Savings for 2021/22 still need to be identified

The Scottish Government has provided conformation to NHS Fife that it will provide funding to assist the board in breaking even in 2021/22.

A Financial plan for 2022/23 has been developed using a confirmed baseline uplift funding of 2% along with further support for the increased employer national insurance costs. In addition, NHS Fife, as one of the boards furthest from NRAC parity is to receive £7m in NRAC funding in 2022/23.

The financial plan which includes a programme of Financial Improvement and Sustainability which aims to deliver £12.7m of savings in 2022/23. The Financial Improvement and Sustainability Programme will drive financial improvement across the organisation.

5 - Transformation

NHS Fife is revisiting the Transformation programme as part of the 2022/23 SPRA process and the development of the new Population Health and Wellbeing Strategy.

2019/20 Recommendations

It should be noted that the recommendations carried over from the 2019/20 External Audit Annual Accounts recommendations are now all either completed or have been superseded by the 2020/21 recommendations.

2.3.1 Quality/ Patient Care

N/A

2.3.2 Workforce

Staffing Risks are covered in recommendation 3 relating to the Payroll Team capacity.

2.3.3 Financial

Financial risks are covered in recommendations 1,3 and 4.

2.3.4 Risk Assessment/Management

It is important to ensure that all audit recommendations receive appropriate attention to ensure risks associated with them can be managed timeously.

2.3.5 Equality and Diversity, including health inequalities

A separate EDA has not been completed in relation to this report however the financial planning and financial governance arrangements in place across the organisation include the appropriate assessments.

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

The recommendations in the External Audit report are shared with the Finance Directorate and key members of staff across the team are involved in ensuring appropriate actions are undertaken.

2.3.8 Route to the Meeting

Progress on the 2020/21 External Audit Annual Accounts recommendations is regularly updated by the Director of Finance and Strategy.

2.4 Recommendation

The Committee is asked to take assurance from the progress made against the 2020/21 External Audit recommendations.

3 List of appendices

N/A

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

NHS in Scotland 2021

AUDITOR GENERAL

Prepared by Audit Scotland
February 2022

Contents

Audit team

The core audit team consisted of: Leigh Johnston, Derek Hoy, Eva Thomas-Tudo, Claire Tennyson and Lucy Ross under the direction of Angela Canning.

Key messages

1 The NHS in Scotland is operating on an emergency footing and remains under severe pressure.

The success of the vaccinations programme has reduced deaths but the ongoing impact of responding to variants of Covid-19 has created a growing backlog of patients waiting much longer for treatment. The backlog poses a significant risk to the Scottish Government's recovery plans, which aim to transform how care is delivered. Reform is key to the sustainability of the NHS, and it must remain a focus, building on the innovation seen throughout the pandemic. Crucially, the public must be kept aware of and involved in changes to service provision. But transforming services will be very difficult to deliver against the ongoing competing demands of the pandemic and an increasing number of other policy initiatives, such as plans for a National Care Service.

2 NHS and social care workforce planning has never been more important.

Frontline NHS and social care staff, leaders and civil servants have shouldered a heavy burden over the last two years, and this has affected their wellbeing. The Scottish Government has introduced measures to support staff and is monitoring their effectiveness. But it must also prioritise addressing workforce availability challenges if its recovery plan is to be successful. Its plans to recruit and retrain staff are ambitious and will be challenging to achieve given the NHS's historical struggles to recruit enough people with the right skills.

3 The NHS's ability to plan for recovery from Covid-19 remains hindered by a lack of robust and reliable data across several areas.

This includes workforce data, as well as primary, community, social care and health inequality data. The collection and use of this data must improve to support decision-making and to ensure policy decisions are delivering the best outcomes for people.

4 The NHS was not financially sustainable before the pandemic and responding to Covid-19 has increased those pressures.

In 2020/21, the Scottish Government allocated £2.9 billion for pandemic-related costs. It has committed additional funding for health and social care in 2021/22 and beyond but there is uncertainty about future Covid-19 funding levels and the longer-term financial position. The Scottish Government plans to bring financial planning, service planning, workforce planning and capital investment together under a new Care and Wellbeing Portfolio. This has the potential to help the NHS become sustainable, but it is very early days. The key to financial stability remains a clear focus on the Scottish Government's long-standing commitment to transform how health and social care services are delivered.

Recommendations

The Scottish Government should:

- address the wellbeing risks affecting staff in the Scottish Government's Health and Social Care directorate as well as the NHS and social care workforce **(paragraph 18).**

The Scottish Government and NHS boards should:

- work with partners in the social care sector to develop a long-term, sustainable solution for reducing delayed discharges from hospital **(paragraph 15)**
- publish data on performance against the clinical prioritisation categories, to enable transparency about how NHS boards are managing their waiting lists **(paragraph 39)**
- work with patients on an ongoing basis to inform the priorities for service delivery, and be clear on how services are developed around patients' needs **(paragraph 57)**
- take a cohesive approach to tackling health inequalities by working collaboratively with partners across the public sector and third sector, and be transparent on how it will do this **(paragraphs 62 and 63)**
- improve the availability, quality and use of workforce data to ensure workforce planning is based on accurate projections of need **(paragraph 87)**
- monitor and manage risks around the impact of additional work outlined in the NHS recovery plan on the NHS workforce, to make sure recovery does not negatively affect staff wellbeing **(paragraph 90)**
- communicate widely with the public on changes to how services are delivered so that people are aware of how best to access services, and monitor the effectiveness of that communication **(paragraph 95)**
- prioritise the prevention and early intervention agenda as part of the recovery and redesign of NHS services, to enable the NHS to be sustainable into the future **(paragraph 98)**
- improve the availability, quality and use of data on primary, community and social care so that service planning is based on accurate measures of existing provision and demand **(paragraph 99)**.

Introduction

1. The Covid-19 pandemic continues to provide a unique and difficult challenge for the NHS in Scotland. This report builds on our coverage of the response to the pandemic in our NHS in Scotland 2020 report.[1] It also follows our Covid-19 briefings on personal protective equipment and the vaccination programme.[2] [3] The report examines the continued impact of the pandemic on services and people's health in 2021. It also considers the Scottish Government's recovery plans for the NHS and looks at how services might be delivered in the future to better meet changing demand. We also provide an overview of financial performance across the NHS in Scotland in 2020/21 and consider the financial challenges that lie ahead. Our audit approach is set out in the Appendix.

2. The Scottish Government and the NHS continue to respond to Covid-19 as the pandemic progresses, while pushing ahead with plans for recovery. Policy and guidance are being updated frequently and our findings reflect the situation at January 2022, using information available before publication. The Scottish Government and the NHS are working in a quickly changing environment, as the emergence of the Omicron variant in late 2021 has shown. A lot of the work we cover in the report is at an early stage. It is too early for us to make judgements on some of these programmes of work.

3. We would like to acknowledge the support and assistance provided by the Scottish Government and NHS boards that has enabled us to prepare this report.

The ongoing response to the pandemic

The NHS continues to operate under extremely challenging circumstances with an ongoing focus on the response to Covid-19 and providing emergency and urgent care

4. The NHS in Scotland is still operating in extremely challenging circumstances. NHS staff have continued to demonstrate their extraordinary commitment to public service, working under significant pressure for a period longer than anyone could have predicted at the outset.

5. Responding to the Covid-19 pandemic is still putting NHS boards under considerable strain and the Scottish Government has confirmed that the NHS will continue to operate on an emergency footing until at least March 2022. This means that non-urgent care and treatment may continue to be postponed, so that NHS boards can manage the immediate demands of responding to Covid-19 and continue to provide emergency and urgent care.

6. The ongoing need to implement public health measures to prevent and control infection continues to affect NHS capacity and resources. The Scottish Government and the NHS have put in place several programmes of work as part of the ongoing response:

- **The Covid-19 vaccination programme.** In September 2021, we published a briefing paper on the rollout of the Covid-19 vaccination programme. The NHS has made excellent progress in vaccinating a large proportion of people aged 18 years and over.[4] The programme has since been extended to offer vaccines to children aged five years and over, and to offer third doses for more vulnerable people and booster vaccinations for adults aged over 18 years. Uptake has been very high: at 16 February 2022, 92.2 per cent of those aged 12 years and over have received at least one dose of a Covid-19 vaccine.[5]
- **Test and Protect.** Scotland's approach to testing and contact tracing has developed as the pandemic has progressed. At 16 February 2022, more than 15.3 million PCR Covid-19 tests had been carried out, and more than 1.1 million of these were positive.[6] [7] In December 2021, the Scottish Government published an evaluation of the asymptomatic testing programme.[8] This found that between 25 November 2020 and 27 June 2021, more than

Covid-19: Vaccination programme
September 2021

7,000 positive cases were identified through this programme. These cases may not have otherwise been detected if they remained asymptomatic or may have been diagnosed later once symptomatic. The evaluation found that there were some barriers to maximising the impact of the programme, including concerns about the perceived reliability of the tests, and the consistency of people self-reporting results.

- **Distribution of personal protective equipment (PPE).** PPE has been supplied to the NHS and social care services, free of charge, throughout the pandemic. The Scottish Government has committed to continue this until at least March 2022. This is currently expected to cost £158.9 million in 2021/22. It is not yet clear what arrangements will be in place after March 2022. Our briefing paper on PPE (June 2021) noted that the Scottish Government and NHS National Services Scotland (NHS NSS) have been working with partners to develop a longer-term approach to supplying and distributing PPE.

Covid-19: Personal protective equipment
June 2021

7. NHS boards' ability to implement their remobilisation plans for 2021/22 is highly dependent on how the pandemic progresses. These outlined NHS boards' priorities for increasing activity while maintaining their capacity to treat Covid-19 patients.

8. The assumptions in these plans understandably included a lot of caveats because of the uncertain ongoing impact of the pandemic on the NHS. The Scottish Government reviewed the strength and content of the remobilisation plans and identified several themes, including:

- good coverage of priorities encompassing acute, primary, community and social care
- the importance of looking after the wellbeing of the workforce
- a clear commitment to doing things differently, building on lessons learned and on innovations such as the redesign of urgent care and Near Me
- the importance of working in partnership with the public sector and third sector, with staff and clinical colleagues, and with local communities.

9. The review also highlighted several risks that had been identified by NHS boards and that could considerably affect the scale and pace of remobilisation during 2021/22. These include:

- uncertainty about how the Covid-19 pandemic will develop and the potential impact of future surges on the NHS
- workforce issues, including the need to make sure that staff have time and support to rest and take leave and concerns about sustainability because of retirals, recruitment challenges, redeployment and having the appropriate skills mix

- concerns about the longer-term impact of Covid-19 on the population and the way in which health and social care services will be delivered. Examples include the resources needed to further develop the role of public health services; the ongoing need for enhanced infection prevention and control measures; and the impact of unidentified and unmet healthcare needs on the demand for services.

The Scottish Government and NHS boards took action to prepare for a challenging winter

10. The Scottish Government acknowledged that winter 2021/2022 was likely to be extremely challenging for the NHS and, along with NHS boards, took action to prepare. The usual winter pressures, such as respiratory illnesses and falls, need to be managed along with Covid-19. The NHS has been rolling out its most extensive flu vaccination programme yet to minimise the spread of infection and the impact on services.

11. The Scottish Government asked NHS boards to update their remobilisation plans in Autumn 2021, to help ensure they were well prepared for the winter. In addition, in October 2021, the Scottish Government published a health and social care winter overview, outlining its winter planning preparations.[9] This was based on four principles:

- maximising capacity through investment in staffing, resources and facilities
- caring for staff by ensuring timely access to wellbeing support, so that they can continue to work safely and effectively
- reducing delayed discharge from hospitals and increased access to care in a range of community settings
- improving outcomes by investing in delivering the right care in the right setting.

12. The emergence of the Omicron variant at the start of winter 2021/22 demonstrated how the uncertain path of the pandemic can impact on NHS services. Covid-19 case numbers spiked dramatically throughout December and into early January followed by a spike in hospital admissions and moderate increases in deaths and ICU stays. This added to the pressure on the NHS during an already difficult winter season. This was further exacerbated by staff absences owing to Covid-19 while case numbers grew and isolation guidelines were tightened.

13. The Covid-19 vaccine booster programme was accelerated in line with updated clinical guidance following the emergence of the Omicron variant. While this was expected to reduce the health impact of the virus it added to the pressure on vaccination teams.

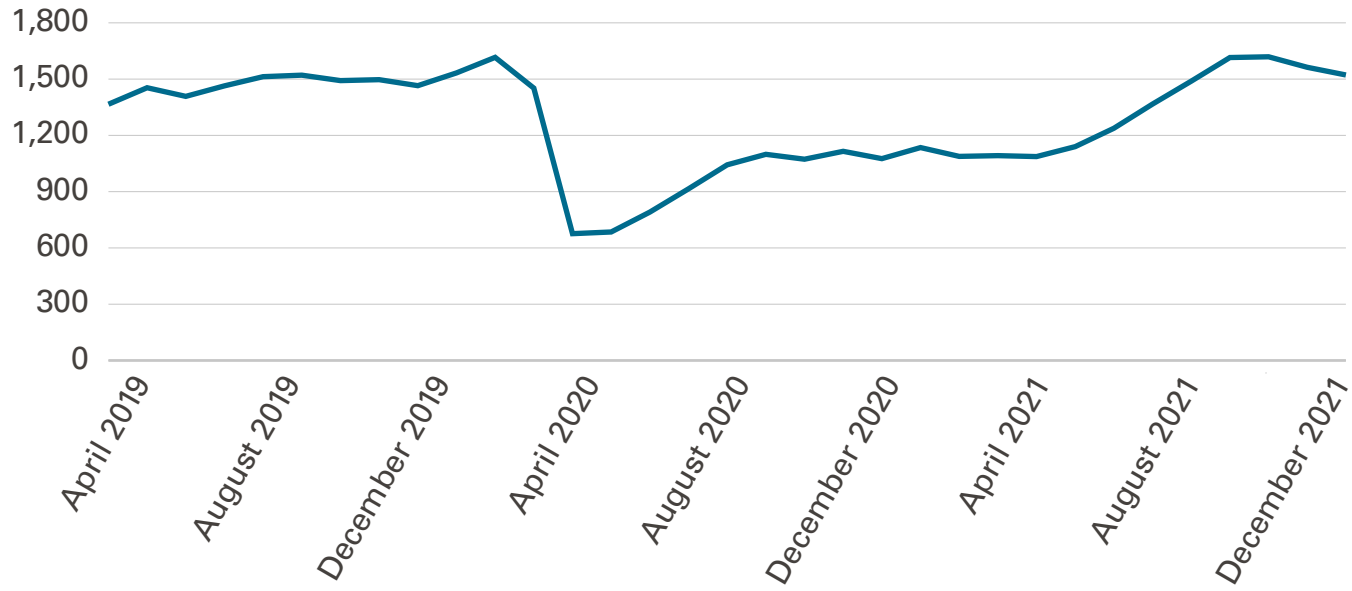
14. At the start of the Covid-19 pandemic, the Scottish Government introduced a rapid discharge strategy aiming to increase capacity in acute hospitals. This was effective, resulting in a substantial drop in delayed discharges between March and April 2020 (Exhibit 1). Delayed discharges gradually increased after April 2020 and had reached pre-pandemic levels by September 2021, putting additional pressure on NHS hospitals. The Scottish Government has said that this is because there have been increasing numbers of people admitted to hospital requiring care packages on discharge.

15. In its health and social care winter overview, the Scottish Government committed to providing £62 million, to increase the capacity for providing care at home, and funding of £40 million, to move people delayed in hospital into care homes on a short-term basis. This aimed to free up capacity in hospitals over the winter. By December 2021 there had been a small decrease in the average daily bed days occupied by delayed discharges (Exhibit 1). The measures to reduce delayed discharges, particularly during the first wave of the pandemic, were effective in the short term but a longer-term, more sustainable solution is needed.

Exhibit 1.

Average daily bed days occupied by patients whose discharge from hospital was delayed – April 2019 to December 2021

There was a substantial decrease in delayed discharges at the start of the Covid-19 pandemic, but they have since returned to pre-pandemic levels.



Source: Public Health Scotland

The unprecedented pressures of the pandemic continue to limit the capacity of the NHS workforce

16. Scottish Government and NHS staff have been working relentlessly to support the ongoing response to the pandemic and deliver services. Staff absences attributable to Covid-19 continue to limit capacity (Exhibit 2, page 11).[10] Vacancy rates for nursing and midwifery, and allied health professionals, such as physiotherapists, were higher in September 2021 than in any of the previous four years.[11]

17. The Scottish Government recognises that the risks relating to workforce capacity and wellbeing are significant. This has been reflected throughout the year in the Scottish Government's Health and Social Care Risk Register. The Scottish Government has introduced a range of controls to mitigate the risks. For example, it developed a recruitment plan to address winter pressures and winter disease. It also set up a Sustainable Vaccination Workforce Group to ensure that delivering the vaccination programme did not put further pressure on the wider healthcare system. It is too early to tell how effective these measures have been.

18. The workforce risks included in the Health and Social Care Risk Register refer only to health and social care staff. The Scottish Government should also consider risks affecting staff in the Scottish Government's Health and Social Care directorate.

19. Our NHS in Scotland 2020 report highlighted the negative impact of the pandemic on NHS staff wellbeing. This impact persists almost two years into the pandemic. Staff surveys carried out by trade unions and regulators continue to show a high number of staff saying their physical and mental wellbeing has been negatively affected. The results of the annual iMatter staff experience survey are currently being analysed and the Scottish Government intends to publish the report in early 2022.

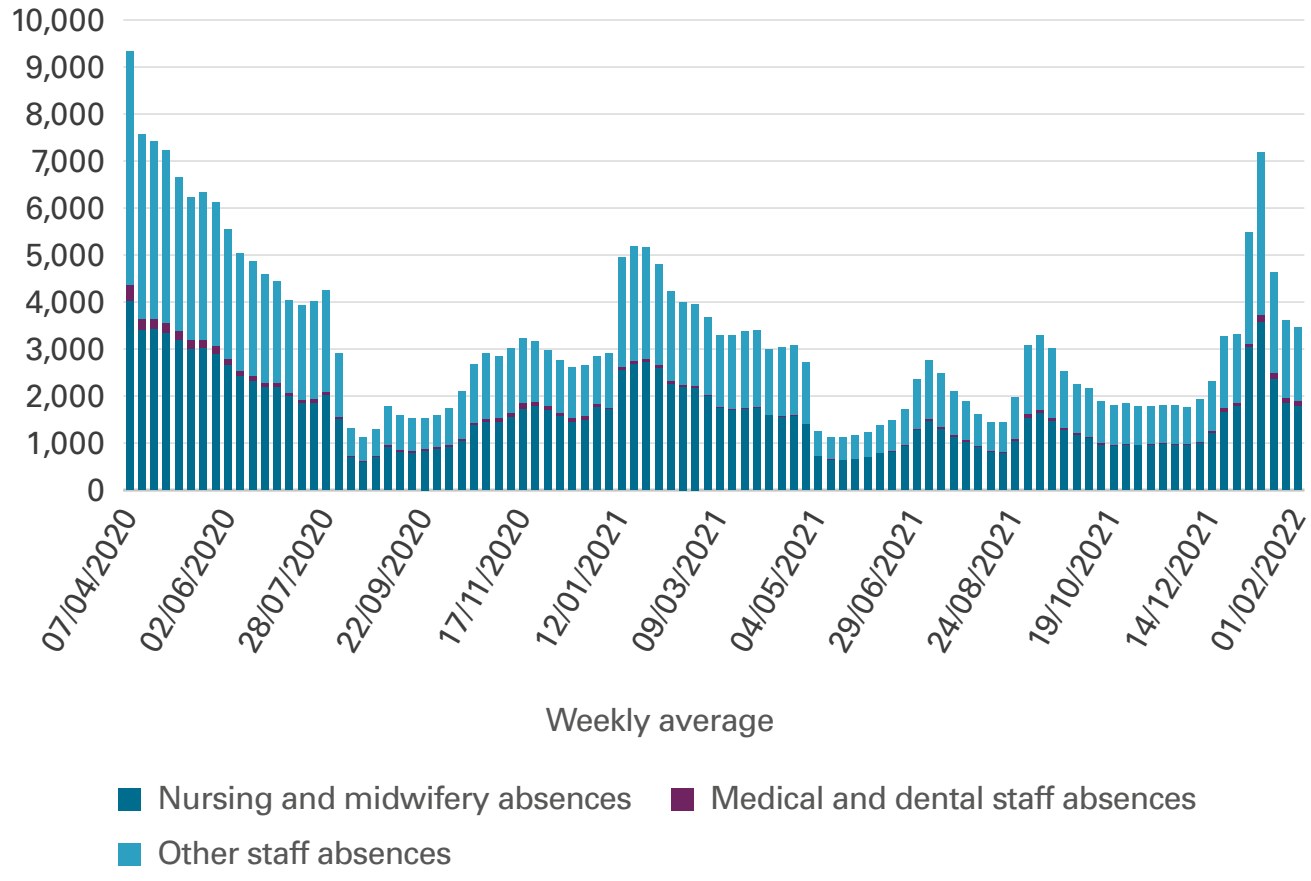
20. The 2021 Royal College of Nursing (RCN) Employment survey found that 40 per cent of nursing staff in Scotland are working beyond their contracted hours on most shifts.[12] Also, 67 per cent said they were too busy to provide the level of care they would like and 72 per cent said they were under too much pressure at work. It also found that 61 per cent are thinking about leaving their current position, with the main reasons being feeling undervalued, feeling under too much pressure, low staff levels and low pay. In comparison, 36 per cent of respondents to the RCN UK-wide Pay and Working Conditions Survey at the start of the pandemic said they were thinking of leaving their current position.[13]

21. The percentage of sickness absence attributable to stress and/or poor mental health increased for most NHS boards in 2020/21, compared with 2019/20. It is not clear whether those increases were caused by work-related stress or poor mental health owing to the pressures of the pandemic. The data also needs to be considered in the context of overall lower rates of non-Covid-19 sickness absence in 2020/21.

Exhibit 2.

The number of NHS staff absent because of Covid-19 – April 2020 to February 2022

Staff absence due to Covid-19 has varied but has been high throughout the pandemic.



Note: This graph shows the weekly average of daily absences.

Source: Scottish Government

The Scottish Government and NHS boards worked quickly to support staff wellbeing, but it is too soon to assess the effectiveness of the measures put in place

22. The Scottish Government and NHS boards worked quickly to increase the support available for the health and social care workforce. In 2020/21, the Scottish Government allocated £8 million for wellbeing support and announced a further £4 million in October 2021 to support wellbeing during the winter pressures.[14] [15] Seven measures have been introduced at a national level to support staff. These include access to support via a National Helpline, an online National Wellbeing Hub and a

Workforce Specialist Service offering specialist support in understanding the mental health needs of health and social care professionals who may be reluctant to seek help or struggle to find confidential care.

23. The measures put in place so far are appropriate, but it is too soon to fully assess their effectiveness. Governance arrangements for the programme of work are in place and include project teams, an oversight group and a programme board. The Scottish Government is monitoring the uptake of the measures and gathering feedback from service users.

24. The Scottish Government has reviewed the first 100 service users of the Workforce Specialist Service, usage of the National Wellbeing Helpline and examined analytics of the National Wellbeing Hub. Feedback has suggested that they have had a positive impact on wellbeing, although the National Wellbeing Helpline has had low call volumes. The Scottish Government will continue to evaluate the staff support measures it has introduced.

25. The scale of need for support is not clear. It is important that the Scottish Government continues to engage with the health and social care workforce and take account of the experiences of different staff groups as this programme of work develops.

26. The Scottish Government established a short life working group, including representatives from the health and social care sector, to provide recommendations to support workforce recovery. These fed into the NHS recovery plan published in August 2021.[16] The Scottish Government is exploring opportunities for a panel of health and social care staff to share their experiences. Our social care briefing, published in January 2022, highlights the immense pressure social care staff are under and the ongoing challenges with recruitment and retention within the sector.[17]

Social care briefing
January 2022

27. The Scottish Government told us that there is not a culture of seeking help in the health and social care sector. Support needs to be improved, for example by ensuring that wellbeing is part of conversations between staff and their managers. Achieving this will take time and involve managing the tension between the competing demands of staff wellbeing, the pandemic response, and remobilisation.

The Scottish Government and NHS are implementing lessons learned during the pandemic

28. Some changes brought in during the pandemic were specific to the response required and will not be adopted permanently. But other changes can bring ongoing benefits to health services and can aid the recovery effort and improve future service delivery.

29. The Scottish Government and NHS have acted quickly to learn from changes brought in during the pandemic and have started to embed that

learning across NHS services. The Scottish Government commissioned a report, published in August 2021, on lessons identified from the health and social care response to Covid-19 in Scotland during the first six months of the pandemic.[18]

30. The report concluded that a considerable amount of work had gone into identifying what had worked well and what opportunities exist for new ways of working. It identified clear examples of good practice at individual board level and through national programmes. It also recommended clearly defining roles and responsibilities for implementing lessons learned exercises, with the Scottish Government coordinating and overseeing to avoid overlap and duplication.

31. The findings have informed other work, for example, the NHS recovery plan, the Programme for Government, and the development of a Care and Wellbeing Portfolio (paragraph 103). The Scottish Government created an action tracker outlining progress against recommendations and additional commitments. It shows where lessons could inform future pandemic preparedness and the development of policy and reform work. It also outlines how lessons identified are being addressed in the creation of its Care and Wellbeing Portfolio.

32. It is important that new ways of delivering services continue to be evaluated to assess the ongoing appropriateness and effectiveness of the changes, and to avoid exacerbating or creating health inequalities.

Scottish ministers are setting up a public inquiry to investigate the handling of the Covid-19 pandemic in Scotland

33. In December 2021, the Deputy First Minister announced terms of reference and the appointment of a chair for a public inquiry into the handling of Covid-19 in Scotland.[19] The inquiry will look at the strategic response to the pandemic and cover 12 areas of investigation, to identify lessons to be learned and recommendations. It will look across pandemic preparedness, the direct and indirect health impacts, education and financial support. The inquiry will cover the period from 1 January 2020 to 31 December 2022 but will also include pandemic planning undertaken before then. The terms of reference for the inquiry were set by the Scottish Government and informed by public engagement.

The continuing health impact of Covid-19

The pandemic continues to have an impact on the health of people in Scotland, but fewer people are dying from Covid-19

34. By the end of January 2022 Covid-19 had caused or contributed to more than 12,900 deaths in Scotland. The number of people dying from Covid-19 has been significantly lower since the rollout of the vaccination programme from late 2020, despite higher numbers of positive cases (Exhibit 3, page 15).

35. From September 2021, there has been another increase in people with Covid-19 being admitted to hospital. This is putting considerable pressure on hospitals at a time when they are already under enormous strain. There is also the risk that if new variants of the virus continue to emerge, the vaccines may become less effective.

36. On average there has been a higher number of deaths from other causes during the pandemic. From the week beginning 24 May 2021, deaths were above average levels for 32 consecutive weeks. For 2021 as a whole, excess deaths were ten per cent above the average for the five-year period 2015 to 2019.[20] The Scottish Parliament has launched an inquiry to investigate what factors have led to this increase.

The Covid-19 pandemic has led to a considerable backlog of people waiting for NHS diagnosis and treatment

37. Responding to the Covid-19 pandemic has severely affected the ability of NHS boards to continue to see and treat people with other healthcare needs. The Scottish Government directed NHS boards to pause non-urgent treatment and screening programmes during the first wave of the pandemic. The NHS has been working to resume the full range of healthcare services but capacity in hospitals continues to be limited. This has led to increasing numbers of people waiting much longer for diagnosis and treatment (Exhibit 4, page 16).

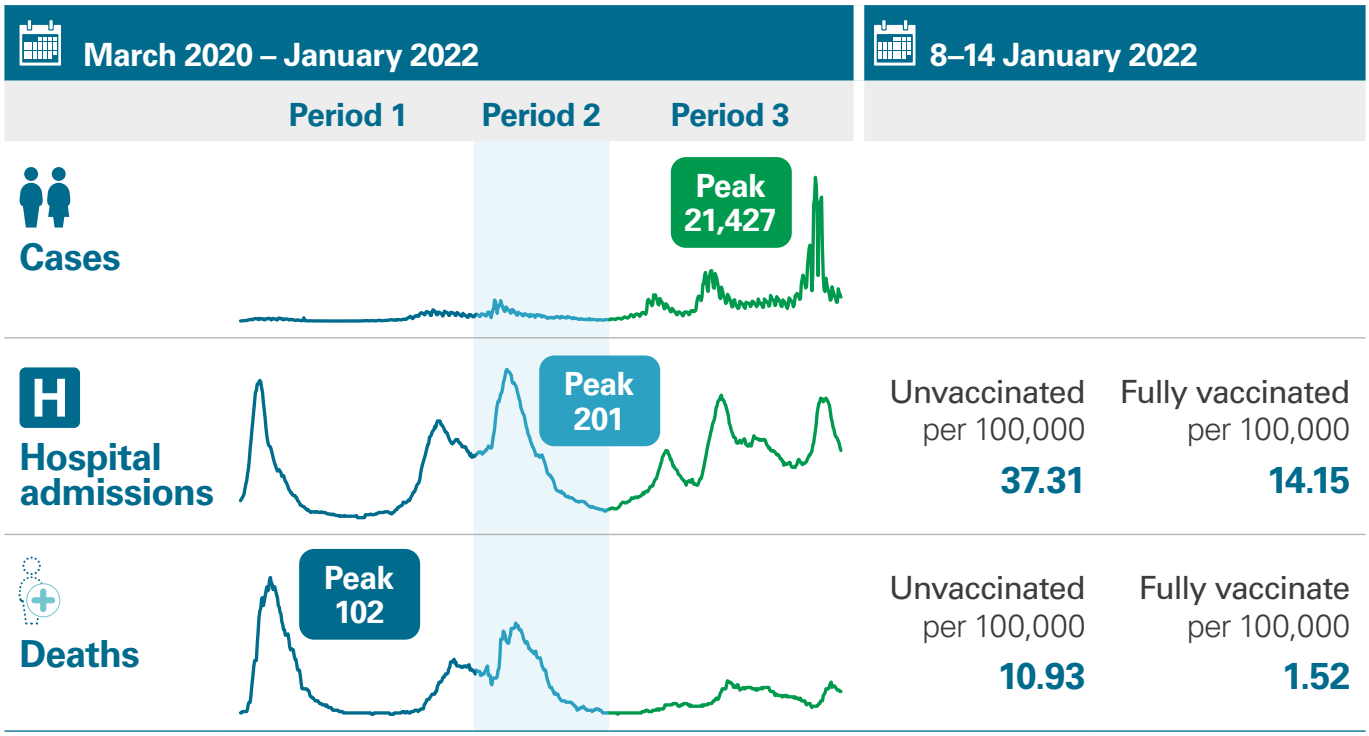
38. In November 2020, the Scottish Government published a clinical prioritisation framework outlining how NHS boards should prioritise patients for treatment during the Covid-19 pandemic.[21] This approach means that patients in most urgent need should be seen first and those of lower clinical priority will need to wait longer. Patients are categorised in priority levels as follows:

- Level 1a emergency – operation needed within 24 hours
- Level 1b urgent – operation needed within 72 hours
- Level 2 surgery – scheduled within four weeks
- Level 3 surgery – scheduled within 12 weeks
- Level 4 surgery – may be safely scheduled after 12 weeks.

Exhibit 3.

Covid-19 cases, deaths and hospital admissions – March 2020 to January 2022

The Covid-19 vaccination programme has helped to reduce the number of people needing hospital treatment or dying from Covid-19.



Period 1 – Before the vaccination programme
Period 2 – 8 December 2020: Vaccination programme began
Period 3 – 7 May 2021: 98% of priority groups 1–9 had received their first dose of a Covid-19 vaccine

Notes:
1. The data for Covid-19 deaths and hospital admissions are based on the average number of registered deaths and the average number of people admitted to hospital over the previous seven days.
2. People who are fully vaccinated are defined as having a third dose or booster shot.
3. The hospitalisation and mortality rates per 100,000 are age-standardised per 100,000 people per week, standardised to the 2013 European Standard Population.

Source: Public Health Scotland

Exhibit 4.

National trends in demand for hospital services and activity April 2019 – September/December 2021

Hospital activity is increasing but remains lower than pre-pandemic levels. Demand for services and the numbers waiting considerably longer for tests and treatment have increased.

Demand			% change
	April 2019 to September 2021		
Number waiting for diagnostic tests	92,239	125,557	↑ 36.1%
	June 2019 to September 2021		
Number waiting for an inpatient or day case admission	75,608	106,496	↑ 40.9%
Number waiting for a new outpatient appointment	323,408	425,242	↑ 31.5%
Activity			**% change**
	April 2019 to December 2021		
Number of scheduled elective operations in theatre system	27,204	17,836	↓ -34.4%
	April 2019 to September 2021		
Number of inpatient and day case admissions	70,691	45,449	↓ -35.7%
Number of new outpatient appointments seen	361,944	286,935	↓ -20.7%
Length of waits			**% change**
	April 2019 to September 2021		
Number waiting longer than 6 weeks for diagnostic tests	16,446	53,023	↑ 222.4%
	June 2019 to September 2021		
Number waiting longer than 12 weeks for an inpatient or day case admission	23,930	66,602	↑ 178.3%
Number waiting longer than 12 weeks for a new outpatient appointment	86,450	220,888	↑ 155.5%

Source: Public Health Scotland

39. We recommended in our NHS in Scotland 2020 report that data on waiting times based on the categories in the clinical prioritisation framework should be published. This will enable transparency and scrutiny of how NHS boards are managing their waiting lists. Public Health Scotland and NHS boards continue to progress this recommendation and the Scottish Government should work with them to publish this information as soon as possible.

NHS in Scotland 2020
February 2021

40. Referrals are increasing but the impact of delayed or missed diagnosis is a big risk. There is evidence that some people avoided accessing health services, particularly during the first months of the pandemic. This creates the risk that health conditions will go undetected for longer, leading to potentially worse outcomes for people.

41. The first port of call for most people with medical concerns is their GP, who can refer them to specialist services where required. Data on the number of GP appointments carried out is not available, so the extent to which people avoided seeing their GPs during the Covid-19 pandemic is based on survey information and referrals to hospital services.

42. A survey by YouGov has been carried out since the start of the pandemic, to monitor public opinion in Scotland. In December 2021, it found that 25 per cent of respondents would avoid contacting a GP for immediate medical concerns unrelated to Covid-19. This has improved since April 2020 (when it was 45 per cent), but it indicates the significant unknown need that is present.[22]

43. Referrals for outpatient appointments, cancer treatment and psychological therapies decreased significantly between April and June 2020. This is concerning, as it is unlikely to be because of a reduced occurrence of illness. There are longer-term risks associated with delayed or missed diagnosis, such as people becoming more acutely unwell and requiring more intensive treatment.

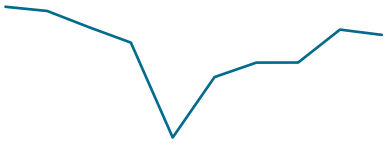
44. Referrals increased throughout 2021, indicating that more people are now seeking help for medical concerns than at the start of the pandemic (Exhibit 5, page 18). Referrals for psychological therapies have now exceeded pre-pandemic levels, and similar trends may be seen in other specialties in future.

45. Clearly the pandemic is having an impact on people's health beyond the direct effects of Covid-19. The scale of delayed diagnosis and treatment and what this means for NHS services and patients is not yet known. The Scottish Government does not yet have an overall strategy for monitoring the wider health impact of Covid-19. Public Health Scotland is monitoring some specific areas, such as the number of undiagnosed cancer cases. But a cohesive strategy is needed to better understand what the wider health impact of Covid-19 will be on NHS services and inform future service provision.

Exhibit 5.

Trend in referrals – April 2019 to September 2021

There were significantly fewer referrals for outpatient appointments, cancer and psychological therapies at the start of the pandemic, but levels have been increasing steadily since.

	April 2019 to September 2021			% change
Number of additions to the outpatient waiting list	464,691		403,770	↓ -13.1%
Referrals to start cancer treatment within 31 days of decision to treat	6,582		6,329	↓ -3.8%
Referrals to start cancer treatment within 62 days of referral	3,907		4,011	↑ 2.7%
Referrals for psychological therapies	38,314		40,528	↑ 5.8%

Source: Public Health Scotland

Demand for urgent and emergency care is putting significant pressure on hospitals

46. During the first few months of the pandemic, the number of people attending accident and emergency departments (A&E) fell significantly, and there were fewer emergency hospital admissions. These have both now increased and are similar to pre-pandemic levels.

47. Additional measures to prevent the spread of Covid-19, such as enhanced infection prevention and control measures, impact on productivity and flow in A&E.[23] This means that it is much more challenging to see and treat people within the four-hour target. For example, between 27 December 2021 and 23 January 2022, 72.9 per cent of unplanned attendances at A&E were seen within four hours, compared with 84 per cent between 30 December 2019 and 26 January 2020.[24]

48. The Scottish Ambulance Service (SAS) has also been under significant pressure. The need for additional PPE has increased the length of time that ambulance crews are spending with patients at the scene, and ambulances are also waiting outside hospitals for considerably longer. This is limiting the ability of ambulance crews to respond to other calls and leading to longer wait times for people who need an ambulance. SAS has required military support to supplement ambulance drivers and staff mobile testing centres. In September 2021, 225 military personnel were drafted in to support SAS.

49. SAS is working to improve the situation. It has accelerated plans to establish a navigation hub to direct paramedics to the most appropriate care for their patients. It is also in the process of recruiting GPs to assess the needs of patients waiting for an ambulance to prioritise their urgency more effectively.

Referrals for mental health services are now exceeding pre-pandemic levels, reflecting the impact of Covid-19 on people's mental health

50. The pandemic has had a considerable impact on mental health. It has been a difficult period for everyone, and lockdowns and physical distancing meant that some people were isolated from friends and family for months. There was, however, a considerable decrease in referrals for both adult and children's mental health services in 2020/21.[25] This is likely to reflect the impact of school closures and limited access to GPs and other services from which referrals are often made, rather than a reduction in demand.

51. In October 2020, the Scottish Government published its mental health transition and recovery plan, to respond to the mental health impacts of the pandemic.[26] The plan contains more than 100 actions, and the Scottish Government has committed £120 million in 2021/22 to take this work forward.[27] Referrals to mental health services and the number of appointments offered have now returned to pre-pandemic levels. In 2022, we plan to carry out further performance audit work on mental health services.

The Scottish Government has started to plan for Long Covid rehabilitation, but the extent of this condition is still unknown

52. Long Covid consists of prolonged symptoms, following a Covid-19 infection, that continue for more than four weeks and are not explained by an alternative diagnosis. In January 2022, an estimated 1.9 per cent of people in Scotland[28] were experiencing Long Covid symptoms.[29] The prevalence of Long Covid in Scotland is based on self-reported data, so this figure may not accurately represent the number of people with the condition. The figure only covers people living in individual

households and does not cover those in communal places of residence, such as care homes.

53. The Scottish Government has funded nine studies to develop the clinical knowledge base for Long Covid and its impact on people's health, which will also inform planning for the expected demand on NHS services.

54. In September 2021, the Scottish Government announced a £10 million Long Covid Support Fund and published its approach to supporting those affected. The approach is based on four key elements: self-management, primary care and community-based support, rehabilitation support, and secondary care services.[30] Many people are able to recover from Covid-19 at home, and the Scottish Government plans to promote self-management where possible. Self-management will also reduce any additional pressure being placed on NHS services. Several pieces of work are under way, including a self-management marketing campaign launched in October 2021.

The Scottish Government aimed to make public health measures inclusive, but some people were disproportionately affected

55. The Scottish Government and NHS Scotland took action to make attempts to control the virus as inclusive as possible. The Scottish Government carried out equality impact assessments (EQIAs) of several measures introduced to respond to the pandemic, such as the expansion of the Near Me video consulting programme. Other measures taken to support an inclusive approach included the following:

- Covid-19 vaccination programme – the Scottish Government and NHS boards worked with partners to increase vaccination uptake and reduce vaccine hesitancy through methods such as improving the accessibility of information, tailoring messages to specific communities and outreach work targeting groups that may be less likely to come forward for vaccinations.
- Test and Protect – working with partners to reach under-represented groups, for example by improving access to testing in targeted settings such as places of worship, making contact tracing scripts more accessible for non-native English speakers and people with other needs, and providing financial support for those self-isolating.

56. The Health and Social Care Alliance Scotland was invited by the Scottish Government to lead engagement work on people's experience of changes to health and social care during the pandemic.[31] The findings of this work included variation in access to services, such as GP services and specialist services. For some, such as those with chronic pain, the reduced access to support resulted in concerns about managing their health. Disability Equality Scotland also reported that disabled people

were anxious about the impact of cancelled or postponed appointments on their health.[32]

57. The Scottish Government and NHS boards should work with patients on an ongoing basis to inform the priorities for service delivery and be clear on how services are developed around patients' needs.

A collaborative approach is required to tackle long-standing health inequalities

58. Our NHS in Scotland 2020 report highlighted that some people have been more adversely affected by the pandemic than others. Those from the most deprived areas and from some ethnic minority backgrounds were more likely to die from Covid-19. Further data has shown that disabled people were more likely to have died from Covid-19.[33] Adults with learning disabilities were also at a greater risk of being hospitalised or dying from Covid-19.[34]

NHS in Scotland 2020
February 2021

59. The pandemic has exacerbated long-standing health inequalities. Life expectancy in Scotland had not changed since 2012–14, and the number of years that people live in good health has started to decrease. The trends in healthy life expectancy show that people living in more deprived areas could expect to live more than 20 fewer years in good health than those living in less deprived areas.[35]

60. Health inequalities continue to be a significant problem in Scotland since we last reported on this topic.[36] The disproportionate impact of Covid-19 on certain groups has led to the Scottish Government increasing its focus on tackling health inequalities, but there is no overarching strategy. Several programmes of work are under way targeting specific areas, for example on improving women's health and mental health, and improving race equality.

61. In September 2021, the Scottish Government published its Race Equality: Immediate Priorities Plan.[37] This aims to ensure a fair and equal recovery from Covid-19 for minority ethnic communities. It sets out the work taking place on race equality across government, as well as the actions being taken to implement the recommendations from the Expert Reference Group for Covid-19 and Ethnicity.

62. While it is positive that these programmes of work are taking place, it only targets some of the groups experiencing health inequalities. For instance, there are no separate plans for people with disabilities or those experiencing homelessness. The Scottish Government should develop an overarching strategy for tackling health inequalities and develop work programmes for all target groups.

63. Improving health and reducing health inequalities require holistic action across the Scottish Government and its partners. Public sector partners can play an important role in changing behaviours. As well as

providing health services, it is necessary to create the conditions that lead to good health, such as employment, education and good quality housing. Better health will also have wider benefits to society and the economy.

64. In December 2020, the Scottish Government established the new Health Inequalities Unit (HIU) within its Population Health Directorate. The HIU aims to embed equity and human rights in the response to the pandemic and across wider healthcare services.

65. The HIU is developing a single health equity vision. This aims to provide NHS boards with clear priorities, but this work is at a very early stage. The HIU includes a fair health team that focuses on the social and economic drivers of health inequality, such as low income, inadequate housing and poverty. The team will work with other government departments including education, social justice and housing, to bring a cross-government approach.

66. The work of the HIU will be crucial to building a sustained approach to reducing health inequalities. Such work should focus on cross-government initiatives and emphasise tackling the wider factors contributing to inequality. The fair health team will have a role in driving this work forward.

Public Health Scotland has had an important role in responding to the pandemic, and work on its wider priorities is now under way

67. Public Health Scotland (PHS) became operational in April 2020, at the start of the pandemic. PHS was established to enable and support local and national bodies to work together to improve health and wellbeing in communities. It has a key role in working with its partners to reduce health inequalities.

68. Since PHS was established, its focus has largely been on responding to the pandemic. This has included developing the Covid-19 daily dashboard, providing public health advice and supporting the Covid-19 vaccination programme. As a newly established body, PHS has also been developing its leadership and organisational structures.

69. PHS has identified priorities as part of its strategic plan 2020–23 and delivery plan 2021–23.[38] [39] These are Covid-19; mental wellbeing; communities and place; and poverty and children. These are complex challenges that will need collective action from PHS and partners across government and the public sector and third sector. Despite the pandemic being a core focus for PHS so far, several pieces of work are now under way, including:

- working with Police Scotland to produce real-time data on suicide and drug-related deaths to allow preventative action

- working with partners to support communities and local planning partners to better consider how climate change will affect their local area and on health and wellbeing
- working with children to develop mental health indicators that capture the key issues for children and young people
- providing guidance to local government on housing and homelessness.

More robust data is needed to understand and respond to long-standing health inequalities

70. Data on health inequalities is often confined to focusing on deprivation and sex, and less data is available on characteristics such as disability and ethnicity. The Scottish Government recognises this and has initiated programmes of work to improve the availability of data that can help inform decision-making. For instance, data is now being collected on Covid-19 vaccination uptake by ethnicity. This provides a better understanding of any inequity in the uptake of the Covid-19 vaccines, which will also allow appropriate action to be taken to increase uptake where it is lower in specific minority ethnic groups.

71. The Scottish Government is developing the Equality Data Improvement Programme. This aims to better understand what equality data is available and the barriers to collecting it, and to promote good practice in collecting better evidence. Some pieces of work have progressed quickly, for example the Scottish Government's chief statistician is leading a programme of work to improve data collation and analysis, by linking healthcare data with other datasets such as census and university data. This aims to improve the analysis of equality characteristics and to enable more preventative work to take place when tackling health inequalities (Case Study 1).

Drug- and alcohol-related deaths remain a serious concern

72. Despite Covid-19 being at the centre of government activity, other significant public health challenges remain. Drug and alcohol-related deaths have increased year on year, with 1,339 drug-related deaths and 1,190 alcohol-specific deaths registered in 2020. Deaths are higher among those living in deprived areas. Scotland's drug related death rates are the worst in Europe, and alcohol specific deaths rates are one of the worst in the United Kingdom.[40] [41]

73. A cross-government approach will be fundamental to providing holistic support for people at risk of drug and alcohol misuse. In the 2020/21 Programme for Government, the Scottish Government committed to investing an additional £250 million over this Parliament's term specifically to tackle the drug death emergency.[42] This will focus on community based support, quick access to treatment and expanding residential rehabilitation.

Case Study 1.
Data linkage to identify the risk factors to homelessness

Linking health data with data on homelessness has illustrated the impact that data can have on outcomes for vulnerable people.

Work led by the Scottish Government's chief statistician has connected these datasets to identify what happened to people before they became homeless. For example, people often go to see their GP about alcohol or drug use, and this information can be linked to other issues such as domestic abuse or involvement in the justice system. Using data in this systematic way helps to predict who is at risk of losing their homes, so that they can receive support to prevent them from becoming homeless in the first place. The use of data in this way supports a multi-agency and preventative approach to homelessness.

Source: Scottish Government

74. The Scottish Government has also committed to publishing quarterly data on drug-related deaths, to enable enhanced monitoring. Data from January to September 2021 shows a four per cent improvement compared to the same period in 2020.[43] But suspected drug deaths remain at a high level and there continues to be an upward trend over the period for which data is available. It is likely that results from new initiatives will take longer to show.

75. We published a drug and alcohol briefing in 2019 and plan to publish a further update in March 2022.[44] This will summarise the ongoing challenges for drug and alcohol services and the improvements needed.

Drug and alcohol services: An update
May 2019

NHS recovery and remobilisation

The Scottish Government's plans for the recovery and redesign of NHS services are ambitious but will be challenging and take a long time to realise

76. The Scottish Government and NHS Scotland are having to balance the immediate priorities of responding to Covid-19 and tackling the ever-increasing backlog of patients waiting to be seen. At the same time, they are planning for how healthcare services can be delivered more sustainably in the future. There is a long road ahead, and it will be challenging to make sufficient progress while dealing with the substantial pressures already in the system, which have been exacerbated by the pandemic.

77. The Scottish Government recognises that innovation and service redesign will be essential for the recovery of NHS services. It has published its NHS recovery plan, which aims to address the substantial backlog in planned care while continuing to meet ongoing urgent health and care needs.[45] The NHS intends to achieve this by increasing the capacity of healthcare services and redesigning patient pathways.

78. Key actions will include opening National Treatment Centres (NTCs) across Scotland to help increase inpatient and day case activity to 20 per cent above pre-Covid levels by 2025/26. Within the same timescale, redesigning care pathways is expected to contribute to an increase in outpatient activity to ten per cent above pre-pandemic levels. The Scottish Government has developed a Centre for Sustainable Delivery (CfSD), which aims to support boards to redesign how services are delivered and embed best practice across Scotland.

79. The ambitions in the plan will be stretching and difficult to deliver against the competing demands of the pandemic and an increasing number of other policy initiatives, such as plans for developing a National Care Service (NCS). The recovery plan will involve new ways of delivering services and these will take a lot of work. There is not enough detail in the plan to determine whether ambitions can be achieved in the timescales set out.

80. In our NHS in Scotland 2017 report we noted the growing complexity in how healthcare is planned, with a mix of local, regional and national planning.[46] The NTCs, CfSD and the NCS have the potential to add to this complexity. It is not yet clear how planning across these

NHS in Scotland 2017
October 2017

different levels will work in practice. It is important that roles and responsibilities, and how they link together, are well defined to ensure:

- there is clear accountability
- it is clear how public money is being used
- the public are easily able to access health and social care services that are joined up effectively.

81. We welcome the Scottish Government's commitment to publishing annual updates on the NHS recovery plan to inform the public on the progress being made.

There are several risks associated with the successful recovery and redesign of NHS services

82. Making significant and ambitious changes in how services are delivered inevitably involves risks. The Scottish Government and the NHS must manage these risks carefully if the objectives set out in the recovery plan are to be achieved.

83. The NHS recovery plan and other key strands of recovery, such as the new Care and Wellbeing Portfolio and the new Digital Health and Care Strategy (paragraph 108), show that the Scottish Government and the NHS have plans in place to manage some of the risks. But it remains to be seen how some other risks will be managed. These are set out in the rest of this section.

New Covid-19 variants could derail recovery plans

84. The emergence of the Omicron variant towards the end of 2021 shows that the future course of the Covid-19 pandemic, and the impact on people's health and NHS services, remains uncertain. There is potential for any new variant to spread more easily, to be more resistant to vaccines, or to result in more severe symptoms. These possible outcomes could all potentially divert efforts away from recovery and back towards the immediate pandemic response.

The Scottish Government must prioritise addressing workforce availability challenges if its recovery plan is to be successful

85. The workforce commitments set out in the recovery plan are significant and build on substantial existing commitments from previous plans (Exhibit 6, page 27).

86. The additional numbers of staff needed to meet the plan's ambitions, alongside existing and potential recruitment challenges, mean that the Scottish Government will need to use innovative recruitment methods to fill positions. The recovery plan includes a commitment to invest £11 million over the next five years in new national and international

recruitment campaigns and establish a Centre for Workforce Supply. There are also plans to increase the number of undergraduate places to study medicine by 100 per year.

87. We have highlighted in previous reports that the NHS has struggled to recruit enough people with the right skills to certain positions, and that the UK's departure from the EU could further reduce the pool of workers available in future years.[47] We also highlighted a lack of robust and reliable workforce data in our NHS workforce planning – part 2 report, particularly in relation to primary care.[48] We are yet to see evidence that this has improved, and there is a risk that it inhibits effective workforce planning. It will also make it difficult to monitor progress in achieving workforce objectives.

NHS workforce planning – part 2
August 2019

Exhibit 6.

New and existing workforce commitments

Existing committments from the Integrated National Workforce Plan 2018

- 800 new mental health workers by 2022
- 500 advanced nurse practitioners
- Increase the GP workforce by 800 by 2027
- 225 new advanced musculoskeletal practitioners by 2024/25
- 30 new reporting radiographer training places over the next three years
- 30 new training places in cardiac physiology

Staffing committments – NHS Recovery Plan 2021/26

- 1,500 new clinical and non-clinical staff for National Treatment Centres by 2026
- 1,000 additional staff in primary care mental health
- 100 more undergraduate medical places per annum and more widening access places
- New recruitment campaigns and establish a Centre for Workforce Supply (£11 million)
- Youth employment opportunities through the Young Person's Guarantee
- Additional training opportunities through the NHS Academy

Source: Scottish Government

88. The Scottish Government, in conjunction with the Convention of Scottish Local Authorities (COSLA), aims to publish a new national workforce strategy for health and social care in early 2022. This will include high level objectives, an action plan covering the short, medium and long term, and projections for anticipated workforce growth. It is crucial that this strategy is aligned with the NHS recovery plan and leads to a more integrated approach to workforce, service and financial planning. Recovery ambitions cannot be met if the right people with the right skills are not in place. We plan to carry out further audit work on this in due course.

Meeting ambitious targets must not come at the expense of staff wellbeing

89. There is clear commitment at Scottish Government and NHS board level to support staff wellbeing, and it features prominently in the NHS recovery plan. However, the plan also outlines significant additional demands on NHS staff that could negatively impact their wellbeing. The ambition to significantly increase activity could undermine the desire to improve staff wellbeing.

90. It will be important for the Scottish Government and health and social care bodies to work together to monitor the progress and evaluate the effectiveness of the new staff wellbeing measures (paragraph 22), and to better understand and provide for staff support needs.

Supporting and developing NHS leaders is vital

91. Leaders in the NHS and Scottish Government have been under considerable pressure throughout the pandemic. The planned NCS will see responsibility for social care transfer from local authorities to Scottish ministers. It will require significant reform which will add further pressure, along with the challenges of responding to the pandemic and the recovery and redesign of NHS services. We set out key risks and challenges in developing a NCS in our response to the Scottish Government's consultation.[49]

92. The recovery and reform of health and social care services needs stable, effective and capable leadership. We have previously highlighted issues with high turnover and short tenures in some NHS leadership positions, as well as concerns about a lack of succession planning and support for new leaders.

93. Over three years ago, the Scottish Government introduced Project Lift. This is a leadership development programme designed to create a more person-centred approach to leadership in the health and social care system. The Scottish Government is now developing a National Leadership Development Programme (NLDP), building on the progress made under Project Lift. The NLDP is at an early stage and is initially

focusing on senior and executive leaders. We will continue to monitor the impact of the NLDP in future audit work.

NHS in Scotland 2018
October 2018

94. The NLDP includes a workstream on succession planning, aimed at creating a system to identify and develop talent for senior leadership roles. In our NHS in Scotland 2018 report we found that a similar succession planning programme was under way.[50] It is not clear how the new workstream links to this previous work.

The Scottish Government needs to ensure that new ways of delivering services are clearly communicated

95. The Scottish Government and NHS boards need to continually engage with the public in a meaningful way to shape priorities for recovery and develop sustainable, person-centred ways of delivering health and social care services. The public will have to access services differently, and that will require a culture change. The Scottish Government and NHS need to clearly communicate to the public any changes to how services should be accessed.

96. The Scottish Government commissioned Health and Social Care Alliance Scotland to engage with the public to identify priorities for accessing services. The priorities it identified put people at the centre of decision-making. The Scottish Government and NHS boards should incorporate these priorities into their plans for the recovery and redesign of NHS services.

The Scottish Government and NHS need to prioritise prevention, early intervention and equity in their recovery plans

97. Early intervention and preventative care are fundamental to the long-term sustainability of NHS services and can help reduce health inequalities. The Scottish Government and NHS need to make sure that the importance of prevention is not lost as they continue to respond to the pandemic and transform how care is delivered. In his September 2021 blog, the Auditor General for Scotland discussed the slow progress in making the shift towards prevention and in improving long-term outcomes for individuals and communities set out in the Christie report.[51]

98. The NHS must prioritise this while also dealing with immediate pressures based on clinical priority and urgency. It will have to address the challenge of moving funding into early intervention and preventative care when there are existing pressures in emergency and planned healthcare.

The collection and use of health and social care data must improve to support decision-making and monitor progress in delivering outcomes

99. The lack of, or analysis of, primary, community and social care data has been a common theme in Audit Scotland reports for several years. This data is important for informed decision-making, planning and scrutiny. It is also needed to demonstrate whether, and the extent to which, government policies and initiatives are delivering improved outcomes. There should be stronger data linkages across the NHS and public sector to help deliver better outcomes for people.

100. Data is a prominent theme throughout the refreshed Digital Health and Care Strategy (paragraph 108). It commits the Scottish Government and COSLA to developing a Data Strategy for Health and Social Care. It also acknowledges the impact that poor data sharing and access to health records can have on the delivery of care and continuity between services. Information governance, assurance and cyber-security will be key elements of the data strategy.

Meeting net zero targets could make the recovery process more challenging

101. Like all public bodies in Scotland, NHS boards are required by law to reduce carbon emissions and become net zero by 2045. NHS Scotland aims to bring this forward to 2040 following consultation on its draft NHS Scotland Climate Emergency and Sustainability Strategy.[52]

102. Net zero requirements add to the challenges of the NHS recovery process and will need additional investment. It is vital that the Scottish Government and NHS make the most of the opportunities arising during the pandemic to reduce carbon emissions in the health sector.

The Scottish Government is developing a Care and Wellbeing Portfolio to improve outcomes and health and social care services

103. The Scottish Government has recognised that a new long-term strategy is needed for health and social care to direct and oversee the recovery and redesign of services. It has set up a Care and Wellbeing Portfolio to set the strategic direction for health and social care in Scotland and to oversee four programmes of work. The programmes and their aims are:

- integrated planned care – to be flexible and adaptable to respond to emerging challenges, embrace rapid change in the delivery of health and care services and be inclusive in the approach to recovery, and promote transformation and innovation to deliver a world class service

- **integrated unscheduled care** – to take a whole system approach to the redesign of services, with an overarching aim of improving outcomes for people and delivering the right care in the right place
- **preventative and proactive care** – to proactively keep people well, independent and in the most appropriate care setting for their needs
- **place and wellbeing** – communities, third sector and public sector organisations working jointly to drive improvement in health and wellbeing and reduce health inequalities of the population within local communities.

104. The Care and Wellbeing Portfolio is at an early stage of development. It has considerable potential and ambitious aims but achieving these will be challenging. The Scottish Government is committed to designing a new coherent and sustainable system, focused on reducing inequality, prioritising prevention and early intervention, and improving health and wellbeing outcomes.

105. Its objectives include developing a decision-making framework that prioritises prevention and early intervention. This is promising, but more detail is needed to determine how it will work in practice.

106. This work will require long-term, dedicated resources and commitment from leaders. It should take a whole-system approach, involving staff across government and other partners across public services and the third sector. The portfolio should embed service redesign, workforce planning, financial planning and capital investment in its approach and governance structure, to ensure that strategies are aligned and are working towards the same goals.

The NHS has implemented a range of new ways of working to improve access to healthcare services

107. Several new ways of working have been introduced throughout the pandemic to enable the NHS to improve access to healthcare services not related to Covid-19. The pandemic has also accelerated improvements that were already under way. The examples shown in Exhibit 7 (page 32) demonstrate the range of and potential for new ways of delivering services emerging from the crisis.

The Scottish Government is committed to embracing digital technologies

108. The Scottish Government is committed to increasing the use of digital technologies as part of the recovery and remobilisation of NHS services. The Scottish Government and COSLA published a revised Digital Health and Social Care Strategy in October 2021.[53] It highlights the progress made during the pandemic, and identifies gaps that need to

Maintaining patient access

The rapid rollout of NHS Near Me and other non-face-to-face consultations helped to maintain some access to healthcare services during the early stages of the pandemic (Exhibit 7).

Exhibit 7.

The NHS has introduced innovative new ways of working throughout the pandemic

There is scope to roll out new ways of delivering services beyond the pandemic with potential benefits to future healthcare provision

Theme	Case study	Benefits
Maintaining patient access	The rapid rollout of NHS Near Me and other non-face-to-face consultations helped to maintain some access to healthcare services during the early stages of the pandemic.	Reduced need for physical attendance at a hospital or GP practice, helping maintain patients at home during the pandemic while reducing the risks associated with delayed diagnosis. There are also timesaving, environmental and travel safety benefits. It helps to reduce the number of missed appointments and cuts back on PPE usage.
Technological innovation in treatment, diagnosis and monitoring	Rollout of faster, simpler alternatives to endoscopic procedures for diagnosing conditions like Barrett's Oesophagus, a known risk factor for oesophageal cancer.	Procedures can be carried out in locations other than traditional hospital environments, like community health centres and GP practices. It frees up senior staff and capacity within endoscopy units and reduces the cost and time needed to diagnose and treat patients.
Using data to improve services	PHS is collaborating with some Scottish universities on the EAVE-II study, which tracks the progress of the Covid-19 pandemic in near real-time across Scotland.	EAVE II shows the difference Covid-19 vaccines make, but it shows that by linking data we can learn about the difference a whole series of interventions can make to Scotland's health. This approach offers opportunity to study other conditions, to describe their risk and the public health benefit of treatments in the future.
Introducing new operational models	The Redesign of Urgent Care (RUC) programme is designed to address the demand issues in urgent and unscheduled care.	The Scottish Government continues to review the new model, but if successful it should reduce A&E waiting times and relieve pressure on A&E staff and ambulance services.
Multi-agency and collaborative working	Local multidisciplinary teams from NHS boards and councils enhanced the oversight of local care homes and wider social care services during the pandemic.	The relationships built up in these multi-disciplinary teams enhanced support for social care services. These relationships will hopefully lay the foundations for further collaborative working and strengthen health and social care integration.

Source: Scottish Government and Audit Scotland

be addressed, particularly digital exclusion. The Accounts Commission's September 2021 blog post on digital exclusion highlights how Covid-19 has exacerbated inequality in this area.

109. The revised strategy aims to improve the care and wellbeing of people in Scotland by making best use of digital technologies and delivery of services. It has three main aims:

- Aim 1 – Citizens have access to, and greater control over, their own health and care data, as well as access to the digital information, tools and services they need to help maintain and improve their health and wellbeing.
- Aim 2 – Health and care services are built on people-centred, safe, secure and ethical digital foundations that allow staff to record, access and share relevant information across the health and care system, and to use digital technology confidently to improve the delivery of care.
- Aim 3 – Health and care planners, researchers and innovators have secure access to the data they need to increase the efficiency of our health and care systems and develop new and improved ways of working.

110. Adopting digital technologies will be crucial to the transformation needed to make sure NHS services are sustainable in the future. But this cannot be done in isolation. It must be part of wider overall service redesign plans that are built around the needs of patients and staff.

NHS finances

The Covid-19 pandemic resulted in significant additional expenditure across the NHS in 2020/21

111. Responding to the Covid-19 pandemic resulted in significant additional costs. In 2020/21, £2.9 billion of funding was allocated across health and social care for Covid-19-related costs.[54] Of this, £1.7 billion was allocated to NHS boards and integration authorities (IAs). In 2020/21, NHS boards' total funding allocation was £16.3 billion (Exhibit 8, page 35). This is 19 per cent more in cash terms than in 2019/20 (£13.7 billion).

112. The Scottish Government provided clear direction to NHS boards about how Covid-19 expenditure should be monitored and reported throughout 2020/21. External auditors found that financial management associated with Covid-19 expenditure was appropriate across all NHS boards, with a clear distinction between reporting of Covid-19 and non-Covid-19 expenditure. Our NHS in Scotland 2020 report sets out detail of the monitoring and reporting arrangements in place during 2020/21.

NHS in Scotland 2020
February 2021

Covid-19 had a considerable impact on NHS boards' ability to achieve efficiency savings

113. Responding to the Covid-19 pandemic has had a considerable impact on NHS boards' ability to deliver efficiency savings. In recognition of this, in February 2021, the Scottish Government stated that it would fully fund NHS boards and Health and Social Care Partnerships (HSCPs) to achieve financial balance for 2020/21.[55]

114. Several NHS boards relied on this support from the Scottish Government in 2020/21. In total, the Scottish Government allocated £102 million to 14 NHS boards for this purpose. The shortfall is recurring, and boards will need to achieve the savings in future years, adding to the substantial financial pressures which existed in the NHS before the pandemic.

115. The Scottish Government is providing additional support to six NHS boards facing a particularly challenging financial position. As part of this, since autumn 2021 these NHS boards have been submitting monthly plans to the Scottish Government on how they plan to achieve savings, with the aim of improving their positions by the start of the 2022/23

Exhibit 8.
A breakdown of NHS funding in 2020/21 and key areas of spending

Total Scottish Government health budget including Covid-19 funding

£18bn

£2.9bn

Of which is Covid-19 funding

35%
of total Scottish budget

£1.7bn
Central Spend

NHS Scotland including Covid-19 funding

£16.3bn

£15.8bn	**£480m**
Revenue	**Capital**
£13.7bn Territorial boards	**£391m** Territorial boards
£2.1bn National boards	**£89m** National boards

Examples of key areas of spend

£8.6bn
Staffing costs
£7.6bn in 2019/20

£2.7bn
Drug and medical supplies
£2.4bn in 2019/20

Notes:
1. Staffing costs include medical and dental (£2bn), nursing (£3.3bn), and other (£3.3bn).
2. Drugs and medical supplies includes prescribed drugs secondary care (£818m), prescribed drugs primary care (£1.1bn), PPE and testing kits (£286m), and medical supplies (£492m).
3. Central spending is the amount spent centrally on behalf of NHS boards – this includes initiatives such as non-discretionary payments (Family Health Services), the £500 thank you payments and the nursing bursary.

Source: Scottish Government 2020/21 Spring Budget Revision, Scottish Government 2020/21 consolidated accounts

financial year. These boards are NHS Ayrshire and Arran, NHS Borders, NHS Dumfries and Galloway, NHS Fife, NHS Highland and NHS Orkney.

116. NHS Tayside has been subject to ongoing parliamentary attention in recent years. In December 2020, we presented a sixth consecutive Section 22 report to the Scottish Parliament on NHS Tayside.[56] This found that NHS Tayside was making progress under its new executive leadership team, financial management was stronger and there were some improvements in service performance. However, there were still

The 2019/20 audit of NHS Tayside
December 2020

Case Study 2.
NHS Tayside

The board operated within its revised financial targets for 2020/21 and achieved its planned efficiency savings of £28.1 million. This was after repaying £3 million to the Scottish Government of its outstanding £7 million borrowed and returning £7 million of its allocated funding to the Scottish Government for re-allocation in 2021/22. In common with all NHS boards, the Covid-19 pandemic has had a significant impact on the focus and priorities of NHS Tayside, and the effect of this on the board's longer-term financial position and savings targets is still uncertain.

Improvements are being made in mental health services in Tayside although significant work is still required. NHS Tayside is considering its response to the recent independent inquiry into mental health services in Tayside, Trust and Respect, Progress Report 2021. The Minister for Mental Wellbeing and Social Care has recently appointed an independent group to provide oversight and assurance, and support progress in improving Tayside's mental health services. We will monitor the board's progress in this area in 2021/22.

In June 2021, the Scottish Government de-escalated NHS Tayside from stage 4 on the escalation framework to stage 2, in relation to financial position, governance and leadership, and performance; and to stage 3, in relation to mental health performance. This further reflects the improvements made by the board.

Source: Audit Scotland

matters to be addressed. The 2020/21 annual audit found that NHS Tayside is continuing to make progress (Case Study 2).

NHS boards face an uncertain and challenging financial position in 2021/22 and beyond

117. The NHS was not financially sustainable before the Covid-19 pandemic, with boards relying on additional financial support from government or non-recurring savings to break even. The scale of the financial challenge has been exacerbated by the pandemic. The cost of delivering services has risen and additional spending commitments made by the Scottish Government add to NHS boards' financial pressures.

118. The Programme for Government 2021-22 sets out the Scottish Government's intention to increase funding for frontline healthcare services by at least £2.5 billion by 2026/27.[57] It also commits to increasing primary care funding by 25 per cent, and to reviewing the NHS funding formula to ensure that the funds are distributed equitably. The Scottish Government has not yet set a date for this review to be completed.

119. The Programme for Government also sets out the commitment to invest £10 billion over the next ten years to replace and refurbish healthcare facilities across Scotland. Of this, a considerable amount, £400 million, will be spent on the NTCs. The Scottish Government has also now committed to bringing forward its target date for the NHS estate to achieve net zero emissions from 2045 to 2040. This will require substantial investment and it is not yet clear whether additional capital funding will be needed to achieve this over and above the £10 billion already announced.

120. The Scottish Government required NHS boards to produce one-year financial plans for 2021/22 because of the ongoing uncertainty about the costs and financial impact of Covid-19 and about what funding would be available. In September 2021, NHS boards and HSCPs submitted updated projections of the costs associated with Covid-19 and remobilisation for the 2021/22 financial year. These showed that they expect to spend £1.5 billion, including predicted unachievable savings of £116.6 million. The main areas of expected spending are as follows:

- Covid-19 vaccination programme – £203.7 million
- testing – £184.6 million
- additional PPE – £158.9 million
- additional staff costs – £95.1 million.

121. The Scottish Government has confirmed that all frontline health-related Barnett consequentials received from the UK Government would continue to be passed on to health and social care in Scotland.[58] At

February 2022, the Scottish Government has confirmed £2.5 billion in Covid-19 health-related consequentials in 2021/22.

122. There is uncertainty in the longer term about what Covid-19 related expenditure will be needed and about what funding will be available. NHS boards should return to medium-term financial planning in 2022/23, to help identify the known factors in NHS funding over the next three to five years and ensure a balance between policy ambitions and available resources.

123. The Scottish Government is working with NHS boards to determine which Covid-19 related costs are likely to become recurring. Uncertainty about how the pandemic will progress makes this particularly challenging. Greater certainty about costs would enable the Scottish Government to develop more accurate funding requirements for NHS boards and would enable NHS boards to develop more accurate financial plans.

124. The Scottish Government has committed to revising the health and social care medium-term financial framework. The timing of this will depend on the impact of Covid-19 across health and social care and planned reforms, including the impact of the Care and Wellbeing Portfolio and establishing an NCS.

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Appendix

Audit methodology

This is our annual report on the NHS in Scotland. Given the continuing challenges of the Covid-19 pandemic in 2021, the report focuses on:

- the ongoing response to the Covid-19 pandemic
- the health impact of the pandemic on the population of Scotland
- the impact of the pandemic on the NHS workforce
- the progress being made towards the recovery and remobilisation of NHS services
- the financial impact of the Covid-19 pandemic on the NHS in Scotland in 2020/21, and challenges for 2021/22 and beyond.

Because of the Covid-19 pandemic, the audit was carried out remotely. Our findings are based on evidence from sources that include:

- strategies, frameworks and plans for responding to Covid-19
- the audited annual accounts and auditors' reports on the 2020/21 audits of NHS boards
- activity and performance data published by Public Health Scotland
- publicly available data and information including results from surveys
- Audit Scotland's national performance audits
- interviews with senior officials in the Scottish Government and some NHS boards.

We reviewed activity and demand information at a national level to present the national picture. We focused on a sample of indicators that cover some of the main activities in the NHS.

NHS in Scotland 2021

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NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**17 March 2022**
Title:	**Partnership Agreement between Health Boards & Counter Fraud Service**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Report Author:	**Kevin Booth, Head of Financial Services**

1 Purpose

This is presented to the Audit & Risk Committee for:

- Assurance

This report relates to a:

- Government policy/directive
- Legal requirement

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

- Safe
- Effective

2 Report summary

2.1 Situation

NHS Scotland Counter Frauds Services (CFS) is part of the National Services Scotland (NSS) and since 2005 a formal partnership agreement has been in place between the Health Boards and CFS. The current partnership agreement is due to expire on 31st March 2022 and as such a new agreement has been reached (see Annex) to extend the agreement period with effect from 1st April 2022 to 31st March 2025.

2.2 Background

The original agreement between Health Boards and CFS was issued in February 2005 (circular HDL (2005) 5 refers). This is the fifth update to the original. Previous iterations were provided in circulars: CEL 18 (2009); CEL 15 (2012); and DL (2016) 3; and DL(2019) 4.

Working with the Directors of Finance, Counter Fraud Champions and the Fraud Liaison Officers, CFS provides NHS Scotland with a central resource to counter fraud, embezzlement, bribery, corruption, systematic theft and other irregularities. It holds Specialist Reporting Agency status with the Crown Office and Procurator Fiscal Service and reports criminal cases on behalf of Health Boards without recourse to any other organisation.

2.3 Assessment

The draft April 2022 Partnership agreement follows on from the previous iteration and clarifies and explains the roles and responsibilities of the partners to the agreement. The partnership agreement states the intention of both parties to promote a counter fraud culture within NHS Scotland.

The types of investigations and other activities that CFS will undertake in partnership with the Boards and their staff are stated. Whilst the escalation procedures for any potential dispute arising are also clarified.

The adoption of the Counter Fraud Standards from 1st April 2022 is the main inclusion into the partnership agreement following on from the last iteration. The twelve components of the standard are stated, and it is the intention of both parties to the agreement to achieve the full compliance within the term of this partnership agreement.

After consultation with the Board's Fraud Liaison Officers, CFS has submitted the draft 2022 Partnership Agreement to Scottish Government for their approval and it is expected that the final draft and the accompanying DL will be submitted to the Directors of Finance before the end of March 2022, ahead of the agreement coming into effect from 1st April 2022.

2.3.1 Quality/ Patient Care

Fraudulent activity influences the resources available to deliver patient care.

2.3.2 Workforce

The partnership agreement clarifies roles and responsibilities between members of NHS Fife and CFS.

2.3.3 Financial

There are no additional cost elements related to the Partnership agreement.

2.3.4 Risk Assessment/Management

The Partnership Agreement helps to safeguard the Boards Financial and Reputational Risk

2.3.5 Equality and Diversity, including health inequalities

N/A.

2.3.6 Other impact

N/A.

2.3.7 Communication, involvement, engagement and consultation

The FLO for NHS Fife attended the quarterly meeting with CFS where the Boards Flo's were updated on the draft agreement and given the opportunity to contribute to any amendments.

2.3.8 Route to the Meeting

The Draft Partnership agreement was shared with the Director of Finance and Strategy prior to feedback being provided on behalf of NHS Fife to CFS.

2.4 Recommendation

- **Assurance**

3.0 List of appendices

N/A

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