NHS Fife Audit and Risk Committee

05 September 2019, 10:00 to 12:00
The Boardroom, Staff Club, Victoria Hospital

Agenda

1. **Apologies for Absence**

2. **Declaration of Members' Interests**

3. **Minutes of Previous Meeting held on 20 June 2019**

Item 3 - Mins Audit & Risk Committee dated 20 June 2019 unconfirmed.pdf (9 pages)

4. **Action List**

Item 4 - A&R Action List 0919.pdf (1 pages)

5. **Matters Arising**

6. **GOVERNANCE - GENERAL**

6.1. **IJB Annual Assurance Statement**

Gillian MacIntosh

Item 6.1 - Assurance Statement Report IJB 2018-19.pdf (9 pages)

6.2. **Corporate Calendar - Future Committee Meeting Dates**

Gillian MacIntosh

Item 6.2 - A&R Schedule of Future Meeting Dates to 2021.pdf (1 pages)

6.3. **Review of Property Transactions**

Barry Hudson

6.3.1. **Add a subitem**

Item 6.3 - B26-20 Property Transaction Monitoring.pdf (9 pages)

7. **GOVERNANCE - INTERNAL AUDIT**

7.1. **Internal Audit - Progress Report/Update on Follow Up Work**

Barry Hudson/Carol Potter

Item 7.1 - NHSF Sept 2019 Progress Report.pdf (12 pages)

7.2. Internal Audit - Summary Report

Barry Hudson

Item 7.2 - Internal Audit Framework.pdf (31 pages)

8. GOVERNANCE - EXTERNAL AUDIT

8.1. Annual Accounts - Progress Update on Audit Recommendations

Carol Potter

Item 8.1-1 - SBAR Annual Audit Report Recommendations.pdf (3 pages)

Item 8 1 - Annual Audit Report Recommendations.pdf (9 pages)

9. RISK

9.1. Board Assurance Framework

Helen Buchanan

Item 9.1 SBAR Update on BAF to NHS Fife Audit and Risk Committee on 050919 V1 0.pdf (6 pages)

Item 9.1 - NHS Fife Board Assurance Framework (BAF) - Environmental Sustainability to FPR 160719.pdf (1 pages)

Item 9.1 - NHS Fife Board Assurance Framework (BAF) - Strategic Planning - CGC 030719.pdf (1 pages)

Item 9.1 - NHS Fife Board Assurance Framework (BAF) - Strategic Planning - FPR 160719.pdf (1 pages)

Item 9.1 - NHS Fife Board Assurance Framework (BAF) - Financial Sustainability - FPR 160719.pdf (1 pages)

Item 9.1 - NHS Fife Board Assurance Framework (BAF) - Workforce Sustainability - to SG 280619.pdf (2 pages)

Item 9.1 -NHS Fife Board Assurance Framework (BAF) - Quality & Safety - CGC 030719.pdf (1 pages)

9.2. Risk Management Report

Helen Buchanan

Item 9.2 - SBAR Update on Risk Management Workplan to NHS Fife Audit and Risk Committee 050919 V 1.0.pdf (3 pages)

Item 9.2 - Appendix 1 NHS Fife Risk Management Work Plan 2018-2019 to Audit Risk Committee on 050919 V1.0.pdf (2 pages)

Item 9.2 - NHS Fife Risk Management Work Plan 2019-2020 to Audit Risk Committee 050919 V1 0.pdf (2 pages)

Item 9.2 - Risk and Controls Evaluation RACES 21 Aug 2019.pdf (8 pages)

10. OTHER

10.1. Issues for Escalation to NHS Board

Martin Black

11. Any Other Competent Business

12. Date of Next Meeting: 9 January 2020 at 10am within The Boardroom, Staff Club, Victoria Hospital.

MINUTES OF THE NHS FIFE AUDIT & RISK COMMITTEE HELD AT 10:30AM ON THURSDAY 20 JUNE 2019 IN THE STAFF CLUB, VICTORIA HOSPITAL, KIRKCALDY.

Present:

Mr M Black, Non-Executive Director (**Chairperson**)
Ms J Owens, Chair, Area Clinical Forum
Cllr D Graham, Non-Executive Director **(from 11am)**
Mrs M Wells, Non-Executive Director
Ms S Braiden, Non-Executive Director

In Attendance:

Mr P Hawkins, Chief Executive
Mr A Brown, Principal Auditor
Mrs H Buchanan, Director of Nursing
Mr A Croxford, Thomson Cooper Accountants
Mr T Gaskin, Chief Internal Auditor
Mr B Howarth, Audit Scotland
Dr G MacIntosh, Head of Corporate Governance & Board Secretary
Mrs C Potter, Director of Finance
Ms K Somerville, NHS Fife Senior Financial Accountant
Ms P Tate, Audit Scotland

ACTION

30/19 APOLOGIES FOR ABSENCE

None from members; as a regular attendee, Mr B Hudson, Regional Audit Manager.

31/19 DECLARATION OF MEMBERS' INTERESTS

Ms Braiden declared an interest in agenda item 11.5 – Losses Schedule – due to a family member's clinical compensation claim.

32/19 MINUTES OF PREVIOUS MEETING HELD ON 16 MAY 2019

The Minutes of the previous meeting were **approved** as an accurate record.

33/19 ACTION LIST

Action 1 – now superseded by the IJB 'stocktake' exercise. The item can be closed
Action 4 – is covered on today's agenda.

34/19 MATTERS ARISING

There were no matters arising.

Governance – Internal Audit

35/19 (a) Annual Internal Audit Plan

Mr Gaskin introduced his report and reminded members that they

had previously considered the report at the May meeting subject to any changes from the Executive Directors Group (EDG). One area initially recommended for inclusion was for a review of sharps management. Following discussion at EDG, however, it was agreed that further dialogue will need to take place with relevant officers around the inclusion of this review. He proposed that the Audit Plan should be reviewed every six months.

The Committee also discussed the IJB Audit Plans, included for information, noting that any recommendations that relate to the also Health Board would be communicated, as per the agreed Information Sharing Protocol. It was agreed that, as integration matures, improved assurances for how risks are managed across the various partners are required, and that internal audit work should be complementary and avoid duplication where possible.

The Audit & Risk Committee **approved** the 2018-19 Internal Audit Operational Plan and **noted** that it may it be subject to revision later in the year, for which approval would be sought. The Committee also **noted** the IJB Strategic Audit Plan 2019-24 and Operational Audit Plan 2019-2020.

Risk

36/19 NHS Fife Risk Management Annual Report - 2018/19

Mrs Buchanan presented the NHS Fife Risk Management Annual Report.

There has been a range of work carried out in the past year, which has contributed to the Board's management of risk, including developments in the following areas:

- Board Assurance Framework
- Adverse Events management and Duty of Candour
- Staff training
- Datix system

She added that NHS Fife was one of the first Boards to have taken forward Complaints Datix in terms of reporting for excellence in care. The Risk Management Framework is currently being reviewed.

The following work will be completed in the next quarter:

- Articulation of the Board's risk appetite
- Agreement on risk management key performance indicators
- Clarification of the delegation of functions to the IJB and the implications for risk management, governance and assurance, in

particular, the treatment of residual risks.
- Update of the Risk Register and Risk Assessment Policy GP/R7

An eHealth BAF is currently being developed and has been to the eHealth Board and will be submitted to the next Clinical Governance Committee for approval.

The Audit & Risk Committee **noted** the report.

Annual Accounts

37/19 Patients Private Funds – Consolidated Abstract of Receipts and Payments for Year Ended 31 March 2019

Mrs Potter advised that NHS Fife as a Board have the responsibility to manage and look after private funds for or on behalf of a number of patients.

This year NHS Fife have had receipts of payments of around £415k and as at 31 March, after deducting payments and other withdrawals, NHS Fife were holding just over £500k of balances for our patients.

She presented the following documentation to the Committee and invited Mr Croxford to speak to these papers:

- Patients' Private Funds – Receipt and Payment Account incorporating the Independent Auditor's unqualified opinion to the Board;

- Thomson Cooper's Audit Completion Memorandum incorporating the Report to Management

- NHS Fife's Draft Letter of Representation to the Auditors

Mr Croxford referred to the Audit Completion Memorandum that highlighted and summarised the wards that have been visited and the outcomes of each visit. He was pleased to report that, in general, the audit testing revealed internal controls to be adequate, well designed and operating effectively.

Mr Black thanked Thomson Cooper on behalf of the Committee for the report and assurances given.

The Audit & Risk Committee **reviewed** the Patients' Private Funds Accounts; **invited** Thomson Cooper Accountant's to report on their audit of the financial statements and **recommended** that the Accounts be approved by the NHS Board.

ACTION

38/19 Endowment Fund – Annual Accounts for Year Ended 31 March 2019

Mrs Potter reported that, in previous years, the Endowment Funds would be formally scrutinised by the Audit & Risk Committee but, on review of the Terms of Reference and the Constitution for the Board of Trustees, it is the responsibility of the Endowment Sub Committee to scrutinise the accounts.

The Endowment Fund Annual Accounts were thus reviewed by the Endowment Sub Committee this morning prior to the Committee's present meeting. Mr Croxford spoke to the audit report on those statements. Pending two separate points, namely:

1. Provide, if available, any confirmatory information from the respective solicitors relating to the four legacies recorded within the accounts
2. At the time of Board's signing of the accounts next week, a view to be provided on whether the value of investments has moved by more than 5%, as this would have an impact on the final figures provided.

The Endowment Sub Committee were content to recommend to the Trustees approval of the accounts subject to these two points.

The new 'glossy' format of the Accounts was commended by the Committee, which was aimed at being of use also to a public-facing audience.

The Audit & Risk Committee **reviewed** the Endowment Fund Accounts; **noted** Thomson Cooper Accountants' report on their audit of the financial statements; and **noted** the Endowment Sub Committee's recommended approval thereof to the Board of Trustees.

39/19 (a) Annual Assurance Statements for 2018/19

(i) Clinical Governance Committee
(ii) Finance, Performance & Resources Committee
(iii) Staff Governance Committee

The Audit & Risk Committee **noted** the signed Annual Assurance for the other standing Committees of the Board.

(b) Service Auditors Reports

Mrs Potter said that there are a number of services run across NHS Scotland that are undertaken at a regional or national level, which include:

Service:	Provided by:
Practitioner & Counter Fraud Services	National Services Scotland
National IT Services Contract	National Services Scotland
National Single Instance of Financial Ledger	NHS Ayrshire & Arran

There are audits undertaken for each of these as required and are detailed in the documentation provided to the Committee. The full reports are made available to the auditors and are available to Committee Members on request.

None of the reports raise any issues of sufficient impact that would require disclosure in the governance statements. The report contains an unqualified opinion from the service auditors.

The Audit & Risk Committee **noted** the unqualified opinion provided for these services which NHS Fife receives from third parties.

(c) Audit & Risk Committee Annual Statement of Assurance

The Audit & Risk Committee **approved** the revised Annual Statement of Assurance for the Audit & Risk Committee 2018/19.

(d) Internal Audit Annual Report

As Chief Internal Auditor, Mr Gaskin advised that, based on work undertaken throughout the year, he has concluded that:

- The Board has adequate and effective internal controls in place;
- The 2018/19 internal audit plan has been delivered in line with Public Sector Internal Audit Standards.

In addition, he was not advising management of any concerns around the following:

- Consistency of the Governance Statement with information that he was aware of from his work;
- The processes adopted in reviewing the adequacy and effectiveness of the system of internal control and how these are reflected;
- The format and content of the Governance Statement in relation to the relevant guidance;
- The disclosure of all relevant issues (the Board has disclosures on the Treatment Time Guarantee, one unannounced HIS inspection and two personal data related incidents).

During the 2018/19 year, 25 audit products were delivered which reviewed the systems of financial management control operating within the Board.

Mr Gaskin briefly took members through each of the key Governance areas, highlighting the findings and audit recommendations given for each. It was agreed that the collation of recommendations under each Committee was helpful for members' consideration. It was noted that Mr Brown has been giving further advice on matters of Information Governance and that the new role of Board Secretary had been a useful point of liaison for the internal audit team.

The Audit & Risk Committee **considered** the report as part of the portfolio of evidence provided in support of its evaluation of the internal control environment and the Governance Statement.

(e) Notification from Sponsored Body Audit Committees

Mrs Potter advised that the Audit & Risk Committee of NHS Fife has a responsibility to ensure any significant issues that are considered to be of wider interest are brought to the attention of the Scottish Government Portfolio Audit & Risk Committee.

The letter from the Scottish Government was received at the end of April 2019. A draft letter was attached for the Chair to sign pending agreement from Committee members that there are no disclosures or significant fraud that needs to be brought to attention.

The Audit & Risk Committee **authorised** the Chair of the Audit & Risk Committee to sign and submit the draft response to Scottish Government Health & Social Care Directorates.

40/19 Draft Annual Accounts for the Year Ended 31 March 2019

(a) Draft Report on Annual Accounts

Mrs Potter reported that NHS Fife has received an unqualified opinion from our independent auditors Audit Scotland on all aspects of the Annual Accounts and that the figures presented confirm that NHS Fife have met their financial targets.

Since 31 March 2019 NHS Fife has not been made aware of any material matters that would need to be reported to the Board that would affect the accounts.

The key results are set out in the summary provided, along with the recommendations for the Committee.

The appointed external auditors are Audit Scotland who review the Financial Statements and look at wider aspects around Financial Management, Sustainability, Governance, Transparency and Best Value.

A number of areas of recommendations and improvements have been identified and are accepted by management.

Mrs Potter brought to the Committee's attention that there had been considerable debate with Audit Scotland throughout the process relating to the calculation of annual leave untaken by staff at 31 March 2019. NHS Fife is required to put into the financial statements Holiday Pay Accrual and this relates to untaken holidays by staff at the end of the financial year. As members of the Committee were aware from previous years, NHS Fife does not have an electronic system that allows NHS Fife to readily identify the number of days that are outstanding at the 31 March. The complexity of this calculation is compounded by the fact that medical and dental staff have different terms and conditions and their holiday year falls in line with their date of employment. This has been reported within Audit Scotland's Annual Report.

NHS Fife use a manual data gathering exercise to determine this calculation and this necessarily brings a degree of estimation and professional judgement. The data gathering for the Agenda for Change staff was based on a sample across the organisation, which identified an average of less than one day per employee. The same estimate of one day was taken for the dental and medical staff this year, which is a different approach to the previous financial year.

Audit Scotland believe that 2.5 days would be a more appropriate estimate, as detailed within their report. This has a difference to the financial statements of over £200k. A course of action has been agreed for the new financial year in terms of having a more robust approach for 2019/20.

It is the role of the Audit & Risk Committee to review the accounts and supporting portfolio of governance and assurance matters on behalf of the Board and recommend approval of the Annual Accounts to the Board meeting next week.

It was acknowledged that the Letter of Representation is a standard letter and is required from the Board back to the external

auditors to confirm that the Board are satisfied that financial statements give a fair and true view of the financial position.

(b) Annual Audit Report for the Board of NHS Fife and Auditor General for Scotland

Mr Howarth presented the Audit Scotland Annual Report, which summarises the findings from their 2018/19 audit of Fife Health Board, and highlighted the following areas from the report:

Financial Management – NHS Fife continues to rely on non-recurring savings and financial flexibility to meet its financial targets.

Financial Sustainability - A high-level three-year financial plan has now been developed, although long-term planning at a regional level is still unclear.

Governance & Transparency – NHS Fife has appropriate governance arrangements in place. There are still concerns over how well the Health & Social Care Partnership is working in Fife.

Paragraph 33 – NHS Fife received additional funding of around £70m, £54m of this on a non-recurring basis.

Value for Money - NHS Fife are quite consistent against the 8 measures that were put in place from the overview last year and achieved a slight improvement from last year. The temporary staffing costs have increased, despite action to reduced this.

(c) Annual Audit Report Cover Letter and draft Letter of Representation (ISA560)

(d) Annual Assurance Statement to the NHS Board

The Committee approved both the Letter of Representation and the Annual Assurance Statement to the NHS Board.

(e) Losses Schedules 2018/19

Mrs Potter introduced this report, noting the overview of the total number of cases and value associated, the largest component linked to compensation or legal cases.

In summary, the Audit & Risk Committee:

- **considered** the draft Annual Accounts for 2018/19;
- **endorsed** the External Auditor's Communication of Audit

Matters, including the draft Independent Auditors' Report;

- **approved** the draft Letter of Representation;
- **approved** the draft Annual Statement of Assurance to the NHS Board; and
- **authorised** the Audit & Risk Committee Chair to recommend to the Board that the Accounts be adopted.

Other

41/19 Issues for Escalation to the NHS Board

Mr Black advised that, due to his tabling his apologies to the meeting, Ms Braiden would represent the Audit & Risk Committee at the Board next week.

42/19 DATE OF NEXT MEETING: Thursday 12 September 2019 at 09.30am, within the Boardroom, Staff Club, Victoria Hospital, Kirkcaldy.

ACTION LIST FROM AUDIT & RISK COMMITTEE – 2019-20

	Title	Action	Lead	Outcome
1	MOU with IJB	Update to September 2018 meeting	CP	Original action now superseded. A meeting with colleagues in the Partnership and Fife Council has recently taken place, to consider the conclusions of the recent Audit Scotland report on Integration and its recommendations for improved H&SCP governance and reporting, with an assessment of the current Fife position to be reported to the Scottish Government by 15 May. Action to be closed as this matter is now being addressed through the H&SCP / NHSF / FC joint response to the Ministerial Steering Group report on Integration, which includes a detailed action plan. This is being led by the Director of Health & Social Care.
2	Patients' Private Funds – Consolidated Abstract of Receipts and Payments for year ended 31.03.18	Archiving of forms for recording specific expenditure prior to audit – ask M Kellet to provide assurance that nothing of concern and ask Finance Dept to review internal control procedures and consider using LearnPro module	CP	Action to be completed as part of year-end accounting process.
3	Annual Accounts Process	Ensure consistency in the format of the Annual Assurance Statements	CP	More consistent approach undertaken this year across the Board's governance committees.

Completed Updated

Fife Health & Social Care Integration Joint Board

Supporting the people of Fife together

DATE OF MEETING:	5 September 2019	
TITLE OF REPORT:	Annual Assurance Statement for IJB	
EXECUTIVE LEAD:	Director of Health and Social Care	
REPORTING OFFICER/ CONTACT INFO:	NAME:	Avril Cunningham
	DESIGNATION:	Chief Internal Auditor
	WORKPLACE:	Fife House
	TEL. NO.:	03451 555555 ext. 446076
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	For Discussion	**For Information**

REPORT

Situation

The Fife Integration Joint Board (IJB) Chief Internal Auditor is required to produce an annual statement of assurance on the adequacy and effectiveness of Corporate Governance and the internal control system of the Integration Joint Board. This report presents the Assurance Statement for the year ended 31 March 2019.

This report is intended to provide some background for Members on the processes adopted for preparing the Assurance Statement, a copy of which is appended to this report.

Recommendation

Members of the NHS Fife Audit and Risk Committee are asked to note my opinion that a medium level of control exists, and that reasonable assurance can be placed on the adequacy and effectiveness of the IJB's systems of corporate governance and internal control in the year to 31 March 2019.

Background

The Assurance Statement contains my overall opinion on the state of corporate governance and internal control within the IJB. That independent opinion is based on the work undertaken by FTF Audit Services and Fife Council's Audit and Risk Management Service (IJB Internal Audit) and reported to this Committee, NHS Fife and Fife Council.

The statement also considers the high level controls and direction across the IJB's activities that contribute positively to the standards required in terms of Corporate Governance and internal control. This includes, for example:

- the development of a corporate governance framework;
- a risk management strategy;
- comprehensive financial management systems;
- regular reviews of financial reports;
- well-defined Chief Officer responsibilities;

- an established Audit and Risk Committee and
- a sound Code of Corporate Governance and its ongoing monitoring and reporting to Committee

It also takes account of External Audit (Audit Scotland) work, the response reports provided to the Audit and Risk Committee by Managers and relevant reports by external inspection agencies.

The Director of Health & Social Care uses the statement, along with information from a number of other relevant sources, as the basis of the IJB Corporate Governance Statement.

Assessment

It is my opinion that a medium level of control exists and that reasonable assurance can be placed upon the adequacy and effectiveness of the Health and Social Care Integration Joint Board's systems of corporate governance and internal control in the year to 31 March 2019.

The reduction in grading from medium-high for the year to March 2017-18 reflects ongoing development of the governance, assurance and risk frameworks and updating of the Strategic Risk Register, the required review of the Performance Management Framework and the budget issues encountered during the year.

Objectives: (must be completed)	
Health & Social Care Standard(s):	
IJB Strategic Objectives:	

Further Information:	
Evidence Base:	
Glossary of Terms:	
Parties / Committees consulted prior to H&SC IJB meeting:	

Impact: (must be completed)
Financial / Value For Money There are no financial impacts arising directly from this report.
Risk / Legal: There are no legal implications arising directly from this report.
Quality / Customer Care: There are no quality/customer care implications arising directly from this report.
Workforce: There are no workforce implications arising directly from this report.
Equality Impact Assessment: An EqIA has not been completed and is not necessary for the following reasons. There are no EqIA implications arising directly from this report.

Consultation: Considered at the IJB Audit & Risk Committee on 5 July 2019.
Appendices: (list as appropriate) 1 **Annual Assurance Statement** 2 **Evaluation Criteria**

ANNUAL ASSURANCE STATEMENT

To the Director of Health and Social Care and the Chief Finance Officer

As Chief Internal Auditor of Fife Integration Joint Board (IJB), I am pleased to present my annual statement on the adequacy and effectiveness of corporate governance and the internal control system of the Health and Social Care Integration Joint Board (IJB) for the year ended 31 March 2019.

Respective responsibilities of management and internal auditors in relation to Corporate Governance and internal control

IJB senior management is responsible for establishing an appropriate and sound system of corporate governance and internal control and monitoring the continuing effectiveness of these systems.

The Chief Internal Auditor is responsible for providing an annual overall assessment of the robustness of the corporate governance and internal control system. However, only reasonable assurance can be given that control weaknesses or irregularities do not exist.

The IJB's Audit and Risk Committee provides independent assurance on the adequacy of the risk management framework, the internal control environment and the integrity of the financial reporting and annual governance processes. In doing so, it places reliance on the NHS Fife and Fife Council (the partners) systems of internal control that support compliance with both organisations' policies and promote achievement of each organisation's aims and objectives, as well as those of the IJB. By overseeing internal and external audit, it plays a crucial role in ensuring effective assurance arrangements are in place.

Sound internal controls

The main objectives of the IJB's corporate governance and internal control systems are to:

- ensure development of and adherence to management policies and directives in order to achieve the IJB's objectives;
- safeguard assets;
- ensure the proper, economic, efficient and effective use of resources;
- secure the relevance, reliability and integrity of information, so ensuring as far as possible the completeness and accuracy of records and
- ensure compliance with statutory requirements.

A sound system of corporate governance and internal control reduces, but cannot eliminate, the possibility of:

- poor judgement;
- human error;
- control processes being deliberately circumvented by employees and others;
- management overriding controls;
- unforeseeable circumstances;
- failure to meet objectives or
- material errors, losses, fraud or breaches of law or regulations.

The work of internal audit

The Chief IJB Internal Auditor plays a critical role in delivering the IJB's strategic objectives by:

- championing best practice in governance;
- objectively assessing the adequacy of governance and management of existing risks;
- commenting on responses to emerging risks and proposed developments and
- giving an objective and evidence-based opinion on all aspects of governance, risk management and internal control.

Fife Council's Audit and Risk Management and the NHS FTF Audit Services, as IJB Internal Audit, provide the internal audit function for the IJB. Both operate in accordance with the Public Sector Internal Audit Standards which apply to Local Government. IJB Internal Audit undertakes an annual programme of work approved by the Audit and Risk Committee based on a five-year strategic audit plan. The strategic audit plan is based on a formal risk assessment process and continually updated to reflect evolving risks and changes within the IJB.

The Chief Internal Auditor is responsible for determining whether appropriate action has been taken on internal audit recommendations or that management has understood and assumed the risk of non-implementation. This is done by means of follow up procedures, and bi-annual reports to the IJB Audit and Risk Committee.

All IJB internal audit reports, including those identifying system weaknesses and/or non-compliance with expected controls, are issued to the Director of Health and Social Care, and copied to Divisional Managers, who are responsible for implementing all agreed recommendations in internal audit action plans.

IJB reports are also issued to the Chair of the Audit and Risk Committee, the Chief Finance Officer and the External Auditor. Audit reports are provided to the Audit and Risk Committee for its scrutiny. Where necessary, the Audit and Risk Committee can seek further reports from the Director of Health and Social Care or the appropriate Divisional Manager.

Similar arrangements are in place both in NHS Fife and Fife Council, and the Chief Internal Auditor places reliance on any relevant work carried out by the internal audit functions of both organisations.

Basis of opinion

My evaluation of the control environment is informed by a number of sources:

- the relevant audit work undertaken by internal audit (in all three organisations) for the year to 31 March 2019, and work carried out in prior years with agreed improvements being implemented in that year or later;
- the assessment of risk completed during the preparation and updating of the strategic audit plan;
- reports issued by Audit Scotland;
- reports issued by other relevant inspection agencies; and
- my knowledge of the IJB's governance, risk management and performance monitoring arrangements.

There are a number of areas of high-level control and direction across the IJB's activities which contribute positively to the standards of internal control in place, for example:

- the ongoing development of a sound corporate governance framework;
- the ongoing review of the risk management strategy and the updating of the Strategic Risk Register;
- comprehensive financial management systems;
- a medium-term financial strategy, and regular reviews of periodic and annual financial reports which indicate financial performance against forecasts;
- the refresh of the strategic plan, including financial and other performance targets;
- unqualified annual accounts for the last 2 years (2016-17 was the first year of operational responsibilities);
- well-defined Chief Officer responsibilities and
- established IJB Audit and Risk Committee.

Audit Findings

Internal and External Audit findings provide evidence that the Health and Social Care Integration Joint Board is in the process of developing a sound system of Corporate Governance and Internal Control which is appropriately monitored and reviewed.

The majority of internal and external audit reports identified that, overall, processes and procedures had met the control requirements, or are working towards them, and revealed only relatively minor non-compliance or system weakness.

Key findings include

- The Health & Social Care Integration Scheme for Fife sets out the IJB's Aims, Outcomes and Functions, and is supported by appropriate policies and protocols for maintaining its Constitution along with Committees for Clinical & Care Governance, Finance & Performance, and Audit & Risk.
- Governance arrangements are in place, such as Financial Regulations and Standing Orders. However, a working group is in the process of reviewing governance documentation and developing a governance framework.
- IJB has a Strategic Risk Register and a Risk Management Strategy and arrangements for reviewing and reporting risks and maintaining the Clinical Care and Governance Risk Register. However, a working group is in the process of reviewing the Strategic Risk Register and the Risk Management Strategy and developing an action plan for embedding Risk Management.
- The IJB Finance and Performance Committee approved the adoption of an IJB Best Value Framework on 31 January 2019, including an assessment on an annual basis on how the IJB has demonstrated best value on management of resources, effective leadership and strategic direction, performance management, joint working with partners, service review/continuous improvement, governance and accountability and engagement with community during the year. The outcome of the annual assessment is to be reported to the Finance and Performance Committee and subsequently to the Board.
- The Integration Joint Board has formally given directions to FC and NHS Fife to carry out each of the functions delegated to IJB, matching the functions delegated by them to IJB under the Integration Scheme. However, the directions currently only relate to financial allocations. This will be subject to review in 2019-20.

- The IJB Strategic Plan for Fife 2016/19 provided appropriate mechanisms for planning to provide delegated HSC functions. Refresh of the Strategic Plan 2019/22 is underway, with the plan due to be submitted to the IJB on 14 August 2019, following submission to the governance committees.
- The Head of Strategic Planning Performance and Commissioning presents a Performance Report to each Finance and Performance and Clinical and Care Governance Committee.
- The Integration Joint Board Accounts for the last two years were unqualified and included an annual Governance Statement.
- The Chief Finance Officer has arrangements in place for the preparation of the annual accounts and future budgeting and financial management, including a 3-year budget and a medium-term financial strategy.
- The Chief Finance Officer presents to each Finance and Performance Committee and IJB a Finance Report that provides members with an update on the current financial position and details the anticipated yearend outturn.
- Significant progress has been made in the last year in reducing the risk of large movements in the risk share at the year end.
- The Workforce and Organisational Development Strategy, and Implementation Plan provide appropriate mechanisms for engaging and communicating with its own workforce and developing the organisation for its delegated HSC functions.
- Whilst a Performance Framework is in place, a review is required to ensure that the information provides sufficient assurance to the Committees through regular focused performance and quality reporting.
- IJB has appropriate mechanisms for reporting to the partners and the public on its delegated HSC functions. Pre-integration engagement and reporting has been maintained through NHS Fife, FC and the Fife Partnership, as well as on-line publishing the regular HSC Finance and Performance integrated reports to Finance and Performance and IJB, and other IJB papers.
- An Information Sharing Protocol compliant with the Scottish Accord on the Sharing of Personal Information has been implemented to provide a high-level governance framework, to be supported by agreements and protocols. Discussions on drafting a data sharing agreement between the IJB as Data Controller and Fife Council as the Data Processor are currently taking place.
- A recent Information Governance internal audit identified good progress towards compliance with the General Data Protection Regulation (GDPR), which came into effect from 25 May 2018.
- Formal arrangements for regular liaison between the IJB Chief Internal Auditor and the IJB Audit Liaison Officer were in place during the year, and an Internal Audit Output Sharing Protocol has been agreed between the IJB, Fife Council and FTF Audit and Management Services (NHS Fife) Chief to enable sharing of internal audit outputs in a controlled manner with Audit Committees for assurance purposes.
- Issues arose with budget forecasting in the Health and Social Care partnership, which
- Where audits and investigations carried out by internal audit in NHS Fife and Fife Council identify processes where control objectives have not been fully achieved or there is a lack of compliance, action is agreed to address these areas for improvement.

However, set against these, my opinion on the level of internal controls has been adversely affected by the following matters:

- An Audit Scotland review of progress on Health and Social Care Integration in November 2018 led to the Ministerial Steering Group report containing recommendations to support progress with integration and effective governance, with a requirement to submit a self-assessment to the Scottish Government in May 2019. The Self Evaluation for the Review of Progress with Integration of Health and Social Care acknowledges areas of challenge in progressing integration. Actions are underway for many of the areas identified as requiring improvement, but little progress has been made to date on delegated hospital and set aside budget requirements, and strategic commissioning of delegated hospital services.
- Whilst some progress has been made, there is still work required by the IJB, NHS Fife and Fife Council in relation to accountability, assurance and governance, and clarity over the ownership of risks regarding delegated services and how the partners will receive sufficient assurance.
- Work is ongoing to review the Strategic Risk Registers and the risk management strategy. The IJB risk management audit has been postponed to 2019/20 to allow time for the risk review to take place, but audit guidance has been offered, as required, to the working group.
- Transformation change, to ensure best value, is ongoing, but concerns have been raised about monitoring and delivery of transformation. A Joint Strategic Transformation Group has been responsible for monitoring implementation of the transformation programme and reporting to the partners.
- Significant overspends are an area for concern and a balanced budget has not been set for 2019/20. However, the financial risk of not setting an in-year balanced budget is mitigated by the three-year financial strategy, and a commitment has been given to achieving a balanced budget from 2020/21.

Level of opinion

Overall, internal controls were operating well and continued improvements to processes are being made.

As part of each audit, a detailed action plan improving controls was agreed, and the outcome monitored. Where control failings or weaknesses were identified, management responded well and have taken appropriate remedial action in line with an agreed, monitored action plan. Follow-up audits show that, whilst not all agreed actions are achieved within the agreed timescales, work is continuing to complete all the action points agreed.

In determining the level of opinion to be provided, I have had regard to five possible categories as detailed in Appendix 2.

Opinion

It is my opinion that a medium level of control exists and that reasonable assurance can be placed upon the adequacy and effectiveness of the Health and Social Care Integration Joint Board's systems of corporate governance and the internal control system in the year to 31 March 2019.

Avril Cunningham
Service Manager, Audit and Risk Management Services, Fife Council, 24 June 2019

Evaluation Criteria

1	**High** level of assurance / well controlled - clean opinion	**:**	internal control objectives have been met - any non-compliance or weaknesses are insignificant.
2	**Medium/high** level of assurance / adequately controlled - clean opinion or qualified opinion	**:**	internal control objectives have been met - any non-compliance or weaknesses are relatively minor and / or relate to specific areas.
3	**Medium** level of assurance / inadequately controlled - qualified opinion	**:**	control objectives have not been fully achieved - control weaknesses or non-compliance are relatively minor but have been identified in a number of areas.
4	**Low/medium** level of assurance - qualified opinion or adverse opinion	**:**	control objectives have not been met - significant or material non-compliance and/or control weaknesses have been identified.
5	**Low** level of assurance – adverse opinion	**:**	control objectives overall have not been met – systemic significant or material non-compliance and/or control weaknesses have been identified.

AUDIT & RISK COMMITTEE

DATES FOR FUTURE MEETINGS

Date
9 January 2020
13 March 2020 (note 2pm start)
14 May 2020
18 June 2020
17 September 2020
17 December 2020
18 March 2021

Please note that all meetings take place in the **Staff Club** and, with the exception of the March 2020 date, start at **10am**

* * * * *

Audit & Risk Committee Meeting

DATE OF MEETING:	05 September 2019
TITLE OF REPORT:	Property Transaction Monitoring (Item 6.3)
EXECUTIVE LEAD:	Tony Gaskin
REPORTING OFFICER:	Barry Hudson

Purpose of the Report (delete as appropriate)		
		For Assurance

SBAR REPORT

Situation and Background

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

The purpose of this report is to advise the Audit and Risk Committee of the Internal audit of the property transaction completed in 2018/19, which provides assurance that the required procedures have been followed.

Assessment

Under the PTH regulations, the Audit and Risk committee is charged with oversight of the monitoring of the process of property transactions. The monitoring process is a cyclical exercise with the Committee receiving details of the property transactions at its May meeting.

Three 2018/19 transactions were advised to the May 2019 Committee , and Internal audit were requested to review all three to ensure the requirements of the PTH were followed.

The audit report assessed each transaction at grade A, i.e. transaction is properly completed with one recommendation, risk assessed as '*merits attention*' which management have accepted.

A clean property transaction return in respect of 2018/19 can therefore be submitted to the SGHSCD by the 30 October 2019 deadline.

Recommendation

The Audit and Risk Committee is requested to note that:

1. The requirements of the PTH have been complied with;
2. The internal audit report is attached at Appendix 1, and
3. Arrangements are in place to issue the Board's Annual Property Transactions Return to SGHSCD by the deadline of 30 October 2019, and that the return be submitted with no significant issues identified.

Objectives: (must be completed)	
Healthcare Standard(s):	The breadth of internal audit work cuts across all Healthcare Standards.
HB Strategic Objectives:	The breadth of internal audit work cuts across all of the strategic objectives within the Board's Strategic Framework.

Further Information:	
Evidence Base:	N/A
Glossary of Terms:	SGHSCD – Scottish Government Health and Social Care Directorates
Parties / Committees consulted prior to Health Board Meeting:	Director of Finance

Impact: (must be completed)	
Financial / Value For Money	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.
Risk / Legal:	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.
Quality / Patient Care:	The Triple Aim is a core consideration in planning all internal audit reviews.
Workforce:	Management responsibilities, skill sets and structures are a core consideration in planning all internal audit reviews.
Equality:	All internal audit reviews which involve review of policies and procedures examine the way in which equality and diversity is incorporated in Board documentation. In addition, equality and diversity is included as a specific topic within our Audit Universe.

FTF Internal Audit Service

Property Transaction Monitoring

Report No. B26/20

Issued To: P Hawkins, Chief Executive
C Potter, Director of Finance

A Fairgrieve, Director of Estates, Facilities & Capital Services
P Bishop, Head of Estates
J Rotheram, Head of Facilities
M Keddie, Property Services Manager

E Ryabov, Chief Operating Officer – Acute Services Division
M Kellet, Director of Health and Social Care

Follow-Up Co-ordinator

Finance, Performance and Resources Committee
Audit and Risk Committee
External Audit

Contents

Draft Report Issued	09 July 2019
Management Responses Received	10 July 2019
Target Audit & Risk Committee Date	12 September 2019
Final Report Issued	**22 July 2019**

CONTEXT AND SCOPE

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

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

3. The following transactions meet the criteria set out in the NHS Property Transaction Handbook for 2018/19:

Sales	**Sale Proceeds**
10 Acre Field, Stratheden	£80,000
34/36 Hazel Avenue, Kirkcaldy	£290,000
Hayfield Clinic, Kirkcaldy	£130,000

4. The Audit and Risk Committee meeting held on 16 May 2019 agreed that all three properties will be audited.

5. Transaction files were examined to ensure that:

   ◊ Property needs are appropriately identified and suitable action taken

   ◊ Transactions are properly managed

   ◊ Certificates are completed as required.

AUDIT OPINION

6. As the audit opinions categories for post transaction monitoring are pre-defined within the Handbook we have not stated an overall opinion on the system but have provided an opinion on each sale using the Handbook categories. A description of the assessment of risks associated with weaknesses identified are given Section 3 of this report.

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

8. Furthermore Section 6.4 states *'The Board is responsible for submitting monitoring reports (including nil returns) to the Scottish Government Health & Social Care Directorates (SGHSCD) no later than 30 October annually. Such monitoring reports should be submitted with appropriate supporting information and explanations for all transactions not classed as Category A*'.

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

   A Transaction has been properly conducted, or

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

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

10. The audit opinions for the transactions concluded in 2018/19 are:

    ◊ Sale of 10 Acre Field, Stratheden: **Category A**

    ◊ Sale of 34/36 Hazel Avenue, Kirkcaldy: **Category A**

    ◊ Sale of Hayfield Clinic, Kirkcaldy: **Category A**

11. A review of the procedures followed for the 2018/19 transactions, confirmed that they were concluded in accordance with the Handbook. We examined evidence which confirms that appropriate advice and guidance was sought and received from the Central Legal Office (CLO) and the appointed external Property Advisers during both transactions.

12. As required by the Handbook, the relevant trawl procedures were carried out as part of the consideration process for the disposal of the three properties. The properties were advertised via trawl notice circulation by the Scottish Government to the Scottish public sector. There was no interest from any other public body for Hayfield Clinic. Fife Council were interested in the land at Stratheden Hospital however this was advertised and sold on open market. Fife Council and Respite Fife were interested in 34/36 Hazel Avenue; Respite Fife withdrew interest and Fife Council purchased the properties in line with valuation.

13. The Mandatory Requirements section of the Handbook requires a Monitoring Proforma to be completed to provide sufficient documentation for audit purposes. This form has been completed for the three property transactions.

14. We were able to confirm that a decommissioning exercise was completed for Hayfield Clinic prior to it being sold, with written documentation being signed off on 22/11/2017 and retained on file.

15. The sale of 10 Acre Field, Stratheden was of land only so a decommissioning exercise was not required.

16. The sale of 34/36 Hazel Avenue was to Fife Council who were the current lease holders and the property was not used by NHS Fife since the beginning of the lease in 1997. Therefore there was no requirement to carry out a decommissioning exercise.

17. Internal Audit Review B27/19 Post Transaction Monitoring recommended that in line with Section C1.18 of the Handbook Certification is required to be signed at the point where an offer for property is to be submitted or accepted. For all three transactions Certification was signed off following final settlement but not at the point where offers were accepted. This was to be addressed with immediate effect. However we noted that

the signing of the certification for the three transactions considered in this review was not being undertaken in line with this recommendation.

- The final settlement of transaction for the sale of 10 Acre Field, Stratheden was on 09/04/2018 and certification wasn't signed off fully until 05/10/2018
- The final settlement of transaction for the sale of 34/36 Hazel Avenue was on 29/06/2018 and certification wasn't signed off fully until 05/10/2018
- The final settlement of transaction for the sale of Hayfield Clinic, Kirkcaldy was on 10/01/2019 and certification wasn't signed off fully until 25/02/2019.

18. Section C2.37 of the Handbook also requires Certification to be signed by the Chief Executive at the date of settlement. The Certification was signed off by the Director of Finance, on behalf of the Chief Executive, on dates significantly after the final settlements (179 days for the Sale of 10 Acre Field, Stratheden, 98 days for the Sale of 34/36 Hazel Avenue and 46 days for Hayfield Clinic.).

ACTION

19. The action plan at section 2 of this report has been agreed with management to address the identified weakness. A follow-up of implementation of the agreed action will be undertaken in accordance with the audit reporting protocol.

ACKNOWLEDGEMENT

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

Barry Hudson BAcc CA
Regional Audit Manager

Action Point Reference 1

Finding:

The two findings reported in our last Post Transaction Monitoring report (B27/19) have recurred in the transactions we have examined this year. These related to non-compliance with the following two sections of the handbook:

- Section C1.18 of the Handbook states that 'Certification should be signed at the point where an offer is to be accepted or submitted'.
- Section C2.37 of the Handbook states that '*Final certification must be completed by the Chief Executive of the Holding Body when the proceeds are received (i.e. date of settlement of transaction)'*.

The non-compliance was found in all three transactions examined as all had been signed off following final settlement but not at the point where offers were accepted and all were signed off by the Director of Finance rather than the Chief Executive on dates significantly after the final settlements (179 days for the Sale of 10 Acre Field, Stratheden, 98 days for the Sale of 34/36 Hazel Avenue and 46 days for Hayfield Clinic).

Audit Recommendation:

An exercise should be undertaken to identify the reasons for these instances of non-compliance with the handbook. Actions should then be taken to prevent these happening for property transactions in 2019/20.

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 requirements of the handbook are impractical therefore a request will be made at the next Scottish Property Advisory Group (SPAG) for requirements C1.18 and C2.37 to be revised to '*at the earliest opportunity*'. There will always be some delays but we will endeavour to reduce this as much as we can.

Action by

Director of Estates, Facilities and Capital Services

Date of expected completion:

31 July 2019

Section 3 Definition of Recommendation Priorities

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

DATE OF MEETING:	5 September 2019
TITLE OF REPORT:	Internal Audit Progress Report and Summary of Reports (Item 7.1)
EXECUTIVE LEAD:	Tony Gaskin, Chief Internal Auditor
REPORTING OFFICER:	Barry Hudson, Regional Audit Manager

Purpose of the Report (delete as appropriate)		
		For Assurance

SBAR REPORT

Situation and Background

The aim of this paper is to brief the Audit and Risk Committee on the audits completed since the last meeting and provide an update on progress towards the completion of the 2018/19 audit plan and the ongoing delivery of the 2019/20 plan.

The Internal Audit year runs from May to April. Since the date of the last meeting the Internal Audit Team has continued to progress the delivery of the 2019/20 plan under the supervision of the Chief Internal Auditor. Audit work is planned to allow the Chief Internal Auditor to provide the necessary assurances prior to the signing of the Board's annual accounts.

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

Assessment

Progress Report

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. An enhanced system of undertaking Audit Follow-up is being progressed, with further detail included within this progress report.

Audit reports issued from May 2019 onwards will be in an improved, more visual format, with revised opinion definitions and risk assessments for each audit finding and recommendation. The progress report therefore contains a mixture of 2019 reports which are reported under the previous format, and 2019/20 reports which use the new format. We will continue to review our progress and audit report formats and seek feedback from clients to ensure that they effectively communicate key findings, assurances and risks and would welcome the views of Audit and Risk

Committee members on the changes.

As of 23 August 2019 actual input against the 2019/20 NHS Fife plan stood at 145 days (27%) of the updated planned audit input of 543 days. We can confirm that we will complete audit work sufficient to allow the Chief Internal Auditor to provide his opinion on the adequacy and effectiveness of internal controls at year-end and to provide robust assurance to the Audit and Risk Committee within his Annual Internal Audit Report.

Improvement Activities

FTF's service to NHS Fife and NHS Forth Valley was subject to External Quality Assessment (EQA) by Midlothian Council on behalf of the Scottish Local Authorities Chief Internal Auditors' Group. Actions from the report are monitored by the FTF Partnership Board who will provide further assurance on progress which will be included in future progress reports.

This progress report includes Key Performance Indicators (KPIs) as set out in the internal audit annual report.

Recommendation

The Audit and Risk Committee is asked to:

I. Note the ongoing delivery of the 2018/19 and 2019/20 NHS Fife internal audit plan

II. Note the proposed changes to the management of the Audit Follow-up system

III. Comment on the change to the reporting format and audit opinion.

Objectives:	
Healthcare Standard(s):	The breadth of internal audit work cuts across all Healthcare Standards.
HB Strategic Objectives:	The breadth of internal audit work cuts across all of the strategic objectives within the Board's Strategic Framework.
Further Information:	
Evidence Base:	N/A
Glossary of Terms:	SGHSCD – Scottish Government Health and Social Care Directorates
Parties / Committees consulted prior to Health Board Meeting:	Director of Finance
Impact: (must be completed)	
Financial / Value For Money	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.
Risk / Legal:	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.
Quality / Patient Care:	The Triple Aim is a core consideration in planning all internal audit reviews.
Workforce:	Management responsibilities, skill sets and structures are a core consideration in planning all internal audit reviews.
Equality:	All internal audit reviews which involve review of policies and procedures examine the way in which equality and diversity is incorporated in Board documentation. In addition, equality and diversity is included as a specific topic within our Audit Universe.

Internal Audit Progress Report

Introduction

This report presents the progress of internal audit activity up to 28 August 2019.

Internal Audit Activity

NHS Fife Completed Audit Work

The following audit products, with the audit opinion shown, have been issued since the last Audit and Risk Committee meeting on 16 May 2019. Each review completed has been categorised within one of the five strands of corporate governance. A summary of each report is included for information within the 'Summary of Audit findings' section.

Audit 2018/19	Opinion on Assurance	Recommendations	Draft issued	Finalised
Audit Process				
B01/19 Annual Audit Plan	N/A	N/A	8 May 2019	20 June 2019
Corporate Governance				
B11/19 Mandatory Training	**B**	Three Priority 3	10 July 2019	27 August 2019
Financial Governance				
B29/19 – Service Contract Expenditure	Moderate Assurance	1 Significant 3 Requires Attention	6 August 2019	28 August 2019
B33/19 - Endowments	B	One Priority 2 Three Priority 3	17 April 2019	5 June 2019
Information Governance				
B31 & 32/19 – Information Governance and eHealth	**C**	Four Priority 2	3 July 2019	5 August 2019

Audit 2019/20	Opinion on Assurance	Recommendations	Draft issued	Finalised
Corporate Governance				
B06 and 07/20 Annual Internal Audit Report and	N/A	Six Priority 2 Two Priority 3	6 June 2019	11 June 2019

Governance Statement				
Financial Governance				
B26/20 Property Transaction Monitoring	Category A	One Priority 3	9 July 2019	22 July 2019
Staff Governance				
B22B/20 Follow up of Staff Lottery (B21C/18)	N/A	Three Merits Attention	12 August 2019	16 August 2019

NHS Fife Draft Reports Issued

Audit 2018/19	Draft issued
B23 and 24/19 – Savings Programme and Financial Planning	28 August 2019
B25/19 – Financial Management	28 August 2019

NHS Fife Work in Progress and Planned:

Audit 2019/20		Status	Target Audit Committee
B08/20	Internal Control Evaluation	Planning	9 January 2020
B09/20	Audit Follow Up – Reporting to Audit and Risk Committee	In Progress	To each meeting, starting in January 2020
B13/20	Risk Management	Planning	9 January 2020
B14/20	Staff and Patient Environment	Planning	9 January 2020
B15 and 16/20	Strategic and Operational Planning – Transformation Programme	Planning	9 January 2020
B21/20	Medicine Management	In Progress	9 January 2020
B23A/20	Attendance Management	In Progress	9 January 2020
B25/20	Capital Management	Planning	9 January 2020
B27/20	Financial Process Compliance	In Progress	9 January 2020
B33/20	Departmental Review -Estates	Planning	9 January 2020

Audit Follow Up

Following initial discussions with the Director of Finance, Internal Audit are currently exploring the possibility of using the DATIX system for Audit Follow Up reporting. This approach has been initially discussed with the Director of Finance. The overall aim is for DATIX to be the repository for recording the status of all internal audit report action points, with reports available from DATIX to allow reporting to the Audit and Risk Committee and Executive Directors.

Internal Audit met key NHS Fife personnel responsible for the operation of DATIX on 20 August 2019. A module has been adapted by the DATIX administrators for internal audit which will allow internal audit to undertake an initial test of change.

The outcome of this test of change will either allow Internal Audit to populate the module with all report action points to start the electronic use of DATIX or will require further adaptation of the system for future reporting.

For the January 2020 Audit and Risk Committee, an enhanced audit follow up report will be produced by Internal Audit, preferably using DATIX if possible or otherwise manually.

Summary of Audit Findings

This section provides a summary of the findings of internal audit reviews concluded since the previous Audit and Risk Committee meeting.

B01/19 Audit Risk Assessment and Planning

Annual audit plan for 2019/20 was approved at the Audit and Risk Committee of 20 June 2019.

B11/19 – Mandatory Training

Audit Opinion – B (Broadly Satisfactory)

Link to strategic / operational risk – NHS Fife aspires to be an exemplar employer and has the following objectives within its Strategic Framework which are relevant to this audit:

- ◊ Create time and space for continuous learning
- ◊ Give staff the skills, resources and equipment needed to do their jobs.

Executive Summary & Agreed Management Action:

NHS Fife has a defined list of mandatory training, with a team responsible for arranging courses. Its mandatory training course list was seen to be directly comparable with similar NHS Boards. We are aware work at national level is being undertaken to define mandatory training for all staff groups to ensure that a consistent approach is adopted throughout NHS Scotland.

There is no specific NHS Fife policy detailing management and staff responsibilities to attend and complete mandatory training. Requirements to undertake training is detailed within individual policies and verbally discussed at corporate induction training.

A system exists to enable management and staff to monitor the completion of mandatory training and investigate non compliance with requirements. However, the information provided is restricted e.g. it does not provide information on individual attendance at courses, so it is not possible to say if the same staff are repeated non-attendees. This limits the use that can be made of this data. Improvements are intended to be provided by the new electronic employee support system (eESS) being introduced across all NHSScotland Boards, which will collate all the information electronically and on an individual basis. This will enable more accurate tracking of compliance with training

requirements, although it will not be available until the end of 2019 at the earliest.

The most recent mandatory training update report (June 2019) presented to the Staff Governance Committee (SGC) detailed a 72% achievement of the annual training requirement for the period 01 June 2018 to 31 May 2019. Figures vary between 58% and 87% for individual mandatory training courses, compared to the 80% target. Initiatives are taken to improve course uptake and meet increases in demand, and these are being reported verbally to the SGC when available.

Agreed findings and management actions were:

- A central record of course updates and reviews will be maintained by the Head of Workforce Development (recruitment ongoing). Assurance will be provided to EDG as this is an operational matter.
- A review of NHS Fife intranet policies and procedures found none specifically relating to mandatory training. Management advised that mandatory training requirements are being addressed as part of national Once for Scotland review and it would not therefore be appropriate for NHS Fife to introduce a standalone policy at this time. In the meantime arrangements will be made to publicise in an appropriate manner the current position regarding mandatory training for the workforce.
- A review of recent reports presented to the SGC indicated that no detail is given on the initiatives being taken to improve course uptake. This would be useful information for the SGC to receive to indicate the action NHS Fife is taking to meet legal training requirements and comply with key quality standards in accordance with organisational policy and regulatory requirements. Management advised that regular updates on this can be built into future reports to EDG and SGC, aligned to national developments

B29/19 Service Contract Expenditure

Audit Opinion – Moderate Assurance

Link to strategic / operational risk –

The NHS Fife Board Assurance Framework (BAF) includes the Quality and Safety Risk which states, *'the risk that due to failure of clinical governance, performance and management systems NHS Fife maybe unable to provide safe, effective person centred care.'*

Executive Summary & Agreed Management Action:

The award of the Managed Service Contract in the Laboratories was appropriately approved by the Finance & Resources Committee in November 2013 for a period of 7 years at an estimated cost of £1.4m per annum. The Laboratory Service holds ISO 15189:2012 accreditation in the Blood Science, Cellular Pathology and Microbiology Departments which is monitored and tested by the United Kingdom Accreditation Service (UKAS).

Internal Audit identified appropriate arrangements in place for the monitoring of the performance of the contract with a comprehensive Business Review report produced and issued by the contractor quarterly to key Senior Management of NHS Fife. This provides clear information on the contract scope and additions, instrument list, unitary charge (fixed cost), contract change notices (CCNs) (variations), statement overview, summary of year to date expenditure against forecast and variation in expenditure and % of expenditure, KPI report, action tracker and minutes of the Quarterly Review meetings. This is further augmented by a quarterly meeting with Senior Management representatives from both NHS Fife and from the Contractor to discuss the performance and operations of the contract along with any service issues.

There are appropriate processes in place to monitor the efficiency of the contract with the contract monitored by quarterly meetings which are informed by the quarterly Business Review Report.

Agreed findings and management actions were:

- The Unitary Contract Payment is appropriately authorised by the Director of Finance (DoF) However, we note that there is no formal update of key changes provided to the DoF before the unitary payment is made. Management have agreed that they will liaise with the DoF to agree key information for an SBAR to be presented to the DoF on an annual basis.
- Audit testing confirmed that the identification and recording of service failures on this contract is robust but there is further scope to enhance the process by performing an independent calculation of the monetary value of service failures/faults and monitoring them to ensure that any service deduction' are receipted on a timely basis. Management have agreed with the contractor that a breakdown of clawback payments will be included in the quarterly Business Report. Management have requested that the contractor provides transparency around the calculation to enable NHS Fife to check and verify the amounts and monitor through to receipt.
- Internal Audit concluded that variations to the contract recorded on the CCNs are of significant monetary value and that three out of the five selected, were in breach of the Standing Financial Instructions (SFIs). Management have agreed to review the process to include formal authority in line with SFIs and a procedure to ensure that all relevant parties are informed of the change and expenditure is monitored and controlled.
- The Managed Service Contract is of significant monetary value and is a critical service of the functioning of NHS Fife Health Board, but the associated risks are not recorded on a departmental risk register. Management have agreed that an internal risk assessment will be performed, held within the Laboratory Quality Management System and reviewed on a yearly basis.

B33/19 Endowments

Audit Opinion – B (Broadly Satisfactory)

Link to strategic / operational risk:

Endowment Policy – '*To ensure that the Endowment Fund is managed within prescribed frameworks and all sources of income are receipted, recorded and utilised within agreed instructions and that risks and operations of the Endowment Fund are monitored at the appropriate forums*'.

Executive Summary & Agreed Management Action:

NHS Fife Endowments Funds policy and procedures are defined in the Fife Health Board Endowment Funds Constitution (updated December 2018) and NHS Fife Financial Operating Procedures, Section 17(a). The Internal Audit review found the stated controls over the governance and operation of the NHS Fife Endowment Funds to be in alignment with guidance issued by the Scottish Government and the Office of the Scottish Charity Register (OSCR). This was also confirmed by OSCRs review of NHS Fife's endowment fund governance arrangements completed and reported in 2018.

Action is being taken by the Board of Trustees and Endowments Sub-Committee to implement the small number of recommendations made by OSCR from its 2018 review of governance arrangements over NHS Fife endowment funds. Consideration has also been given to recommendations arising from the review of NHS Tayside's finances by Grant Thornton with an action plan being created to implement its recommendations. The Board of Trustees is updated on a regular basis on the actions taken in response to all these reports.

Audit testing on income received through donations found it to be allocated to the designated endowment fund specified by donors. For a sample of cash and cheque receipts reviewed, controls as per FOP 17 (a) Endowments were seen to be operating effectively with appropriate receipting recorded. Similarly, the review of a sample of expenditure items confirmed that expenditure was in

line with the charitable purpose of the Endowment Funds.

The Endowment Funds Constitution was reviewed and updated in December 2018 and, in line with OSCR guidance, includes an appropriate description of the duties of Trustees for the governance, management and administration of the endowments charity. Neither an annual workplan or self assessment by the Board of Trustees was in place for 2018/19, but steps have been initiated to introduce both.

A small number of improvements to Board of Trustees governance and the controls in place over endowment income and expenditure were agreed.

B31 & 32/19 Information Governance and eHealth

Audit Opinion – C (Adequate)

Link to strategic / operational risk:

NHS Fife Board Assurance Framework – eHealth Section - *'There is a risk that due to failure of Technical Infrastructure, Internal & External Security, Organisational Digital Readiness, ability to reduce Skills Dilution within eHealth and ability to derive Maximum Benefit from Digital Provision, NHS Fife may be unable to provide safe, effective, person centred care'.*

NHS Fife Corporate Risk Register – Risk 529 – Information Security – '*There is a risk that NHS Fife's information or data assets including patient data, commercially sensitive data or personal data may be compromised through deliberate or accidental misuse of IT Systems, malicious attack designed to damage or steal electronic data, or loss, theft or misuse of paper based records during transportation, clinical process or storage*'.

Executive Summary & Agreed Management Action:

We identified issues with the quality and level of detail included in assurances on Information Governance related matters to the Information Governance and Security Group (IG&SG) and to the Clinical Governance Committee in our annual report (B06/20) and these had not yet been adequately addressed. For the meetings of the IG&SG held in 2018/19 there were instances of verbal updates being provided in place of expected papers, non-presentation of expected papers without explanation and late distribution of papers all of which deny members adequate opportunity to scrutinize papers in advance of the meeting. Issues were also identified regarding the management of Information Governance risks related to activity undertaken in services delegated to the Integrated Joint Board.

Management agreed to:

- Update the terms of reference for the IG&SG to include the assurances required by the group to fulfil its purpose and to arrange for these assurances to be provided
- Prepare a workplan to schedule the business to be considered by the IG&SG in 2019/20
- Require that each item presented to the IG&SG will be in the format of an SBAR (Situation, Background, Assessment, Recommendation report) or will be covered by an SBAR (eg for risk registers or external reports)
- Provide the Clinical Governance Committee and the IG&SG with quarterly reports regarding NHS Fife's status against the controls included in the revised NHS Scotland Information Security Policy Framework which integrates the controls of ISO27001:2013 alongside the legal compliance requirements of NIS:2018 and GDPR:2018 and addresses the features of the Public Sector Action Plan and Cyber Essentials which Boards need to comply with
- Record the Information Governance risks associated with activities undertaken in services delegated to the Integration Joint Board on the NHS Fife Risk Register together with current and planned joint mitigations.

B06 and 07/20 Annual Internal Audit Report and Governance Statement

Annual Internal Audit Report was presented to the 20 June 2019 Audit and Risk Committee meeting.

B26/20 Property Transaction Monitoring

The full report for this audit is presented as a separate agenda item for this meeting.

B22B/20 Follow up of Staff Lottery (B21C/18)

Audit Opinion – N/A

Link to strategic / operational risk: N/A

Executive Summary & Agreed Management Action:

In our opinion significant progress has taken place, with 6 out of the 7 recommendations substantially completed (recommendations 1-6), although recommendation 7 remains outstanding.

As part of the 'The Follow Up Process,' proactive notifications are sent to the Director of Finance on the status of implementation of actions to address recommendations made in internal audit reports. We reviewed the proactive notifications sent to the Director of Finance on the 31 March 2018 and 30 June 2018 and we are pleased to note that they were comprehensive, clear and accurate as to the status of the implementation of actions to address recommendations in B21c/18.

Management have advised that the Lottery Committee minutes will be presented to the APF in the future and in our opinion this formal arrangement will enhance the governance arrangements.

Recommendation 7 stated that the Lottery Committee Annual General Meeting (AGM) should be aligned with the committee meeting to which the annual accounts are submitted. However, the 2019 AGM has not yet taken place and this recommendation therefore remains outstanding. Management advised that the AGM is scheduled for 1 October 2019, to align with the presentation of the annual accounts.

Key Performance Indicators 2019/20

Performance against service specification as at 23 August 2019:

	Planning	Target	05 Sep 2019	9 Jan 2020
1	Audit assignment plans for planned audits issued to the responsible Director at least 2 weeks before commencement of audit	75%	100%	
2	Draft reports issued by target date	75%	100%	
3	Responses received from client within timescale defined in reporting protocol	75%	100%	
4	Final reports presented to target Audit Committee	75%	100%	
5	Number of days delivered against plan	100% at year-end	145	
6	Number of audits delivered to planned number of days (within 10%)	75%	100%	

Audit & Risk Committee Meeting

DATE OF MEETING:	5 September 2019
TITLE OF REPORT:	Internal Audit Framework (Item 7.2)
EXECUTIVE LEAD:	Tony Gaskin
REPORTING OFFICER:	Tony Gaskin

Purpose of the Report (delete as appropriate)		
For Noting and Approval		

SBAR REPORT

Situation and Background

Internal Audit Charter

Public Sector Internal Audit Standards (PSIAS) state:

"*The internal audit charter is a formal document that defines the internal audit activity's purpose, authority and responsibility. The internal audit charter establishes the internal audit activity's position within the organisation, including the nature of the chief audit executive's functional reporting relationship with the board; authorises access to records, personnel and physical properties relevant to the performance of engagements; and defines the scope of internal audit activities. Final approval of the internal audit charter resides with the board."*

In this context, the Board is represented by the Audit and Risk Committee which has delegated responsibility for audit matters.

The Internal Audit Charter was fully updated and approved by the Audit and Risk Committee in September 2018. It is subject to annual review and has been updated to take account of the revised remit of the Audit and risk Committee, the NHS Fife and NHS Forth Valley External Quality Review (EQA) and relevant aspects of the NHS Tayside EQA.

The Internal Audit Charter – Appendix 1 requires to be approved by the Audit and Risk Committee in accordance with PSIAS and will be updated annually.

Specification for Internal Audit Services

FTF Audit provides the internal audit service to NHS Fife as part of a shared service which is hosted by NHS Fife. A Partnership Board comprising the Directors of Finance for NHS Fife, Forth Valley and Tayside has recently been reconstituted for FTF, chaired by the NHS Forth Valley Director of Finance.

FTF Clients include:

- NHS Tayside, NHS Fife, NHS Forth Valley as partners in the Consortium
- NHS Health Scotland
- NHS Lanarkshire as a managed audit service
- Chief Internal Auditor function for Angus, Dundee and Stirling/Clacks IJBs
- Joint Chief Internal Auditor Function for North and South Lanarkshire IJBs

Each mainland Health Board has in place a Consortium Shared Services Agreement (SSA) for Internal Audit Services and a Specification for Internal Audit Services. The SSA and Specification were recently updated and approved by the FTF Partnership Board. The Director of Finance NHS Fife has the delegated responsibility to approve these agreements on behalf of NHS Fife. The Service Specification

for NHS Fife is shown as Appendix 2.

The Service Specification incorporates both the follow-up protocol and the NHS Fife Internal Audit reporting protocol (Appendix 3) which has been updated to reflect current practice and requires the approval of the Audit and Risk Committee. An updated follow-up protocol will be presented to this Audit and Risk Committee for approval to take into account the future proposed changes to the operational management and reporting of AFU to the Audit and Risk Committee.

Assessment

As the Audit and Risk Committee is responsible for "all audit activities", it is important the members of the Audit and Risk Committee have oversight of the Internal Audit function and any specific requirements of PSIAS.

The documents as above provide the Audit and Risk Committee with the background and operational oversight of the internal audit function and allow the Audit and Risk Committee to meet the requirements of PSIAS.

Recommendation

The Audit and Risk Committee is requested to:

1. Note the NHS Fife Specification for Internal Audit Services
2. Approve the updated Internal Audit Charter
3. Approve the updated NHS Fife Internal Audit Reporting Protocol

Objectives: (must be completed)	
Healthcare Standard(s):	The breadth of internal audit work cuts across all Healthcare Standards.
HB Strategic Objectives:	The breadth of internal audit work cuts across all of the strategic objectives within the Board's Strategic Framework.

Further Information:	
Evidence Base:	N/A
Glossary of Terms:	SGHSCD – Scottish Government Health and Social Care Directorates
Parties / Committees consulted prior to Health Board Meeting:	Director of Finance

Impact: (must be completed)	
Financial / Value For Money	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.
Risk / Legal:	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.
Quality / Patient Care:	The Triple Aim is a core consideration in planning all internal audit reviews.
Workforce:	Management responsibilities, skill sets and structures are a core consideration in planning all internal audit reviews.
Equality:	All internal audit reviews which involve review of policies and procedures examine the way in which equality and diversity is incorporated in Board documentation. In addition, equality and diversity is included as a specific topic within our Audit Universe.

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 Fife 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 Fife. The Chief Executive has made arrangements within this Charter for an operational interface with internal audit activity through the Director of Finance.
- FTF Audit and Management Services (FTF) are the Internal Auditors for NHS Fife.

Purpose and responsibility

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

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 Audit and Management Services provides further organisational independence.

The Shared Services Agreement sets out the operational independence of FTF as internal auditors to NHS Fife. 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 and risk 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 Shared Service Agreement (SSA), 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 Manager 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 Audit and Management Services and assigns a named contact to NHS Fife. 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 with 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 Deputy Director of Finance and Board Secretary.

In order to maximise its contribution to the Board's overall system of assurance, Internal Audit will work closely with NHS Fife Executive Directors Group 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 will agree with each Audit and Risk Committee which of these they want reported to them and how often.

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 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 a holistic annual review of risk management will be undertaken by FTF through the Internal Control Evaluation and Annual Report, and review of specific elements of risk management will be 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 Fife. 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 Fife.

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.

Assurances provided to parties outside the organisation;

Internal Audit will not provide assurance on activities undertaken by NHS Fife to outside parties without specific instruction from NHS Fife 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 Fife'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 established 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.

Resolving Concerns

S5.2 of the Specification 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 Management 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: September 2019

Date of next review September 2020.

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 Management 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 B

Specification for Internal Audit Services

APPENDIX B

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 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 Committee and consistent with professional standards and complies with the Internal Audit Charter approved by Audit 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 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 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 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 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 Committee. They will comprise a strategic audit plan and an annual plan in a format agreed with the Audit Committee.

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

4.5. **Strategic Audit Plan**

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 Committee members and management, and be presented by the Chief Internal Auditor for formal approval by the Audit Committee by 31st March. The Strategic Plan should be updated annually in order to inform the Annual Audit Plan.

4.6. **Annual Audit Plan**

The Chief Internal Auditor in each year of the Agreement shall submit to the Audit 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 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.

4.7. **Audit Assignment Plans**

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 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 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 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 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 Committee as a contribution to the control environment within the organisation
- ✧ Audit reporting
- ✧ Attendance at Audit 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 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 Committee with regular reports on progress (see 6.9 below)

6.4. The Audit Committee should approve a formal follow-up protocol for ensuring that agreed Internal Audit recommendations have been actioned. This is incorporated as Appendix IV 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 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 Committee.

6.7. **Individual Audit Project Reporting**

For each audit project, the Internal Auditor shall prepare and submit a draft report of findings in a form agreed by the Audit Committee and Director of Finance. The reporting protocol shall be approved by the Audit 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 Committee.

6.8. **Annual Audit Reporting**

The principal report to be produced by Internal Audit will be the Annual Internal Audit Report for each audit year. This needs be prepared in time for submission to the Audit 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 Committee as requested by the Director of Finance.

6.9. **Progress reporting**

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 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 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.

7.5. Client Satisfaction Survey

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 Committee within the Annual Audit Report.

7.6. In addition, the Chief Internal Auditor will seek to ascertain the views of the Audit 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 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.

10.3. The 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

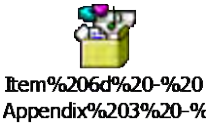
The following performance measures shall be monitored by FTF, reported to the client Director of Finance bi-annually and included within the Annual Internal Audit Report, with comparative figures for the previous year.

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

Appendix II

INTERNAL AUDIT SPECIFICATION

INTERNAL AUDIT REPORTING PROTOCOL



Appendix III

INTERNAL AUDIT SPECIFICATION

Follow-up of agreed Internal Audit Recommendations

Protocol agreed by Client Audit Committee:

Item%2010a%20-%20Follow%20Up%20Pro

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 IV

INTERNAL AUDIT SPECIFICATION
AUDIT SERVICE

Public Sector Internal Audit Standards


PSAIS 2017.pdf

Appendix 3

NHS Fife

INTERNAL AUDIT REPORTING PROTOCOL

1. INTRODUCTION

1.1 This paper details the procedure by which Internal Audit reports are cleared for publication. It clarifies the role and responsibility of Executive Directors (the Responsible Directors) designated by the Chief Executive as being responsible for liaising with Internal Audit within specified areas, consistent with the Scheme of Delegation.

2. PROCESS

2.1 The Annual Internal Audit Plan, presented to the April Audit and Risk Committee for approval, details the audit reviews to be carried out for that year. Prior to the start of a review the Responsible Director is contacted to ascertain whether they or an operational manager within the Directorate (the Responding Officer) will review the audit Assignment Plan and clear the draft report.

2.2 The audit **Assignment Plan** is agreed with the Responsible Director / Responding Officer prior to the commencement of the audit and copied to the Director of Finance.

The Assignment Plan is issued approximately two weeks prior to the commencement of the audit activity.

2.3 At the end of the fieldwork stage of the audit, the auditor will discuss findings with staff, including the Responding Officer.

2.4 Following review by the Regional Audit Manager, a **draft report** is issued to the Responding Officer / Responsible Director for agreement of the accuracy of the findings and consideration of the audit opinion and recommendations detailed in the Action Plan appended to the draft report.

The target deadline for this stage is within 2 weeks of fieldwork end.

2.5 Following discussions with the Responding Officer / Responsible Directors, the **Action Plan** commitments are recorded and line responsibilities determined together with a timeframe for action. It is the responsibility of the Responding Officer and Responsible Director to ensure that the response accurately reflects the official position of the Directorate and the proposed action and timescale for completion is appropriate to the risk.

The target deadline for this stage is within 2 weeks of issue of the draft report.

2.6 In the event of a failure to receive a suitable response from the Responding Officer within the required timescale, or to reach agreement on a fundamental recommendation, the matter will be referred to the Responsible Director.

This will normally take place within 3 weeks of issue of the original draft report.

2.7 In the event of a failure to receive a suitable response from the Responsible Director within the required timescale or to reach agreement on a fundamental recommendation, the matter will be referred to the Director of Finance.

This will normally take place within 4 weeks of issue of the original draft report.

2.8 A **draft final report** is then issued to the Director of Finance for clearance prior to the final report being issued.

The target deadline for this stage is within 2 weeks of issue of the draft final report.

2.9 The **final report** will be prepared and issued by the Office Manager to :

- Chief Executive(s)
- Director of Finance
- Responsible Director
- Responding Officer
- Deputy Director of Finance

- Board Secretary
- Other relevant Officers
- Audit and Risk Committee Members
- External Audit
- Follow Up Co-ordinator

Target deadline is within 1 week of Director of Finance clearance.

2.10 Audit and Risk Committee members receive Internal Audit reports as they are finalised. A paper summarising each audit report issued between Audit and Risk Committees is provided in support of the Progress Report presented by the Regional Audit Manager at each Audit and Risk Committee. All audit reports with an audit opinion in the range D to F will be issued in full with the Audit and Risk Committee papers.

2.11 Progress on reporting timescales will be monitored at the Audit Liaison meetings between the Director of Finance and the Chief Internal Auditor/Regional Audit Manager.

Assignment Milestone	Stage	Processes involved	Responsibilities	Response Time
	Annual Audit Plan agreed	Formulated from Strategic Audit Plan for agreement by Audit and Risk Committee	Regional Audit Manager/Chief Internal Auditor with Executive Directors and Audit and Risk Committee.	
1	Planning Started	Identification and consideration of risks.	Principal Auditor and Regional Audit Manager	
2	Assignment Plan agreed	Terms of reference for the assignment agreed with Audit	Regional Audit Manager with Director of Finance and Responding Officer/Responsible Director	Issued 2 weeks before commencement of audit

3	Fieldwork commenced	Audit team conduct audit assignment in accordance with Job Sheet	Principal Auditor with co-operation of NHS Tayside staff	
4	Fieldwork completed	Audit findings evaluated and draft report prepared for review	Principal Auditor in discussion with NHS Tayside staff for review	
5	Draft report issued to Directorate	Audit report issued to Directorate in draft for review and consideration of action plans	Regional Audit Manager with Principal Auditor to Responding Officer/Responsible Director	Within 2 weeks of fieldwork end
6	Directorate response	Formal response required from Directorate to include completed time bound action plan matrix	Responding Officer with agreement of Responsible Director	Within 3 weeks of draft report release
7	Report issued to Director of Finance	Audit report reviewed for clearance from corporate financial perspective	Regional Audit Manager and Director of Finance	Within 1 week of Directorate response Within 2 weeks of receiving report
8	Final Report released	Report issued in full to relevant NHS Tayside officers and External Auditor. Executive summary to Audit and Risk Committee members	Regional Audit Manager to recipients shown in Para 8 above	Within 1 week Director of Finance clearance

Audit & Risk Committee

DATE OF MEETING:	5 September 2019
TITLE OF REPORT:	Annual Accounts – Progress Update on Audit Recommendations
EXECUTIVE LEAD:	Carol Potter, Director of Finance
REPORTING OFFICER:	Carol Potter, Director of Finance

Purpose of the Report (delete as appropriate)		
		For Assurance

SBAR REPORT

Situation

The purpose of this report is to provide an overview of the recommendations emerging from both the Internal Audit Annual Report and the Audit Scotland Annual Report for 2018/19, and the resultant actions progressed to date.

Background

As part of the overall governance and assurance processes of the Board, both the Chief Internal Auditor and the Board's External Auditor (currently Audit Scotland) are required to provide an annual report within the dimensions of their respective remits.

Assessment

Internal Audit:

The Chief Internal Auditor's report is a key component of a wider portfolio of evidence to support the evaluation of the internal control environment and the Governance Statement set out in the statutory annual accounts. This report is prepared for, and presented to, the Audit & Risk Committee. On 20 June 2019, the Committee received the *Annual Internal Audit Report for 2018/19* which concluded that subject to the matters highlighted in the report narrative and in the appendices to the report:

- "The Board has adequate and effective internal controls in place;
- The 2018/19 internal audit plan has been delivered in line with Public Sector Internal Audit Standards."

In addition, the Chief Internal Auditor confirmed that he had not advised management of any concerns around the following:

- "Consistency of the Governance Statement (GS) with information that we are aware of from our work;
- The processes adopted in reviewing the adequacy and effectiveness of the system of internal control and how these are reflected;
- The format and content of the GS in relation to the relevant guidance;
- The disclosure of all relevant issues."

External Audit:

As part of their initial work on the annual accounts, Audit Scotland prepared a *Management Report*. This report represented the first step in their routine external audit process and was presented to the Audit & Risk Committee in May 2019. The report summarised the key issues identified during the interim audit work carried out in advance of the financial year end. This is a common approach across all public sector bodies and includes testing of key internal controls within financial systems in order to gain assurance over the processes and systems used in preparing the financial statements. In addition, for NHS Boards, there are wider aspects of audit work including financial planning, financial sustainability,

governance & transparency, and best value. The outcome of the report was the conclusion that key controls operate satisfactorily. However, there were control weaknesses identified at the time of the review, which is not uncommon at that stage in the process of external audit work. This report set out a number of specific recommendations for management and also informs the work plan required for the second step of the external audit process, which incorporates the audit of the statutory annual accounts (including the performance report, accountability report and financial statements) and further review and testing of the wider aspects of their work as set out above.

Following completion of this second stage of work, Audit Scotland prepared their *Annual Audit Report for the NHS Board and Auditor General*. This was presented to the Audit & Risk Committee on 20 June and the NHS Board on 26 June alongside the Annual Report and Accounts for the year ended 30 June 2019. Within the Annual Accounts, the independent auditor's report confirmed:

- an unqualified opinion on the financial statements
- an unqualified opinion on the regularity of expenditure and income
- the audited part of the remuneration and staff report performance report and governance statement were all consistent with the financial statements and properly prepared in accordance with the accounts direction
- [they] have nothing to report in respect of those matters which [they] are required by the Auditor General to report by exception

There were a number of recommendations highlighted in the Audit Scotland Annual Report and an accompanying action plan was agreed with management. This action plan, as an appendix to the Annual Report, was presented to the Audit & Risk Committee and NHS Board in the timelines mentioned above

Audit Recommendations:

As described above, both internal and external audit provided a series of recommendations for the Board, with these set out in the form of Action Plans. These are attached as Appendices to this paper, with details of specific actions taken to date for recommendations within the current timescale.

Recommendation

The Audit & Risk Committee is asked to:

- **note** the actions taken to date;
- **note** this update will also be considered by the Finance, Performance & Resources Committee on 10 September;
- **consider** whether any further action or assurance is required by another standing committee of the Board; and
- **request** a regular update at future meetings of the Committee.

Objectives: (must be completed)	
Healthcare Standard(s):	Governance and assurance is relevant to all Healthcare Standards.
HB Strategic Objectives:	All

Further Information:	
Evidence Base:	N/A
Glossary of Terms:	SGHSCD – Scottish Government Health and Social Care Directorates
Parties / Committees consulted prior to Health Board Meeting:	Executive Directors Group

Impact: (must be completed)	
Financial / Value For Money	Financial Governance is a key component of the assurance process.
Risk / Legal:	Actions taken in response to audit recommendations seek to address / mitigate any risks identified
Quality / Patient Care:	Quality & patient care are a core consideration in all aspects of governance including financial governance.
Workforce:	Workforce issues are a core consideration in all aspects of governance including financial governance.
Equality:	Equalities issues are a core consideration in all aspects of governance including financial governance.

Annual Internal Audit Report 2018/19 Action Plan

Finding	Recommendation	Management Response	Responsible Director Action by Date	Update on Progress as at 31 August 2019
1. The annual statements of assurance from the Standing Committees provide an opportunity for reflection on the work of the Committee in the year, key issues for the coming year and the BAF risk4s delegated to the Committee as well as the quality and timing of assurances received. Our work indicates that this opportunity is not always being taken and that the quality of assurances provided by Standing Committees could be improved. Standing Committee Annual Reports do not routinely contain assurances over the BAFs assigned to that Committee.	The Board should consider the process by which the Annual Reports are approved and whether there would be merit in setting aside more time for considered reflection, rather than the Annual Report being potentially considered as just another item on a crowded agenda. The template for Standing Committee Annual Assurance Statements could assist in this process by including: • confirmation that they have considered all items on their workplan • explanations for any exceptions and overt consideration of whether they impact on the Committee's ability to provide meaningful assurance • Consideration of relevant internal and external audit reports (see recommendation 3) and external reviews received and their impact on the assurance provided • Commentary on any BAFs for which the Committee is responsible including: • assurance on the accuracy of the score, • the reasons for any movements in-year • the adequacy and effectiveness of the controls described in the BAF • the sufficiency of actions intended to bring the score to its target level the relevance and reliability of assurances over those controls and actions Some Committees may benefit from additional support/training in understanding the assurance requirements of the Board and we would note that the assurance mapping due for 2019/20 should assist in this process.	At present, Board Committee annual statements of assurance are largely prepared by the lead Director for each Committee, leading to some variability in both format and content. For future years, it is proposed that the Board Secretary co-ordinates their production and work to enhance the current template will be part of that exercise. Consideration will be given to including the additional content above to improve the quality of the assurances given.	**Board Secretary** **31 May 2020**	Initial consideration being given as to how to progress this, taking the advice of the internal auditors on the assurance letter guidance contained within the Scottish Public Finance Manual.
2. Formal assurances were provided by the Executive Directors and Senior Managers of NHS Fife that adequate and effective internal controls have been in place in their areas of responsibility, we note that only seven out of twelve assurance statements included a statement on the risk management arrangements within their area.	As with Standing Committees there is an opportunity to enhance the template but also to consider the process through which these assurance statements are produced and quality assured. Consideration should be given to the SPFM assurance letter guidance which is the subject of ongoing discussions between Internal Audit and the SGHSCD.	A review of the current process for capturing the assurances of senior staff, including the revision of the current template and consideration of which posts should be included in the exercise in future years, has already been agreed in discussions with the External Auditors. The input of Internal Audit would be welcome, to ensure that the new process is fully compliant with SPFM guidance and how this is expected to be implemented locally.	**Director of Finance & Performance and Board Secretary** **31 March 2020**	As above. Amended letter used for recent departure of Director of Health & Social Care.

3. The findings from our annual and interim reviews and other internal audit reports are not routinely reported to the relevant Standing Committee(s). We also noted that Audit Scotland's reports are not routinely presented to the relevant standing committee (eg the Audit Scotland Management Report 2017/18 included a finding relevant to Information Governance but was not presented to the Clinical Governance Committee). We also found areas where findings were reported but were not followed to their conclusion by the Committee. As a consequence, significant governance findings for which the agreed action had not been implemented were not identified by Standing Committees in their annual assurance statements.	Internal Audit reports, including annual and interim reports should be presented to the relevant standing committee(s) and relevant sub-committees/groups as they are published. External Audit findings should be similarly communicated. For significant findings, the Committee should establish a suitable monitoring process and ensure it is followed through to completion.	In conjunction with Internal Audit we will seek to align individual audit reports to a specific Committee of the NHS Board. As and when reports are issued, the distribution of the report will include the lead Director for the relevant Committee, for inclusion at the next meeting. The covering email should include an explicit statement reminding the Director of this responsibility (1). Any actions required and taken will be reported accordingly through the minute (2), with a parallel monitoring process (already in place) via the Audit & Risk Committee for both internal and external audit recommendations (3)	**Internal Audit(1)/Board Secretary(2)/Director of Finance(3)** **30 September 2019**	Actioned initially for September governance committee meetings.
4. There have been significant and persistent delays in taking forward agreed improvements to the Risk Management Framework, going back many years.	An SBAR should be presented to the Audit & Risk Committee highlighting the challenges and reasons for the delay to the revision of the Risk Management Framework and how they will be addressed so that a realistic and achievable implementation schedule can be agreed and monitored and, most importantly, delivered.	We accept the recommendation and a report will be provided as described above	**Director of Nursing** **30 September 2019**	Risk Management report on agenda for A&R September meeting and risk appetite workshops scheduled with all governance committees.
5. Although high level updates on the preparation and approval of the NHS Fife Workforce Strategy have been provided to the SGC in 2018-19 it has not been formally updated on progress towards implementing the NHS Fife Workforce Strategy Action Plan, though we have been informed that the intention is to provide updates to the SGC using the action plan to the new strategy. The Terms of Reference of the NHS Fife Strategic Workforce Planning Group state that '*Work Generated by the group shall be formally reported to EDG and the Staff Governance Committee as appropriate*' but does not include a specific responsibility to provide an annual update on progress against the Workforce Strategy Action Plan to the SGC.	The Terms of Reference of the NHS Fife Strategic Workforce Planning Group should be amended to include a specific responsibility to provide an annual update on progress against the NHS Fife Workforce Strategy Action Plan to the SGC. This is particularly important given that the Workforce Strategy is the key control listed in the Workforce Sustainability BAF. Assurance on progress against the NHS Fife Workforce Strategy from the NHS Fife Strategic Workforce Planning Group to the Staff Governance Committee should be scheduled in the Committee's Annual Workplan for 2019-20 before the SGC Annual Assurance Statement is approved.	The workforce strategy forms part of the current workplan for the Staff Governance Committee. The above recommendation will be incorporated into future workplans and reports will be made as appropriate to the Staff Governance Committee. The ToRs described above will be amended accordingly.	**Director of Workforce** **30 September 2019**	Currently being progressed.
6. The NHS Fife Remuneration Sub-Committee has not undertaken a self assessment using the self assessment pack issued by Audit Scotland for 2017/18 or 2018/19.	The self assessment checklist for the Remuneration Sub-Committee should be completed for the years of 2017/18 and 2018/19. The self assessment should be completed annually before the Remuneration Sub-Committee's Annual Assurance Statement	Discussion on a retrospective self assessment will be discussed at the Sub Committee in June 2019. The self assessment checklist will be incorporated into the overarching Board and Committee self assessment process for 2019/20. Any relevant aspects of the recommendations emerging from national work through the Blueprint for Good Governance will be taken into consideration.	**Director of Workforce** **30 June 2019** **Board Secretary** **31 March 2020**	Confirmed with Scottish Government process for this year's self assessment exercise for this Committee, pending issue of further national guidance for operation of Remuneration Committees.

7. Our recommendation from B08/19 (action point 10) regarding providing the Clinical Governance Committee with adequate assurance regarding compliance with the General Data Protection Regulations (GDPR), the Data Protection Act 2018, the Networks and Information Systems (NIS) Directive, the Public Sector Cyber Resilience Action Plan and the NHS Scotland Information Security Policy Framework has not yet been fully addressed as aside from high level reports on GDPR compliance presented to CGC in January and March 2019 overt assurance on these areas has not been provided. The original timescale for implementation of actions to address this recommendation was by 31 December 2018.	A report should be provided to the NHS Fife Clinical Governance Committee clearly stating the Board's current status of compliance with the General Data Protection Regulations (GDPR), the Data Protection Act 2018, the Networks and Information Systems (NIS) Directive, the Public Sector Cyber Resilience Action Plan and the NHS Scotland Information Security Policy Framework. The report should include overt statements on • How compliance with the NIS Directive will be managed and monitored • How NHS Fife will prepare for external review by the Competent Authority • How existing processes for GDPR, cyber-essentials and any other IG requirements will be assimilated/made congruent with the actions required for the NIS Directive • Overall assessment of likely gaps • Risk assessment.	We accept improvements are required in respect of overt assurance reporting to the Clinical Governance Committee. A detailed report, as described, will be considered by the Information Governance and Security Group in August 2019 for submission to the CGC in September.	**DPO/SIRO** **30 September 2019**	Initially to be considered at the August meeting of IG&SG, with an update to CGC thereafter and full report later in the calendar year.
8. The Executive Director's Annual Assurance Letter from the Chief Operating Officer for Acute Services Division who was identified as the Board's SIRO from 28 January 2019 provided their assurance as SIRO but only for the period from 28 January 2019 to 31 March 2019. No Executive Director's Assurance Letter was requested from the previous SIRO before they left.	The disengagement process for Executive Directors who leave NHS Fife should include obtaining from them an Executive Director's Assurance Letter covering the period they were in post.	We accept the recommendation and a process will be implemented to ensure appropriate assurances are received in the event of a Director leaving post	**Board Secretary** **30 September 2019**	Complete (see 2 above). Process now in place to capture these assurances at times other than year end.

Issue / Risk	Recommendation	Management Response	Responsible Director Action by Date	Update on Progress as at 31 August 2019
1. PECOS access controls In 2017/18 we found three users with approval permissions on the PECOS purchasing system that were not appropriate to their job role. Audit testing this year found one of the users identified last year still had inappropriate access, a further three users had approval rights despite having left the health board and one user had changed roles and access to PECOS was no longer appropriate. **There is a risk that users have inappropriate access to PECOS and erroneous or fraudulent entries could be made.**	User access permissions for PECOS should be reviewed on a regular basis to ensure that the permissions granted are appropriate to job roles and relate only to current employees.	On occasion, individuals may remain on the system with authorisations delegated to their deputy, pending the replacement starting. We will work with eHealth colleagues to ensure the IT access termination documentation also covers PECOS; and with HR colleagues to remind line managers of the requirement to advise on movers/leavers.	***Head of Procurement*** ***31 July 2019***	Currently being progressed.
2. Changes to supplier details We reported last year that in the majority of cases no independent verification of changes to suppliers bank details were sought. From discussions with Finance staff this year there is still no agreed or consistent procedure for verifying changes. The Assistant Director of Finance – Financial Services confirmed the current procedure is to telephone suppliers when a letter from the supplier notifying a change in bank details is received. If an invoice is received that has new bank details on it there is no further verification. **There is a risk of exposure to fraud as not all requests to change bank details are verified from an independent source.**	A formal procedure should be prepared and shared with Finance staff which clarifies that all changes to supplier bank details should be verified as agreed by management in 2017/18.	An email has been sent to all ledger staff confirming the procedure for requested changes to supplier bank details. The desktop procedure is under review.	***Assistant Director of Finance*** ***31 July 2019***	Complete
3. Delivery of savings There is no information on the specific savings plans within the high level workstreams reported in the IPR or the proposals to address outstanding savings. **There is a risk financial targets will not be met as there is no detail on how savings will be achieved.**	Specific and achievable savings plans should be developed to ensure that the Board can deliver the required savings. Sufficient information on these plans should be provided to enable the FP&RC and Board to carry out effective scrutiny.	Detailed savings plans for 2019/20 have been considered via the IJB for Health & Social Care services but these are not sufficient to close the gap overall. The impact on the NHS Fife position has been requested from the Director of Health & Social Care. Detailed savings plans are in development for Acute Services, with a report to the FP&R Committee in May	***Director of Health & Social Care / Chief Operating Officer*** ***31 May 2019***	Discussions ongoing within the IJB in relation to delivery of savings. Deloitte LLP engaged to drive forward a robust programme of savings across Acute Services. Presentation to be provided to the FP&R Committee in September. Delivery of savings, within the context of the overall financial position is a high risk on the BAF
4. Reliance on non recurrent savings NHS Fife continues to rely on non recurrent savings to deliver against the statutory financial target of break even and is relying on financial flexibility to offset the significant overspend within Acute Services. **There is a significant risk that the Board will not deliver the savings required to achieve a balanced budget on a recurring basis which increases the pressure on budgets in future years.**	The Board should take steps to reduce its reliance on non recurrent savings to achieve financial targets.	This issue is recognised and will be addressed in line with the previous action above.		

5. Openness and transparency The NHS Fife website is not user friendly and some information, including committee papers, is either not available or is difficult to find. **There is a risk that the lack of information on the website impacts on the public's perception of the health board's openness and transparency.**	The NHS Fife website requires further improvement to make it more user friendly. Committee papers should be uploaded on a timely basis.	This issue is recognised. NHS Fife intends to invest in the creation of a new website design, hosting and development platform in 2019. This will be equipped witih enhanced search, clear navigation and accessible service modules, viewable on a range of devices. A new content management system will ensure that the new NHS Fife website will be future proof, while still being capable of accommodating and indexing existing historical content. Meantime, a more robust checking procedure has recently been introduced to ensure that Board and Board Committee papers are uploaded timeously after the issue of papers to members and that the resultant file posted on the website is subsequently accessible to all users.	***Head of Communications 31 December 2019***	Procurement process underway
6. Escalation of issues to the NHS Fife Board There is a lack of follow up in relation to some items escalated to the NHS Fife Board by the Board committees. **There is a risk that issues escalated for consideration by the NHS Fife Board are not subject to effective scrutiny at this level.**	Further enhancement of the Board escalation process is required. There should be sufficient time and resources set aside at Board meetings to ensure there is proper consideration of the items escalated from committees. This should include appropriate follow up of ongoing issues.	There is no limitation placed by the Board on the time presently allowed for the escalation of items from Board Committees. Some key issues initially identified by Committees as matters for escalation to the Board can on occasion be covered elsewhere in the agenda, but Committee Chairs are all aware of the need to discuss potential topics for escalation at Committee meetings and explicitly identify these in the cover sheet accompanying Committee minutes. Items for subsequent follow-up by the Board will be flagged as such in the Board's rolling Action List.	***No further action required***	Complete
7. Committee self- assessment process Members have identified several areas to improve the effectiveness of committees but no action on these has been taken to date. **There is a risk that action is not taken on the results of the self-assessment process to improve the effectiveness of governance committees.**	A Board meeting or development session to consider common and/or ongoing issues identified as well as any further improvements to the process should be arranged and appropriate actions agreed.	After initial consideration by each Committee in March, the Board has considered the results of the Committee self-assessment exercise at its scheduled Development Session in April 2019. An action plan has been created, aligning this improvement work with the local implementation of the new NHS Scotland Blueprint for Good Governance, to ensure that governance-related improvements are co-ordinated and standardised across all Board Committees. A revised Committee questionnaire format, taking account of members' feedback on this year's process, will be put in place for the next iteration of the survey, to be undertaken across all Committees in late 2019.	***Board Secretary 31 October 2019***	Update to be given to the Board in November on completion of the current Blueprint Action Plan and work presently underway to revise the standard committee self-assessment questionnaire for completion by members in December 2019.

8. Health and social care partnership arrangements Some of the local challenges around operational and governance arrangements for the health and social care partnership have not been fully resolved. Staff and members are sometimes predisposed towards the interests of their employing organisation rather than the partnership. **There is a risk that the health and social care arrangements in Fife are not operating effectively.**	The operational and governance arrangements between the Board and IJB should be clarified to ensure that staff, senior management and members of the partner bodies work as a partnership.	Fife – like all HSCP's – have been asked by SG & COSLA to complete a self-assessment against the recommendations of the Ministerial Steering Group Review of Integration. That self-assessment is to be completed and returned by 15 May. Senior leaders in the HSCP, NHS Fife and Fife Council met recently to discuss the self-assessment. That is now being worked up and will be agreed amongst all partners before submission on 15 May. The governance structure of the IJB remains under development, though further work has been undertaken in recent months by Partnership colleagues to create H&SCP versions of key governance documents (such as induction manuals and revised Committee Terms of Reference) to address the outstanding deliverables of the IJB's Governance Framework Action Plan (dated July 2018). A proposed review of the Integration Scheme by the parent bodies in 2019 will provide an opportunity to reflect on the current governance structures in place and make further changes to clarify roles and responsibilities, supporting effective partnership working.	***Chief Executive 30 September 2019***	This matter is being addressed through the H&SCP / NHSF / FC joint response to the Ministerial Steering Group report on Integration, which includes a detailed action plan. This is being led by the Director of Health & Social Care.
9. IT data recovery There is no technical recovery procedure for either Trakcare or Patientrack at the present time. Scheduled data recovery testing has not been done for several years. **There is a risk that data recovery procedures are not effective resulting in the loss of data essential to patient care and/or business continuity.**	Technical recovery procedures for critical IT systems should be prepared. IT data recovery should be tested on a rotational basis that ensures all aspects are included, procedures are effective and that staff are familiar with the procedures and can implement them in a variety of scenarios.	Ongoing Network improvements between primary and secondary platforms for these systems will drive new recovery point and time objectives. These will be documented within a Business Impact Analysis (BIA) and new Technical Recovery Procedure Documentation. The BIA will also drive future recovery testing scope and frequency.	***General Manager, eHealth 31 December 2019***	
10. Organisational resilience self-assessment There is no formal action plan to monitor progress in respect of those standards included in the NHRU framework which were identified as not fully implemented following the Board's self-assessment in August 2018. **There is a risk that improvements to the Board's organisational resilience identified from completing the self-assessment are not achieved.**	A formal action plan should be prepared to monitor progress in implementing the NHRU resilience standards.	Whilst the Board has been addressing the issues outlined in the report, a formal action plan has not yet been approved. This will be submitted to the NHS Fife Resilience Forum in July 2019.	***Director of Public Health 31 July 2019***	TBC

11. Cyber security There is no evidence of regular updates on issues such as progress towards achieving cyber essentials accreditation being provided to the Board during 2018/19. **There is a risk that cyber resilience efforts do not receive support and commitment at Board level.**	Updates on progress towards achieving cyber essentials accreditation and other digital issues should be reported to the NHS Fife Board periodically to ensure these receive the necessary support.	A Cyber Resilience Governance plan was agreed under Key Action 2 of the Scottish Government Cyber Resilience Framework 2018. This includes a reporting and assurance path to the NHS Fife Board. The scope and context of these reports are now being devised and will drive the level of detail presented to the Board.	***General Manager, eHealth 31 December 2019***	
12. GDPR compliance We have been informed that the health board is not expected to be fully compliant with GDPR until December 2019. **There is a risk that non compliance could result in data breaches, fines and adverse publicity**	NHS Fife should take action to address compliance with GDPR as a matter of urgency.	NHS Fife currently have the correct policies and procedures in place to satisfy the Information Commissioners Office from a legislative perspective. NHS Fife are conducting a robust audit of the 12 areas in relation to GDPR as part of a business improvement plan, to ensure full compliance which is anticipated to be completed by no later than 31/12/19. Audits in this area will be continuous as compliance is at a 'point in time' and is subject to constant change.	***General Manager, eHealth 31 December 2019***	
13. Sickness absence Sickness absence remains at a high level despite continuing efforts to improve performance. There is no clear action plan to enable more effective scrutiny and no monitoring of what actions are achieving a successful outcome. **There is a risk that sickness absence will remain at a high level and impact on staff morale, quality of care and the achievement of statutory performance targets.**	NHS Fife should develop a better understanding of the underlying reasons behind sickness absence levels and identify those actions which are resulting in improvements. An action plan, with clear objectives and milestones, would help to monitor progress and enable the SGC to scrutinise the process. The Board could also ask other health boards what actions they have taken to improve attendance rates.	Attendance Management is a standing item on the Staff Governance Committee Agenda. This enables monitoring of performance in this area and surveys have been conducted in "hot spot" areas to identify further underlying reasons for absence. The report also includes data on reasons for absence and the work and actions being taken to improve attendance levels. Dialogue has taken place with other Boards in terms of improvement actions. Improvement targets are also being set for all areas. This narrative will be converted into an Action Plan as per the recommendation.	***Director of Workforce 30 September 2019***	Monthly improvement trajectory is discussed at EDG in advance of consideration at APF and Staff Governance Committee. An action plan has been agreed and is being taken forward for the Well @ Work initiative. The recently revised IPQR highlights key improvement actions. This will continue through the year.
14. Transformation programme governance framework Revised transformation programme governance arrangements have not been formally agreed by any NHS Fife or IJB governance committees or the NHS Fife Board. There is a lack of consistency in the understanding of the assurance lines to the Board and its governance committees on the programmes reported separately through the IJB. The JSTG is not operating effectively and the Community Transformation Board does not appear to be operating as expected. **There is a risk that transformational change and implementation of the Clinical Strategy does not progress as planned.**	The transformation programme governance arrangements and any subsequent revisions should be formally agreed by the Board and the IJB The revised framework should clarify the assurance lines to NHS Fife for the transformation programmes led by the IJB, including the remit of the Community Transformation Programme Board	A joint programme of strategic and operational transformation is essential to the sustainability of services. As such we are implementing a refreshed approach under the leadership of the Chief Executive and Director of Finance & Performance; as well as an enhanced framework of performance and accountability between operational services and the Board's governance Committees	***Director of Finance & Performance 30 September 2019***	The need for focus on joint transformation has been recognised and the outcomes from the recent Joint Transformation Workshop will inform the savings plans of the Health Board and IJB for 2020-21. There are also some transformation projects that will contribute to achieving savings targets for 2019-20.

15. Reporting on progress with the transformation programme There is no consistent reporting framework for the transformation programme. There is a lack of focus on targets, milestones and timescales and papers are not always available on a timely basis. **There is a risk that progress with the transformation programme is not subject to effective scrutiny.**	The agreed governance framework should include a basis for reporting to each of the groups identified in the framework, including the CGC and JSTG or its replacement. Reporting on progress should focus on outcomes and timescales and papers should be issued on a timely basis.	This issue is recognised and will be addressed in line with the previous action above		A refresh of the governance arrangements for transformation across Fife is currently being undertaken. A transformation workshop was held in July. A governance framework is currently being discussed and agreed with Fife Council.
16. Update on the Clinical Strategy The report on the Clinical Strategy - Two Years On is overdue. Previous updates on the Clinical Strategy recommendations summarised progress to date but didn't highlight the outstanding actions or identify the timescales needed to ensure all the recommendations are fully implemented by the end of the five year period. **There is a risk that gaps in transformational change required to implement the Clinical Strategy are not identified.**	An annual update on the Clinical Strategy recommendations should be prepared on a timely basis. The update should highlight outstanding areas and how these will be addressed as well as the progress that has been made.	The first annual update of the Clinical Strategy was a very high level document outlining some of the progress against the Clinical Strategy recommendations. Plans were in place to repeat this update but was delayed due a vacancy since February 2018 in the Planning team until March 2019. An update on the progress of the transformation programmes associated with the Clinical Strategy is provided to the Clinical Governance Committee every 2 months. These programmes are reviewed and agreed at the start of each financial year in the Annual Operational Plan which includes the identification of the strategic priorities for NHS Fife. This is the process that would identify risks to the organisation in the delivery of the Clinical Strategy. A paper providing an update on the recommendations from each of the Clinical Strategy workstream reports was provided for the Clinical Governance Committee in March 2019 and described progress of the transformation programmes as well as other improvement work in individual clinical services not captured elsewhere	***Associate Director of Planning & Performance 30 September 2019***	A refresh of the clinical strategy is underway and is expected to be completed by the end of the calendar year.
17. Timetable for unaudited accounts We received the unaudited accounts on 10 May 2019 therefore the deadline of 3 May 2019 agreed in our annual audit plan was not met. We identified several areas where improvements to working papers or dependency on key personnel could improve the efficiency of the audit. **There is a risk his could delay completion of the final accounts audit beyond 30 June.**	NHS Fife should ensure that the agreed timetable for presenting the unaudited annual report and accounts for audit is met and a more complete set of working papers should be readily accessible. Consideration should also be given to addressing key person dependencies.	Agreed. We will review our internal timetable and key responsibilities to ensure the complete draft accounts are available on a timely basis. We accept the level of knowledge and expertise in some technical areas is held by one individual but in a small team it is difficult to have more than one person fully up to speed but where feasible, we will look to put cross over arrangements in place.	***Director of Finance 31 March 2020***	

18. Holiday pay accrual The holiday pay accrual includes medical and dental staff who have individual leave years beginning on the anniversary of their start dates. There is no centralised record of annual leave and data from individual staff are not collected. Management estimates the leave accrual for this group of staff based on the percentage applied to all other staff. This amounted to one day per medical and dental individual. In the previous year this was set as a maximum of five days. The estimate is subject to management bias **There is a risk expenditure is subject to manipulation through management estimates and expenditure for the year is misstated.**	A method of collecting and collating a significant sample of individual balances should be introduced for medical and dental staff.	We will review the sampling method in place to determine if it is feasible to replicate the process for medical & dental staff or identify an alternative means of ensuring a robust approach for this calculation.	***Deputy Director of Finance*** ***31 March 2020***	
19. Efficiency savings NHS Fife is required to achieve efficiency savings of £17 million on a recurring basis from 2019/20. The majority of savings have been allocated to workstreams but the detailed plans on how these will be delivered have yet to be fully developed. **There is a risk financial targets will not be met as there is a lack of clarity in how the required savings will be achieved.**	Detailed savings plans should be developed to ensure that NHS Fife can deliver the required savings.	There are detailed plans in place for the health budgets delegated to the Health & Social Care Partnership (c£7 million). The remaining £10 million target (for the Acute Services Division) is under review and a detailed plan requested for the Finance, Performance & Resources Committee in July 2019. Significant efforts have been made to reduce from a recurring gap of £30 million in 2016/17 to a £17 million gap for 2019/20.	***Chief Operating Officer*** ***31 July 2019***	See items 3 & 4 above.

NHS Fife Audit and Risk Committee

DATE OF MEETING:	5 September 2019
TITLE OF REPORT:	NHS Fife Board Assurance Framework (BAF)
EXECUTIVE LEAD:	Helen Buchanan
REPORTING OFFICER:	Pauline Cumming

Purpose of the Report (delete as appropriate)		
	For Discussion	

SBAR REPORT

Situation

This report updates the Committee on the BAF since the last report on 16 May 2019.

Background

The BAF identifies risks to the achievement of Fife NHS Board's objectives, particularly, but not exclusively related to delivery of the:

- NHS Fife Strategic Framework
- NHS Fife Clinical Strategy
- Fife Health & Social Care Integration Strategic Plan

It integrates information on underpinning operational risks, controls, assurances and mitigating actions, as well providing a brief assessment of current performance.

Assessment

As reported previously to this Committee, the BAF currently has 6 components. These are:

- Financial Sustainability
- Environmental Sustainability
- Workforce Sustainability
- Quality & Safety
- Strategic Planning
- Integration Joint Board (IJB)

See 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 Feb- Mar 2019	Current Level & Rating April- May 2019	Current Level & Rating June- July 2019
1413	**Financial Sustainability**	High 16	Likely 4	Major 4	16 (4x 4) High	16 (4x 4) High	16 (4x 4) High
1414	**Environmental Sustainability**	High 20	Likely 4	Extreme 5	20 (4x 5) High	20 (4x 5) High	20 (4x 5) High
1415	**Workforce Sustainability**	High 20	Almost certain 5	Major 4	16 (4x 4) High	16 (4x 4) High	16 (4x 4) High
1416	**Quality& Safety**	High 20	Likely 4	Extreme 5	15 (3x 5) High	15 (3x 5) High	15 (3x 5) High
1417	**Strategic Planning**	High 16	Likely 4	Major 4	16 (4 x 4) High	16 (4 x 4) High	16 (4 x 4) High
1418	**Integration Joint Board**	High 16	Likely 4	Major 4	16 (4 x 4) High	16 (4 x 4) High	16 (4 x 4) High

Each BAF risk is reviewed and updated regularly by the responsible Executive Director to ensure that its content is relevant, current, and sufficiently detailed.

The risks are reported bi monthly to the standing committee to which they are aligned. Each BAF is supported by a complementary SBAR report providing the Executive Director's assessment of the risk, and highlighting key issues and questions for the committee to consider as part of its scrutinising function. These include:

- Does the risk score feel right?
- Do the current controls match the stated risk?
- Will the mitigating actions bring the risk down to its target level?
- If the mitigating actions are fully implemented would the outcome be achieved?
- Does the assurance provided describe how the controls are performing?
- Do the assurances come from more than one source including independent sources?
- How reliable are the assurances?
- What do they tell me?
- Is anything missing?

Since the last report to the Committee, the BAF risks have been discussed at the respective standing committees in May, June and July 2019. All but the IJB BAFs are provided separately. The IJB is undergoing review by the Interim Director of Health & Social Care.

The current BAFs are progressing through the August / September committee cycle.

Developments:

Further to the last report to the Committee, key points of note are summarised below.

- **Financial Sustainability**

Current Controls

The current controls have been strengthened to include a system-wide Transformation programme. Lessons will be learned from the successes of the medicines efficiency programme in terms of its approach and use of evidence based, data-driven analysis.

Additionally, where appropriate, external support will be appointed to accelerate a programme of cost improvement across Acute Services.

Mitigating Actions

Actions around engagement with Health & Social Care / Council colleagues on the risk share methodology further emphasise the need to ensure that Executive Directors' Group, Finance, Performance & Resources Committee and the Board are appropriately advised on the options available to manage any overspend within the IJB before applying the risk share arrangement.

Current Performance

The current score reflects the ongoing financial challenges facing Acute Services in particular, and the early stage in the delivery of efficiencies across the health budgets delegated to the Health & Social Care Partnership.

Changes in Linked Risks

Risk 1357: Financial management, planning and performance. The risk level has decreased from high to moderate as a result of the likelihood of the risk reducing from likely to possible and the risk is no longer on the BAF.

- **Environmental Sustainability**

There are no changes to report in relation to the overarching BAF risk. Estates and Facilities continue to work to address the risks as and when funding allows.

- **Workforce Sustainability**

There are no changes to report in relation to the overarching BAF risk. The national shortage of radiologists remains a high risk.

Changes in Linked Risks

Risk 1420: Loss of consultants in the Rheumatology Service. The risk level has decreased from high to moderate and is no longer on the BAF.

- **Quality & Safety**

There are no changes to report in relation to the overarching BAF risk.

Linked Risks:

Two risks were added:

Risk ID 1502:3D Temperature Monitoring System (South Lab).This relates to the age of the hardware and issues associated with technical support from the supplier. The risk level had increased from moderate to high.

Approval has been received from the Equipment Review meeting to acquire a replacement system. An order has been placed for new equipment and the department is now awaiting confirmation of delivery note and installation plan.

Risk ID 1524: Oxygen Driven Suction. This relates to the potential for portable oxygen on a resuscitation trolley to run out quickly if oxygen driven suction is used simultaneously.

The Chair of the Capital Equipment Management Group is in the process of securing funding to allow purchase of electro mechanical suction on the VHK and QMH resuscitation trolleys.

- **Strategic Planning**

Mitigating Actions

The group is now chaired by the Chief Executive, NHS Fife.

Key changes relate to the redefinition of the role and purpose of the Joint Strategic Transformation Group (JSTG) and refocusing of its work plan on delivery and sustainability.

A workshop took place on 23 July 2019 to review and share progress of programmes.

Gaps in assurance

In July 2019 these were reported around the governance of programmes through JTSG.

Current Performance

Challenges associated with delivery of the strategic objectives continue to include the focus on the 4 key priorities:

1. Acute Transformation Programme
2. Joining Up Care (including Urgent Care, Community Hubs & Community Hospital Redesign)
3. Mental Health Redesign
4. Medicines Efficiencies

Key health issues and challenges will be escalated to EDG and the Executive Board. Governance will continue to be with the 4 committees (x2 NHS and x2 IJB).

A refreshed Acute Transformation Programme is being developed.

Integration Joint Board

Continuing to develop with the Health and Social Care Partnership.

eHealth BAF

An eHealth BAF has been developed. It was approved by the eHealth Board on 24 May 2019 and will be reported to the Clinical Governance Committee on 6 November 2019.

Recommendation

The Committee is invited to:

- **Note** the BAF
- **Note** the developments

Objectives: (must be completed)	
Healthcare Standard(s):	To aid delivery
HB Strategic Objectives:	Supports all of the Board's strategic objectives

Further Information:	
Evidence Base:	A broad national and international evidence base informs the delivery of safe, effective, person centred care in NHS Fife.
Glossary of Terms:	N/A
Parties / Committees consulted prior to Health Board Meeting:	Executive Directors Staff Governance, Clinical Governance and Finance, Performance & Resources Committees

Impact: (must be completed)	
Financial / Value For Money	Promotes proportionate management of risk and thus effective and efficient use of scarce resources.
Risk / Legal:	Inherent in process. Demonstrates due diligence. Provides critical supporting evidence for the Annual Governance Statement.
Quality / Patient Care:	NHS Fife's risk management system seeks to minimise risk and so support the delivery of safe, effective, person centred care.
Workforce:	The system arrangements for risk management are contained within current resource.
Equality:	The arrangements for managing risk apply to all patients, staff and others in contact with the Board's services.

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?	Responsible Person	Timescale	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
Environmental Sustainability																													
1414	Sustainable, Clinically Excellent	07/06/2019	07/09/2019	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	4 - Likely - Strong possibility this could occur	5 - Extreme	20	High	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.	Director of Estates, Facilities & Capital Services (E,F &CS)	Finance, Performance & Resources (F,P&R) Chair: 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 2. Increase number of site audits	Director of Estates, Facilities & Capital Services Estates Quality Manager	Ongoing as limited funding available 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	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		Current Risk Rating	Risk Owner
1296	Emergency Evacuation - VHK- Phase 2 Tower Block		High 20	A Fairgrieve
1384	Microbiologist Vacancy		High 20	TBC
1252	Flexible PEX hoses Phase 3 VHK - Legionella Risk		High 15	A Fairgrieve
1007	Theatre Phase 2 Remedial work		High 15	M Cross
1207	Water system Contamination STACH		High 15	A Fairgrieve

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Reason for unlinking from BAF	Current Risk Rating	Risk Owner
735	Medical Equipment Register	No longer high risk	Moderate 10	D Lowe
749	VHK Phase 2 - Main Foul Drainage Tower Block	Risk Closed		
1083	VHK CL O2 Generator - Legionella Control	Risk Closed		
1275	South Labs loss of service due to proximity of water main to plant room	No longer high risk	Moderate 8	D Lowe
1306	Risk of pigeon guano on VHK Ph2 Tower Windows	No longer high risk	Moderate 12	D Lowe
1312	Vertical Evacuation - VHK Phase 2 Tower Block	No longer high risk	Moderate 10	A Fairgrieve
1314	Inadequate Compartmentation - VHK - Escape Stairs and Lift Enclosures	No longer high risk	Low 6	A Fairgrieve
1315	Vertical Evacuation - VHK Phase 2 - excluding Tower Block	Risk Closed		
1316	Inadequate Compartmentation - VHK - Phase 1, Phase 2 Floors and 1st - risk of fire spread	No longer high risk	Moderate 12	A Fairgrieve
1335	Fife College of Nursing - Fire alarm potential failure	Risk Closed		
1341	Oil storage - risk of SEPA prosecution/ HSE enforcement due to potential leak/ contamination/ non compliant tanks	No longer high risk	Moderate 10	G Keatings
1342	Oil Storage - Fuel Tanks	No longer high risk	Moderate 10	J Wishart
1352	Pinpoint malfunction	Risk Closed		
1473	Stratheden Hospital Fire Alarm System	Risk Closed		

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?	Responsible Person	Timescale	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
Strategic Planning																													
1417	Person Centred, Clinically Excellent, Exemplar Employer, Sustainable	**15/01/2019**	**01/09/2019**	There is a risk that NHS Fife will not deliver the recommendations made by the Clinical Strategy within a timeframe that supports the service transformation and redesign required to ensure service sustainability, quality and safety at lower cost. **Key Risks** 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 JSTG remains with 4 committees - 2 from the IJB and 2 from NHS. This may impact on effectiveness of scrutiny. 3. Regional Planning risks around alignment with regional plans are currently reduced as regional work is focussed on specific workstreams.	4 - Likely - Strong possibility this could occur	4 - Major	16	High	4 - Likely - Strong possibility this could occur	4 - Major	16	High	The transformation programmes have been agreed and reports to the Joint Strategic Transformation Group. Organisational challenges have impacted on the meeting schedule. Meeting have been paused from February 2019 until a full review has been undertaken. The workplans is at varying stages of development with some programmes more advanced than others. Reporting of progress of transformation programmes has improved with written updates to JSTG for two of the programmes. Papers to IJB produced about the other two programmes.	Medical Director	Clinical Governance	*Ongoing actions designed to mitigate the risk including:* 1. Establishment of IMPACT in 2016 - a small internal business unit which provides focussed, co-ordinated, client tailored support to accelerate delivery of NHS Fife's strategic objectives. Provides a programme management framework to ensure the programme is delivered. 2. Establishment of the Joint Strategic Transformation Group (JSTG) to drive the delivery of the H&SC Strategic Plan and the Clinical Strategy. 3. 3 of the 4 key strategic priorities are being taken forward by the H&SCP/IJB. The remaining priority is being taken forward by Acute services and progress shared through regular highlight reports. Programme Boards provide oversight and strategic guidance to the programme. Collaborative oversight is provided by the JSTG. 4. NHS Fife is a member of SEAT with executive attendance at Regional Planning meetings. Progress is being made in some areas. 5. NHS Fife is a member of the East Region Programme Board established to develop the East Region Health and Social Care Delivery Plan and is represented by directors on all workstreams. 6. Establishment of the Executive Board to provide strategic and operational oversight of the health boards services including the transformation programmes. 7. The Service Planning Reviews have taken place for 2019/20 -21/22 which will inform actions to deliver Clinical Strategy and prioiritise transformation programmes.	JSTG not performing role adequately but tranformation programmes being progressed.	Leadership to strategic planning coming from the Executive Directors Group. Clinical Strategy workstream update has been produced to reflect progress against recommendations. First meeting of refreshed JSTG chaired by Chief Executive held on 16 April. Due to other commitments, workshop planning for June is now being held on 23 July 2019. 1. The NHS Fife CEO chairs the Acute Services workstream of the East Region Health and Social Care Delivery Plan. Plan has not bee published so workstreams have been paused and specific work taken forward by SEAT 2. Chief Executive and Chief Operating Officer participate in Regional planning via SEAT and appropriate sub/working groups.	Chief Executive Chief Operating Officer (COO)	31/08/2019 Ongoing, First plan to be submitted 31/03/2018. Paused	1. Minutes of meetings record attendance, agenda and outcomes. 2. Action Plans and highlight reports from the Joint Strategic Transformation Group. 3. Action plans, minutes and reports from the SEAT Regional Planning meetings and East Region Programme Board. 4. Performance and Accountability Reviews now underway which will provide assurance to committees on performance of all services	1. Internal Audit Report on Strategic Planning (no. B10/17) 2. SEAT Annual Report 2016 3.Governance committee oversight of performance assurance framework	Governance of programmes through JSTG.	Current challenges associated with delivery of our strategic objectives include the focus on the 4 strategic priorities (Acute Transformation, Joining Up Care, Mental Health Redesign and Medicines Efficiencies), the interdependencies of workplans (NHS Fife/H&SCP/ Region) in terms of the whole system oversight of operational plans, delivery measures and timescales. CEO now chairing the JSTG providing senior oversight and drive to the transformation programmes. Site Optimisation Programme has now been with a refreshed Acute Transformation Programme being developed. JSTG workshop planned for 23 July 2019 will review programmes and agree a workplan and revised TOR.	3 - Possible - May occur occasionally - reasonable chance	4 - Major	12	Moderate	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	Current Risk Rating	Risk Owner
	Nil currently identified		

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Reason for unlinking from BAF	Current Risk Rating	Risk Owner
	NIL APPLICABLE			

NHS Fife Board Assurance Framework (BAF)

Strategic Planning

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?	Responsible Person	Timescale	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
1417	Person Centred, Clinically Excellent, Exemplar Employer, Sustainable	**15/01/2019**	**01/09/2019**	There is a risk that NHS Fife will not deliver the recommendations made by the Clinical Strategy within a timeframe that supports the service transformation and redesign required to ensure service sustainability, quality and safety at lower cost. **Key Risks** 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 JSTG remains with 4 committees - 2 from the IJB and 2 from NHS. This may impact on effectiveness of scrutiny. 3. Regional Planning risks around alignment with regional plans are currently reduced as regional work is focussed on specific workstreams.	4 - Likely - Strong possibility this could occur	4 - Major	16	High	4 - Likely - Strong possibility this could occur	4 - Major	16	High	The transformation programmes have been agreed and reports to the Joint Strategic Transformation Group. Organisational challenges have impacted on the meeting schedule. Meeting have been paused from February 2019 until a full review has been undertaken. The workplans is at varying stages of development with some programmes more advanced than others. Reporting of progress of transformation programmes has improved with written updates to JSTG for two of the programmes. Papers to IJB produced about the other two programmes.	Medical Director	Clinical Governance	*Ongoing actions designed to mitigate the risk including:* 1. Establishment of IMPACT in 2016 - a small internal business unit which provides focussed, co-ordinated, client tailored support to accelerate delivery of NHS Fife's strategic objectives. Provides a programme management framework to ensure the programme is delivered. 2. Establishment of the Joint Strategic Transformation Group (JSTG) to drive the delivery of the H&SC Strategic Plan and the Clinical Strategy. 3. 3 of the 4 key strategic priorities are being taken forward by the H&SCP/IJB. The remaining priority is being taken forward by Acute services and progress shared through regular highlight reports. Programme Boards provide oversight and strategic guidance to the programme. Collaborative oversight is provided by the JSTG. 4. NHS Fife is a member of SEAT with executive attendance at Regional Planning meetings. Progress is being made in some areas. 5. NHS Fife is a member of the East Region Programme Board established to develop the East Region Health and Social Care Delivery Plan and is represented by directors on all workstreams. 6. Establishment of the Executive Board to provide strategic and operational oversight of the health boards services including the transformation programmes. 7. The Service Planning Reviews have taken place for 2019/20 -21/22 which will inform actions to deliver Clinical Strategy and prioiritise transformation programmes.	JSTG not performing role adequately but tranformation programmes being progressed.	Leadership to strategic planning coming from the Executive Directors Group. Clinical Strategy workstream update has been produced to reflect progress against recommendations. First meeting of refreshed JSTG chaired by Chief Executive held on 16 April. Due to other commitments, workshop planning for June is now being held on 23 July 2019. 1. The NHS Fife CEO chairs the Acute Services workstream of the East Region Health and Social Care Delivery Plan. Plan has not bee published so workstreams have been paused and specific work taken forward by SEAT 2. Chief Executive and Chief Operating Officer participate in Regional planning via SEAT and appropriate sub/working groups.	Chief Executive Chief Operating Officer (COO)	31/08/2019 Ongoing, First plan to be submitted 31/03/2018. Paused	1. Minutes of meetings record attendance, agenda and outcomes. 2. Action Plans and highlight reports from the Joint Strategic Transformation Group. 3. Action plans, minutes and reports from the SEAT Regional Planning meetings and East Region Programme Board. 4. Performance and Accountability Reviews now underway which will provide assurance to committees on performance of all services	1. Internal Audit Report on Strategic Planning (no. B10/17) 2. SEAT Annual Report 2016 3.Governance committee oversight of performance assurance framework	Governance of programmes through JSTG.	Current challenges associated with delivery of our strategic objectives include the focus on the 4 strategic priorities (Acute Transformation, Joining Up Care, Mental Health Redesign and Medicines Efficiencies), the interdependencies of workplans (NHS Fife/H&SCP/ Region) in terms of the whole system oversight of operational plans, delivery measures and timescales. CEO now chairing the JSTG providing senior oversight and drive to the transformation programmes. Site Optimisation Programme has now been with a refreshed Acute Transformation Programme being developed. JSTG workshop planned for 23 July 2019 will review programmes and agree a workplan and revised TOR.	3 - Possible - May occur occasionally - reasonable chance	4 - Major	12	Moderate	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	Current Risk Rating	Risk Owner
	Nil currently identified		

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Reason for unlinking from BAF	Current Risk 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?	Responsible Person	Timescale	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
Financial Sustainability																													
1413	Sustainable	30/06/2019	31/08/2019	There is a risk that the funding required to deliver the current and anticipated future service models will exceed the funding available. 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.	4 - Likely - Strong possibility this could occur	4 - Major	16	High	4 - Likely - Strong possibility this could occur	4 - Major	16	High	Current financial climate across NHS/public sector	Director of Finance	Finance, Performance & Resources (F,P&R) Chair: Rona Laing	*Ongoing actions designed to mitigate the risk including:* 1. Ensure budgets are devolved to an appropriate level aligned to management responsibilities and accountabilities. This includes the allocation of any financial plan shortfall to all budget areas. This seeks to ensure all budget holders are sighted on their responsibility to contribute to the overall requirement to deliver breakeven. 2. Refreshed approach established for a system-wide Transformation programme to support redesign; reduce unwarranted variation and waste; and to implement detailed efficiency initiatives. Lessons will be learned from the successes of the medicines efficiency programme in terms of the system-wide approach and use of evidence based, data-driven analysis 3. Engage with external advisors as required (e.g. property advisors) to support specific aspects of work. In addition, appoint external support to accelerate a programme of cost improvement across Acute Services.	Nil	1. Continue a relentless pursuit of all opportunities identified through the transformation programme in the context of sustainability & value. 2. Continue to maintain an active overview of national funding streams to ensure all NHS Fife receives a share of all possible allocations. 3. Continue to scrutinise and review any potential financial flexibility. 4. Engage with H&SC / Council colleagues on the risk share methodology and in particular ensure that EDG, FP&R and the Board are appropriately advised on the options available to manage any overspend within the IJB *prior* to the application of the risk share arrangement	Director of Finance / Chief Operating Officer / Director of Health & Social Care Director of Finance	Ongoing Ongoing	1. Produce monthly reports capturing and monitoring progress against financial targets and efficiency savings for scrutiny by all responsible managers and those charged with governance and delivery. 2. Undertake regular monitoring of expenditure levels through managers, Executive Directors' Group (EDG), Finance, Performance & Resources (F,P&R) Committee and Board. As this will be done in parallel with the wider Integrated Performance Reporting approach, this will take cognisance of activity and operational performance against the financial performance.	1. Internal audit reviews on controls and process; including Departmental reviews . 2. External audit review of year end accounts and governance framework.	1. Enhanced reporting on various metrics in relation to supplementary staffing. 2. Confirmation via the Director of Health & Social Care on the robustness of the social care forecasts and the likely outturn at year end	The financial challenge prevalent since 2016/17 has continued into 2019/20, albeit with a reducing recurring gap each year. The Annual Operational Plan shows a c.£17m gap for 2019/20 prior to any remedial action, with £10m of this relating to Acute Services and the (majority) of the balance relating to health budgets delegated to the Health & Social Care Partnership. A detailed savings plan for the HSCP has been agreed by the IJB and if achieved would result in the delegated health budgets being broadly breakeven. A detailed savings plan has not yet been developed by the Acute Services Division but at the end of June, work is underway to accelerate this at pace, with the support of external advisors. It is anticipated that non delivery of savings may be mitigated, in part, through in year non recurring financial flexibility, however at this stage in the year it is difficult to provide a definitive position in this respect. A year end break even position remains the target, per the AOP, and this will continue to be closely monitored and reported over the coming months.	3 - Possible - May occur occasionally - reasonable chance	4 - Major	12	Moderate	Financial risks will always be prevalent within the NHS / public sector however it would be reasonable to aim for a position where these risks can be mitigated to an extent.

Linked Operational Risk(s)

Risk ID	Risk Title	Current Risk Rating	Risk Owner
1513	Financial and Economic impact of Brexit	High 25	C Potter
1363	Health & Social Care Integration - Overspend	High 20	M Kellett
1364	Efficiency Savings - failure to identify level of savings to achieve financial balance	High 16	C Potter
1357	Financial Planning, Management & Performance	High 16	C Potter

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Reason for unlinking from BAF	Current Risk Rating	Risk Owner
522	Prescribing & Medicines Management - unable to control Prescribing Budget	No longer a high risk	Moderate 9	Dr Christopher McKenna

NHS Fife Board Assurance Framework (BAF)

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Workforce Sustainability																													
1415	Exemplar Employer	**01.04.19**	**30.06.19**	There is a risk that failure to ensure the right composition of workforce, with the right skills and competencies deployed in the right place at the right time 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	5 - Almost Certain - Expected to occur frequently - more likely than not	4 - Major	20	High	4 - Likely - Strong possibility this could occur	4 - Major	16	High	Failure in this area has a direct impact on patients' health. NHS Fife has an ageing workforce with recruitment challenges in key specialities. Failure to ensure the right composition of workforce with the right skills and competencies gives rise to a number of organisational risks including: reputational and financial risk; a potential adverse impact on the safety and quality of care provision; and staff engagement and morale. Failure would also adversely impact on the implementation of the Clinical strategy. The current score reflects the existing controls and mitigating actions in place.	Director of Workforce/ Partnership	Staff Governance Chair: Margaret Wells	*Ongoing actions designed to mitigate the risk including:* 1. • Development of the Workforce Strategy to support the Clinical Strategy and Strategic Framework. 2. • Implementation of the Health & Social Care Workforce and Organisational Development Strategy to support the Health & Social Care Strategic Plan for 2016/19. 3. • Implementation of the NHS Fife Strategic Framework particularly the "exemplar employer"	Nil	Implementation of the Workforce Strategy to support the Clinical Strategy and Strategic Framework	Director of Workforce/Partnership		1. Regular performance monitoring and reports to EDG, APF, Staff Governance Committee 2. Delivery of Staff Governance Action Plan is reported to EDG, APF and Staff Governance Committee	1. Use of national data 2. Internal Audit reports 3. Audit Scotland reports	Full implementation of eESS will provide an integrated workforce system which will capture and facilitate reporting including all learning and development activity	Overall NHS Fife Board has robust workforce planning and learning and development governance and risk systems and processes in place. Continuation of the current controls and full implementation of mitigating actions, especially the Workforce strategy supporting the Clinical Strategy and the implementation of eESS should provide an appropriate level of control.	2 - Unlikely - Not expected to happen - potential exists	2 - Minor	4	Low	Continuing improvement in current controls and full implementation of mitigating actions will reduce both the likelihood and consequence of the risk from moderate to low.
																4. • A Brexit Steering Group has been established to consider the impact on the workforce with regard to these arrangements once they are known. 5. An Assurance Group has also been established which will link to existing resilience planning arrangements 6. • Implementation of eESS as a workforce management system within NHS Fife	Nil	Implementation of proactive support for the workforce affected by Brexit. Full implementation of eESS manager and staff self service across the organisation to ensure enhanced real time data intelligence for workforce planning and maximise benefit realisation from a fully integrated information system.												
																7. • A stepped approach to nurse recruitment is in place which enables student nurses about to qualify to apply for certain posts at point of registration. This model could also be applied to AHP, eHealth, Pharmacist, Scientific and Trades recruitment and other disciplines considered. 8 • Strengthening of the control and monitoring associated with supplementary staffing with identification and implementation of solutions to reduce the requirement and/or costs associated with supplemental staffing. 9. • NHS Fife participation in regional and national groups to address national and local recruitment challenges and specific key group shortage areas, applying agreed solutions e.g. SERRIS 10. Review of risks related to Mental Health recruitment with Risk owners	Nil	Strengthen workforce planning infrastructure ensuring co-ordinated and cohesive approach taken to advance key workforce strategies												
																11. • Absence Management Steering Group and local divisional groups established to drive a range of initiatives and improvements aligned to staff health and wellbeing activity, 12. • Well@Work initiatives continue to support the health and wellbeing of the workforce, facilitate earlier interventions to assist staff experience and retain staff in the workplace, along with Health Promotion and the Staff Wellbeing & Safety Service	Nil	Continue to support the implementation of the Health & Wellbeing Strategy and Action Plan, aimed at reducing sickness absence, promoting attendance and staff health and wellbeing.												
																13. • The roll out and implementation of iMatter across the organisation, to support staff engagement and organisational values.	Nil	Optimise use of iMatter process and data to improve staff engagement and retention												
																14. • Staff Governance and Partnership working underpins all aspects of workforce activity within NHS Fife and is key to development of the workforce. 15. • Training and Development	Nil	Continue to implement and promote Staff Governance Action plans and staff engagement												
																16. • Development of the Learning and Development Framework strand of the Workforce Strategy 17. • Leadership and management development provision is constantly under review and updated as appropriate to ensure continuing relevance to support leaders at all levels	Nil	Implementation of the Learning and Development Framework strand of the Workforce Strategy.	Director of Workforce/Partnership												
																18. • The improvement made in Core Skills compliance to ensure NHS Fife meets its statutory obligations	Nil	Review of L&D processes , planning and resources to ensure alignment to priorities.												
																19. • The implementation of the Learning management System module of eESS to ensure all training and development data is held and to facilitate reporting and analysis	Nil	Full roll out of learning management self service												
																20. • Continue to address the risk of non compliance with Staff Governance Standard and HEAT standard requirements relating to KSF.	Nil	Continuing implementation of the KSF Improvement and Recovery Plan												
																21. • Utilisation of the Staff Governance Standard and Staff Governance Action Plans (the "Appropriately trained" strand) is utilised to identify local priorities and drive local actions.	Nil												
																22. • The development of close working relationships with L&D colleagues in neighbouring Boards, with NES and Fife Council to optimise synergistic benefits from collaborative working	Nil		Director of Workforce												

Linked Operational Risk(s)

Risk ID	Risk Title	Current Risk Rating	Risk Owner
90	National shortage of radiologists	High 16	J Burdock

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Reason for unlinking from BAF	Current Risk Rating	Risk Owner
503	Lack of capacity in Podiatry Service unable to meet SIGN/ NICE Guidelines	Risk Closed		
1042	Staffing levels Community Services East unable to meet staffing establishment	No longer high risk	Moderate 12	K Nolan
1324	Medical Staff Recruitment	No longer high risk	Moderate 9	J Kennedy
1349	Service provision- GP locums may no longer wish to work for NHS Fife salaried practices	Risk Closed		
1353	Medical Cover- Community Services West- expected shortfalls on nurse staffing and GP cover	No longer high risk	Moderate 9	C Dobson
1375	Breast Radiology Service	No longer high risk	Moderate 12	M Cross
1420	Loss of consultants	No longer high risk	Moderate 12	H Bett

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?	Responsible Person	Timescale	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
Quality & Safety																													
1416	Person Centred, Clinically Excellent	**04/06/2019**	**04/08/2019**	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	3 - Possible	5 - High	15	High	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.	Medical Director	Clinical Governance Chair: Dr Les Bisset	*Ongoing actions designed to mitigate the risk 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 This is supported by the following: 7. Risk Registers 8. Quality Report, Performance reports dashboard data 9. Performance Reviews 10. Adverse Events Policy 11. Scottish Patient Safety Programme 12. Implementation of SIGN and other evidence based guidance 13. Staff Learning & Development 14.System of governance arrangements for all clinical policies and procedures 15. Participation in relevant national and local audit 16.Complaints handling process 17.Using data to enhance quality control 18.HIS Quality of Care Approach & Framework,Sept 2018 19. Implementing Duty of Candour legislation 20.Adverse event management process 21.Sharing of learning summaries from adverse event reviews 22.Implementing Excellence in Care 23. Using Patient Opinion feedback 24.. Acting on recommendations from internal & external agencies 25. Revalidation programmes for professional staff 26. Electronic dissemination of safety alerts	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	1. Continually review the Quality Reports to ensure they provide an accurate, current picture of clinical quality / performance in priority areas. 2. Refresh the extant Clinical Governance structures and arrangements to ensure these are current and fit for purpose. 3..Review the coverage of mortality & morbidity meetings. 4.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. 5.Review annually, all technology & IT systems that support clinical governance e.g. Datix, Formic Fusion Pro, Clinical Effectiveness Register. 6. Consider the HIS Quality of Care Framework and agree our approach to implementation. 7.Fully understand what the patient experience 'looks like' and take any required actions.	Medical Director	31/10/2018	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. Accreditation systems 7.Quality control process e.g. specific audits 8.External agency reports e.g. GMC 9..Quality of Care review	1. Internal Audit reviews and reports 2. External Audit reviews 3. HIS visits and reviews 4. Healthcare Environment Inspectorate (HEI) visits and reports 5. Health Protection Scotland (HPS) support 6. Health & Safety Executive 7. Scottish Patient Safety Programme (SPSP) visits and reviews 8. Scottish Govt DoC Annual Report 9.Scottish Public Service Ombudsman (SPSO) 10. Patient Opinion	1.Key performance indicators relating to corporate objectives e.g. person centred, clinically excellent, exemplar employer & sustainable. 2.Executive commissioning of reviews e.g. internal audit, external peer and 'deep dives'	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	5 - Extreme	10	Moderate	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	Current Risk Rating	Risk Owner
1296	Emergency Evacuation - VHK- Phase 2 Tower Block	High 20	Andrew Fairgrieve
1514	Impact of the UK's withdrawal from the EU on the availability and cost of medicines and medical devices	High 20	Evelyn McPhail
43	Vascular access for haematology/Oncology	High 20	Shirley-Anne Savage
1502	3D Temperature Monitoring System (South Lab)	High 20	Ken Campbell
1524	Oxygen Driven Suction	High 20	Jacqueline Beatson
521	Capacity Planning	High 16	TBC
529	Information Security	High 16	Carol Potter
637	SAB HEAT TARGET	High 16	Christina Coulombe
1365	Cancer Waiting Times Access Standards	High 15	TBC
356	Clinical Pharmacy Input	High 15	Dr Christopher McKenna
1515	Impact of the UK's withdrawal from the EU on Nuclear Medicine and the ability to provide diagnostic and treatment service(s)	High 15	Jeanette Burdock

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Reason for unlinking from BAF	Current Risk Rating	Risk Owner
1366	134 syringe drivers in the Acute Division	Closed Risk		
1297	Obsolete Equipment In Use – No Replacement Plan In Place (Graseby 3000 Series)	Closed Risk		
528	Pandemic Flu Planning	No longer a high risk	Moderate 12	Dona Milne

NHS Fife Audit and Risk Committee

DATE OF MEETING:	5 September 2019
TITLE OF REPORT:	Update on NHS Fife Risk Management Workplan 2018 -19
EXECUTIVE LEAD:	Helen Buchanan
REPORTING OFFICER:	Pauline Cumming

Purpose of the Report (delete as appropriate)		
		For Information

SBAR REPORT

Situation

This report provides an update on the NHS Fife Risk Management Workplan since the last report to the Committee on 14 March 2019.

Background

The Workplan defines the key pieces of work that require to be carried out.

Assessment

Appendix 1 provides the status of the workplan actions in relation to stated timescales.

Standard Reporting to the Audit & Risk Committee

Actions complete.

Scheduled Work

The Committee is asked to note the following updates:

Risk Appetite

Further to the last report to the Committee, the Risk Appetite Short Life Working Group has:

- Agreed to adopt HM Treasury risk appetite definition and classification[1].
- Reviewed examples of risk appetite statements and expressed a desire to work towards an 'at a glance' matrix approach used by a NHS England Foundation Trust which mapped risks and appetites against its strategic objectives.
- Agreed the content should be in Plain English and where possible include info graphics.
- Agreed the work should be taken forward initially through the standing committee(s) with members asked to review appropriate risks and apply a risk appetite classification to each.

[1] HM Treasury The Orange Book: Management of Risk- Principles and Concepts, (October, 2004)

e.g. Staff Governance Committee to review risks to the Strategic Framework aspirations and objectives relating to Exemplar Employer and the Workforce Sustainability BAF.

- Agreed committee outputs will be discussed at a Board Development Session with a view to defining the Board's appetite for risk.

This approach was tested successfully at the Staff Governance Committee on 3 May 2019. Arrangements have been made to replicate the exercise with the Clinical Governance and Finance, Performance & Resources Committees on 4 and 10 September 2019 respectively. The aim is to conclude this work at a Board Development Session on 30 October 2019.

Risk Key Performance Indicators (KPIs)

A suite of KPIs has been developed for EDG consideration.

Review and update of NHS Fife Risk Register & Risk Assessment Policy GP/ R7

A comprehensive update will follow completion of the work on risk appetite and the review of arrangements around the corporate risk register.

Risk Management Framework

An updated Framework will be submitted to the Board following the completion of several pieces of work including:

- definition of the Board's risk appetite
- a review of the processes relating to the corporate risk register
- agreement on risk management KPIs
- update of the Risk Register and Risk Assessment Policy GP/R7
- clarification of the delegation of functions to the IJB and the implications for risk management, governance and assurance

Recommendation

The Committee is invited to:

- **Note** the update

Objectives: (must be completed)	
Healthcare Standard(s):	To aid delivery
HB Strategic Objectives:	Supports all of the Board's strategic objectives

Further Information:	
Evidence Base:	A broad national and international evidence base informs the delivery of safe, effective, person centred care in NHS Fife.
Glossary of Terms:	N/A
Parties / Committees consulted prior to Health Board Meeting:	Executive Directors

Impact: (must be completed)	
Financial / Value For Money	Promotes proportionate management of risk and thus effective and efficient use of scarce resources.
Risk / Legal:	Inherent in process. Demonstrates due diligence. Provides critical supporting evidence for the Annual Governance Statement.
Quality / Patient Care:	NHS Fife's risk management system seeks to minimise risk and so support the delivery of safe, effective, person centred care.
Workforce:	The system arrangements for risk management are contained within current resource.
Equality:	The arrangements for managing risk apply to all patients, staff and others in contact with the Board's services.

Appendix 1

UPDATED RISK MANAGEMENT WORK PLAN 2018-19

STANDARD REPORTING TO THE AUDIT & RISK COMMITTEE

ACTION	DATE	STATUS
Risk Management Work Plan 2017-2018 to Audit & Risk Committee	June 2018	Complete
Risk Management Annual Report 2017-18 to Audit & Risk Committee	June 2018	Complete
Report to Audit & Risk Committee on implementation of Board Assurance Framework and organisational risk profile	Sept 2018	Complete
Report to Audit & Risk Committee against Risk Management Work Plan	Dec 2018	Complete
Report to Audit & Risk Committee on Board Assurance Framework and organisational risk profile	Dec 2018	Complete
Risk Management Annual Report 2018-19 to Audit & Risk Committee	June 2019	Complete
Risk Management Work Plan 2018-19 to Audit & Risk Committee	Sept 2019	Complete

SCHEDULED WORK

ACTION	DATE	STATUS	REVISED DATE
Agree risk appetite	March 2019	In progress	Oct 2019
Agree Risk Key Performance Indicators (KPIs)	March 2019	In progress	Sept 2019
Review and update Risk Register & Risk Assessment Policy GP/R7	March 2019	In progress	Dec 2019
Review and update Risk Management Framework	March 2019	In progress	Dec 2019

ONGOING WORK

ACTION	DATE	STATUS
Support the implementation of the Board Assurance Framework	Current	Ongoing
Input as required to Executive Directors' Group	Current	Ongoing
Contribute to the development of H&SCI risk management arrangements	Current	Ongoing
Continue to develop the Datix IT Risk Management system	Current	Ongoing
Continue to support the management of adverse events	Current	Ongoing
Continue to support Organisational Duty of Candour implementation	Current	Ongoing
Support the production of a Duty of Candour annual report	Current	Ongoing

RISK MANAGEMENT WORK PLAN 2019-20

STANDARD REPORTING TO THE AUDIT & RISK COMMITTEE

ACTION	DATE	STATUS
Risk Management Work Plan 2019 - 20 to Audit & Risk Committee	Sept 2019	Complete
Report to Audit & Risk Committee on Board Assurance Framework	Sept 2019	Complete
Report to Audit & Risk Committee against Risk Management Work Plan	Dec 2019	
Report to Audit & Risk Committee on Board Assurance Framework	Dec 2019	
Risk Management Annual Report 2019-20 to Audit & Risk Committee	June 2020	
Risk Management Work Plan 2020-21 to Audit & Risk Committee	June 2020	

SCHEDULED WORK

ACTION	DATE	STATUS	REVISED DATE
Agree risk appetite	March 2019	In progress	Oct 2019
Agree Risk Key Performance Indicators (KPIs)	March 2019	In progress	Sept 2019
Update Risk Register & Risk Assessment Policy GP/R7	March 2019	In progress	Dec 2019
Update Risk Management Framework	March 2019	In progress	Dec 2019
Contribute to the further development of NHS Fife's assurance framework in accordance with: NHS Scotland's Blueprint for Good	March 2020	Pending	

Governance [1] HM Treasury guidance [2] Scottish Government Audit and Assurance Committee guidance [3]			

ONGOING WORK

ACTION	DATE	STATUS
Further develop the implementation of the Board Assurance Framework	Current	Ongoing
Input as required to Executive Directors' Group	Current	Ongoing
Continue to develop the Datix IT Risk Management system	Current	Ongoing
Continue to support the management of adverse events	Current	Ongoing
Continue to support organisational Duty of Candour implementation	Current	Ongoing
Contribute to the production of a Duty of Candour annual report	Current	Ongoing
Contribute to the development of H&SCI risk management arrangements	Current	Ongoing

[1] DL(2018) – 02 NHS Scotland Health Boards and Special Health Boards- Blueprint for Good Governance ,(October 2018)
[2] HM Treasury :Assurance frameworks, (December 2012)
[3] Scottish Government Audit and Assurance Committee Handbook, (March 2018)

RISK AND CONTROL EVALUATIONS (RACEs) 1

VERSION: 2

RISK

The organisation may not be managing risks appropriately because it does not have a comprehensive risk management framework in place comprising appropriate strategy, structures, policies and procedures

TEST DETAILS *(Testing section of guidance)*

TEST 1.1	Check that a Risk Management Strategy has been produced and approved by the Board following endorsement by the appropriate Standing Committee(s) including the Audit Committee. The Strategy should include:	Select Yes/No from the Drop Down List	Comments
	• Linkage to the Board's vision	No	At the inception of the Risk Management Framework (RMF), the Board's vision had not been articulated. This is now contained in the NHS Fife Strategic Framework. The RMF will be amended to reflect this at its next iteration.
	• Reference to the Board's corporate objectives	No	At the inception of the Risk Management Framework (RMF), the Board's objectives had not been articulated. These are now contained in the NHS Fife Strategic Framework. , The RMF will be amended to reflect these at its next iteration.
	• The organisation's risk priorities	Yes	Identified in Board Assurance Framework (BAF)
	• Philosophy & risk culture	Yes	
	• Objectives of the Risk Management Strategy (including links to relevant legislation and guidance)	Yes	
	• Description of how risk management contributes to achieving outcomes	Yes	
	• Governance & reporting	Yes	
	• Monitoring, Audit and review	Yes	
	• Roles and Responsibilities for all Staff	Yes	
	• Risk Management Methodology (risk identification assessment and resolution)	Yes	In Risk Management Framework & Risk Register and Risk Assessment Policy GP/R7
	• Risk Appetite and Risk Tolerance	No	Work to define risk appetite & tolerance commenced January 2019 and to be agreed by Oct 2019
	• Arrangements for working with Partner Organisations and management of joint risks	Yes	
	• Key dependencies and resources required	Yes	
	• Training and Development	Yes	
	• Risk Management Structure	Yes	
	• Risk Escalation Process	Yes	In Risk Management Framework and Risk Assessment & Risk Register PolicyGP/R7.
	• Business and Continuity Planning	Yes	
	• Communication of the Strategy	Yes	
	• KPIs	No	Further work required on KPIs . To be approved as part of update of Risk Management Framework update by Sept 2019.
	• Review date and version control	Yes	

TEST 1.2	Determine if responsibility for risk management has been delegated in line with the Risk Management Strategy. Review:	Select Yes/No from the Drop Down List	Comments
	• Scheme of Delegation	Yes	Will be reviewed as part of Risk Management Framework update by Dec 2019.
	• Risk management responsibilities delegated to Standing and other Committees evidenced by remits, work plans and annual reports to check content and frequency of reporting	Yes	
	• Chief Executive and Executive Team objectives to ensure risk management is included		To be confirmed
	• Senior Officer responsible for 'Championing' risk	Yes	Board Director of Nursing, NHS Fife.
	• Governance statement for positive conclusion on risk management arrangements	Yes	Annual Assurance Statement, Lead Officer Reports to Governance Committees

TEST 1.3	Review adequacy of the Board's risk management arrangements including assessing if:	Select Yes/No from the Drop Down List	Comments
	• The Board has a strategic overview of risks e.g. a corporate risk profile which is reviewed and reported on a regular basis.	Yes	Board Assurance Framework in place from Nov 2017. Reported bi monthly to standing committees and thereafter to Audit & Risk Committee and the Board.
	• The Board has considered how frequently it considers risk and has an agreed timetable for this	Yes	
	• There is a process to ensure that Committees are aware of and ensure that corporate and significant operational risks associated with their remit are managed appropriately	Yes	See 41above. Board Assurance Framework in place .
	• The Board considers risk factors for all key decisions (include review of papers to Board which are for decision making to ensure a risk assessment section is included and has been appropriately populated)	Yes	
	• The Board considers risk regularly as part of its normal flow of management information about the organisation's activities and links performance management information to risks to the achievement of objectives	Yes	
	• The Board has a top down approach to risk management which ensures corporate risks and risk appetite is considered at departmental / service level	No	Not formally. . This will be made explicit through the work on risk appetite and tolerance, and the update of the Risk Register and Risk Assessment Policy GP/R7 and Risk Management Framework.
	• The escalation process ensures key operational risks are considered by the Board /Committees where appropriate	Yes	Through reporting of linked operational risks in the BAF
	• Having weighed the identified risks, the Board seeks to distinguish unidentified risks through, for example, horizon scanning to identify emerging trends, problems or opportunities that might change the organisation's working environment.	Yes	Reports of national significance e.g. Francis report, Gosport , Scottish Govt e.g. Health and Sport Committee, National frameworks e.g Adverse events External reviews e.g.HEI and HIS reviews local and of other boards , are considered and appropriate action taken, national frameworks,
	The Board has considered the use of assurance mapping and/or Board assurance framework approaches, particularly for key risks	Yes	A Board Assurance Framework (BAF) has been in place since Nov 2017.This requires assurances to be stated. Assurance mapping being considered in light of the NHS Scotland's Blueprint for Good Governance

TEST 1.4	Check that appropriate assurance on risk is provided to Board including reporting on:	Select Yes/No from the Drop Down List	Comments
	• Compliance with the Risk Management Strategy for all risks	Yes	

• Adequacy of management of key risks / controls	Yes	
• Effectiveness of controls i.e. the extent to which they are actually being applied	Yes	
• Assurance on adequacy of the above	Yes	

		Select Yes/No from the Drop Down List	Comments
TEST 1.5	Risk management responsibilities have been allocated to an appropriate management committee which co-ordinates risk management activity, ensures consistency of application of the Board's Risk Appetite, escalates risks as appropriate and considers the Risk Management Annual Report prior to presentation to the AC	Yes	Risk management responsibilities are allocated to EDG and governance committees. Risk appetite is to be defined. See 22 above

		Select Yes/No from the Drop Down List	Comments
TEST 1.6	Arrangements are in place to ensure the availability of appropriate competent advice on risks and controls, through an officer with appropriate experience and qualifications	Yes	Director of Nursing(Executive Lead for Risk Management). Director of Finance. NHS Fife Risk Management Team and HSCP Clinical Governance & Risk Management Leads and Fife Council counterparts . Internal Audit provide objective advice and scrutiny.

		Select Yes/No from the Drop Down List	Comments
TEST 1.7	Check if the organisation has appropriate risk management policies and procedures in place and confirm that these are reviewed and updated in line with the organisation's policy approval route in general these will often have been reviewed separately e.g. Resilience, H&S, or though a review of polices and procedures).	Yes	Risk Register & Risk Assessment Policy updated 2015.Update to be completed by Dec 2019.

		Select Yes/No from the Drop Down List	Comments
TEST 1.8	Determine whether appropriate governance and reporting arrangements are in place for risk management including obtaining and reviewing:		
	• the organisation chart documenting the reporting arrangements at both operational and strategic level	Yes	
	• the annual risk management work plan which should be approved and monitored by a Standing Committee of the Board.	Yes	Approved by Audit & Risk Committee

		Select Yes/No from the Drop Down List	Comments
TEST 1.9	There is a Risk Management Annual Report presented to the Audit Committee which includes positive assurance on the adequacy and effectiveness of Risk management Arrangements and compliance with the Risk Management Strategy, with supporting evidence including performance against KPIs	Yes	Annual report presented to the Audit & Risk Committee . KPIs drafted for EDG consideration Sept 2019 - see 30 above

RISK AND CONTROL EVALUATION (RACE) 2

RISK
All relevant strategic and operational risks may not be accurately identified, assessed, evaluated, recorded and monitored (PIAS 2020)

TEST DETAILS *(Testing section of guidance)*

Identification

		Select Yes/No from the Drop Down List	Comments
TEST 2.1	Check if Risk Management guidance is available to all relevant staff and includes:		
	• definition and explanation of risk management	Yes	Risk Management Framework and Risk Register and Risk Assessment Policy
	• methodologies for identifying risks e.g. horizon scanning	Yes	
	• reference to the organisation's risk register including how to access the risk register	Yes	
	• a description of the risk identification, assessment, recording and monitoring process. This includes action plans to mitigate risk to the appropriate tolerance).	Yes	
	• How to apply the organisation risk appetite to individual risk tolerance	No	Appetite and tolerance to be defined see Races 1 -22.
	• process for risk escalation	Yes	
	• management of joint risks	Yes	

		Select Yes/No from the Drop Down List	Comments
TEST 2.2	From discussion with a sample of relevant staff, determine whether the risk management guidance note has been appropriately communicated and staff are aware of their responsibilities.		We do not have a 'risk management guidance note'.Guidance provided in Risk Register and Risk Assessment Policy.

		Select Yes/No from the Drop Down List	Comments
TEST 2.3	For a sample of risks check that guidance has been appropriately applied.	Yes	

		Select Yes/No from the Drop Down List	Comments
TEST 2.4	Determine whether the organisation has in place an appropriate process to identify all risks including:		
	Board level		
	• Board development events	Yes	
	• Horizon Scanning	Yes	EDG have discussed . Also at Board development sessions . See RACES1 - 48
	• Review of corporate objectives and risks to achievement of these objectives	Yes	Strategic objectives for 2019-20 were agreed at the Board in May 2019; The related paper to NHS Fife Clinical Governance Committee
	Management identification of risks associated with operating activities		Identification at Operational, Divisional, Specialty and Strategic Groups & Committees
	• Complaints & Claims	Yes	
	• Losses and Compensation Register	Yes	
	• Incident reporting & associated investigation	Yes	
	• Internal Audit Reports	Yes	
	• External Audit Reports	Yes	
	• Internal reviews such as Fire Safety, H&S, Clinical Audit	Yes	
	• External reviews such as HSE, HIS, MWC, Care Commission	Yes	
	• Other legal or regulatory reviews	Yes	

		Select Yes/No from the Drop Down List	Comments
TEST 2.5	Check that where appropriate, departmental risks have been aggregated i.e. where a departmental / site risk has been identified consideration has been given to whether the risk should be applied to the organisation as a whole and recorded in the risk register as such.	Yes	There are examples of this having occurred.

		Select Yes/No from the Drop Down List	Comments
TEST 2.6	Confirm that the Clinical Governance Strategy overtly describes the risk management process for Clinical Risks and how they will be comprehensively identified, recorded, managed and monitored.	Yes	

Evaluation

TEST 2.7	Check that there is a documented scoring mechanism for evaluation of risks across the organisation. Check that the mechanism is:	Select Yes/No from the Drop Down List	Comments
	• Based on recognised good practice e.g. Australia / New Zealand 4360 and reflects organisational realities.	Yes	In line with national approach (HIS). Australia /New Zealand Standard, NHS HIS Matrix,Office Govt Commerce
	• includes assessment of inherent and residual risk	Yes	Initial and Current Risk
	• Communicated through a risk management guidance note which is available to all staff	Yes	Risk Register and Risk Assessment Policy/ Datix
	• Reviewed on a regular basis by an appropriate group or committee	No	Divisional Management teams, EDG, Board Committees
	• Communicated to Board	Yes	Through Risk Register and Risk Assessment Policy/ Datix/ staff training

TEST 2.8	Review a sample of risks from the organisation's risk register and check that:	Select Yes/No from the Drop Down List	Comments
	• the narrative description of the risks adequately describes the risk	Yes	Need to test
	• the scoring method used was in compliance with the approved scoring mechanism	Yes	Need to test
	• the scores allocated were based on judgement that appears appropriate and consistent with available evidence e.g. incidents, performance management data		Need to test
	• Risk tolerance is in line with the organisation wide agreed risk appetite	No	To be defined - see RACES 1 - 22
	• Scores and tolerances have been applied consistently	No	Tolerances still to be established See RACES 1 -22
	• Risks have been reviewed in line with procedures and at a frequency appropriate to the scoring of the risk and at least annually	Yes	
	• the identified risk owners and managers are appropriate and their responsibilities for risk are included in their objectives	Yes	Need to confirm if responsibility for risk management is included in all staff objectives
	• responses to risk are SMART, effective but not excessive in managing risks within the risk appetite.		Need to test. Develop related KPI

Recording

TEST 2.9	There are data quality checks of the risk register which include:	Select Yes/No from the Drop Down List	Comments
	• Completeness of all fields	Yes	Mandatory fields created in Datix. Undertaken through performance reviews, clinical & clinical & care governance groups and committees
	• Adequacy of information	Yes	As above. KPI will address
	• Risks updated in line appropriately and in line with policy	Yes	As above/ KPI will address
	• Scoring appears reasonable	Yes	As above. Undertaken through performance reviews, clinical & clinical & care governance groups and committee scrutiny .KPI will

TEST 2.10	Review the risk register to ensure that:	Select Yes/No from the Drop Down List	Comments
	• All corporate risks are recorded	Yes	In Datix
	• it includes details of the movement in the scoring of risks from one period to the next	Yes	Rationale for changes in scoring mandatory in Datix web. Audit trail via Datix security function.

TEST 2.11	Review the risk management reports produced and check if reporting is appropriate to the audience at each level of the organisation and includes:	Select Yes/No from the Drop Down List	Comments
	• New risks (by category)	Yes	Needs to form part of planned work. d - currently ad hoc from central RM team perspective Through performance review, scrutiny of the
	• Movement in risks (up or down)	Yes	Needs to form part of planned work. d - currently ad hoc from central RM team perspective Through performance review, scrutiny of the
	• Changes in corporate risk appetite	No	Appetite to be defined. SEE RACES 1 -22
	• Breached risks i.e. not updated	Yes	Needs to form part of planned work. d - currently ad hoc from central RM team perspective Through performance review, scrutiny of the
	• Identify any gaps in reporting	Yes	Needs to form part of planned work. d - currently ad hoc from central RM team perspective Through performance review, scrutiny of the

TEST 2.12	Document and assess arrangements for risk reporting across the organisation and check that there is regular reporting to Board / Standing committee including:	Select Yes/No from the Drop Down List	Comments
	• Process in place for immediately reporting and serious emerging risk to the Board / Senior Management	Yes	High risks> 15 escalated to Senior manager e.g. Divisional General manager. Risks>20 to responsible Director and EDG Opportunistic
	• Corporate risk register, link to assurances and movement of risks	Yes	Bi monthly BAF report, Board Assurance Framework(BAF) in place and reports bi monthly to committees and then to A&RC o Board.
	• Action plans detailing outstanding actions	No	Current Management Actions detailed
	• Audit reports on the effectiveness of risk management	Yes	Internal and external audit reports
	• HIS reports on the effectiveness of risk management	Yes	
	• Annual and mid term reports on the effectiveness of risk management	Yes	

		Select Yes/No from the Drop Down List	Comments
TEST 2.13	Check a sample of responses to risks to confirm that the responses are operating as expected and achieving their objectives in relation to managing the risk(s) they were designed to address.	Yes	KPI will ibe developed . Action to be taken as part of planned work.

		Select Yes/No from the Drop Down List	Comments
TEST 2.14	For a sample of departments ensure that where it is not considered appropriate or necessary to record risks on the organisation risk register, risks are recorded and managed at a local level i.e. record on a local risk register and appropriately reviewed and monitored.		Datix is promoted as the repository for risks in NHS Fife

Monitoring

	Select Yes/No from the Drop Down List	Comments

TEST 2.15	Determine whether the organisation has established a corporate risk register which is regularly reviewed and updated by senior management and presented to Board	Yes	EDG risk owners update in line with timescales and report on their risks to relevant Governance Committees Board Assurance Framework in place .

		Select Yes/No from the Drop Down List	Comments
TEST 2.16	Role of risk management group	No	We do not have a dedicated Risk Management Group.

		Select Yes/No from the Drop Down List	Comments
TEST 2.17	Review Board and committee minutes to confirm that:		
	• risk management is included as an agenda item and is discussed	Yes	Risks are escalated / highlighted to Board committees via BAF, EXECUTIVE LEAD REPORTS AND MINUTES FROM LINKED COMMITTEES
	• corporate risks are assigned to an appropriate Standing Committee and reviewed in line with protocol	Yes	Through BAF
	• Papers to Board / committee include appropriate and meaningful risk assessments	Yes	This requires further objective assessment

		Select Yes/No from the Drop Down List	Comments
TEST 2.18	Check that methods to monitor the proper operations of key processes, responses and action plans are in place and managers regularly provide assurance on the effectiveness of their risk management. Assurance can be provided through:		
	• corporate risk reporting to Board	Yes	
	• strategic and operational risk management meetings	Yes	

		Select Yes/No from the Drop Down List	Comments
TEST 2.19	From discussion with a sample of risk managers, determine how risks are monitored at departmental / operational level and assess adequacy.		Evidenced through performance reviews and clinical and clinical & care governance routes

RISK AND CONTROL EVALUATION (RACE) 3

RISK

Appropriate risk responses may not be appropriate and aligned with the organisation's risk appetite (PIAS 2020)

TEST DETAILS ***(Testing section of guidance)***

		Select Yes/No from the Drop Down List	Comments
TEST 3.1	Determine if the organisation's objectives support and align with the organisation's mission statement.	Yes	Organisation's objectives and mission defined in Strategic Framework, H&SCP Strategic Plan and Clinical Strategy

		Select Yes/No from the Drop Down List	Comments
TEST 3.2	Review the corporate risk profile and ensure it maps to the Boards vision, LDP / corporate objectives i.e. risk have been considered for all key objectives	Yes	risks on Corporate risk rguster are mapped to HEAT targets and Quality Ambitions. BAF risks are mapped against objectives and mission defined in Strategic Framework.

		Select Yes/No from the Drop Down List	Comments
TEST 3.3	Check if the organisation has formally discussed and agreed its risk appetite. Evidence should include:		
	• Board agreement and formal approval of an overall risk appetite including risk levels for key elements of financial / VFM, Compliance / regulatory, Innovation / Quality / Outcomes, Reputation.	No	See RACES 1 -22 In progress

		Select Yes/No from the Drop Down List	Comments
TEST 3.4	Check if the risk appetite of the Board has been communicated to staff	No	See RACES 1 - 22 In progress

		Select Yes/No from the Drop Down List	Comments
TEST 3.5	Determine what has already been done to improve the risk maturity of the organisation such as training, risk workshops, questionnaires about risks and interviews with risk managers.	Yes	Range of staff training, EDG and Board Development Sessions networking with other Boards.

		Select Yes/No from the Drop Down List	Comments
TEST 3.6	Determine whether managers feel that the risk register is comprehensive. Discuss whether an understanding of risk management is embedded so that managers feel responsible not only for identifying, assessing and mitigating risks but also for monitoring the framework and the responses to risks.		To be determined. Assume this means the register plural. Does the entirety of the organisational risk profile truly reflect the risks to NHS Fife is achieving its objectives?

		Select Yes/No from the Drop Down List	Comments
TEST 3.7	Check a sample of responses to risk scoring to confirm that they align risks to and are consistent with the risk appetite expressed by the Board.	No	RACES 1 -22 In progress

		Select Yes/No from the Drop Down List	Comments
TEST 3.8	Check that where risks are above the risk appetite, or here risk mitigation actions are not sufficient to manage the risk in line with the risk appetite of the organisation, appropriate escalation and remedial action is undertaken	No	RACES 1 -22 In progress

		Select Yes/No from the Drop Down List	Comments
TEST 3.09	Conclude on the overall risk maturity of the organisation based on all information available. Ensure that overall, evidence of the following has been obtained:		
	• The objectives of the organisation	Yes	Organisation's objectives and mission defined in Strategic Framework.
	• How risks are analysed, for example by scoring their impact and likelihood.	Yes	.Consequence and Likelihood. Risk matrix. Datix Risk Assessment module.
	• A definition, approved by the board, which defines its risk appetite in terms of the scoring system used for risks.	No	see RACES 1 -22 . In progress
	• The processes followed to identify risks which threaten the organisation's objectives.	No	
	• How management considers risks as part of their decision making. For example, including risks and the response to them, in project approval documents.	Yes	
	• The processes followed to report risks at different levels of management.	Yes	Through local,Divisional,and strategic groups.Through Safety Huddles,Performance Reviews
	• The sources of information used by management and the Board to assure themselves that the framework is working effectively to manage risks within the risk appetite.	No	See RACES 1 Risk appetite to be defined- work In progress
	• The risk register of the organisation, including the types of information described in the previous section.	Yes	Information available
	• Any existing assessment by management or the board of the risk maturity of the organisation.	No	
	• Any other documents which indicate the commitment to risk management.	Yes	RM Framework, BAF,Risk Register& Risk Assessment Policy, Board / other formal papers & reports

RISK AND CONTROL EVALUATION (RACE) 4

RISK
Relevant risk information may not be captured and communicated in a timely manner across the organisation, enabling staff, management and the board to carry out their responsibilities (PIAS 2020).

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TEST DETAILS ***(Testing section of guidance)***

		Select Yes/No from the Drop Down List	Comments
TEST 4.1	Review the reports and other data produced from the risk register and determine whether risk information is communicated across the organisation in an appropriate and timely manner e.g. reports on breached risks, red risks, escalated risks, reporting relevant to committee / audience.	Yes	Some of this information is reported via performance reports. Will be addressed by KPIs

		Select Yes/No from the Drop Down List	Comments
TEST 4.2	Check how risk owners are made aware of their responsibilities for recording and managing risks and from discussion with risk owners determine if this process is working e.g. risk management guidance note, training.	Yes	Could be evidenced from Policy, Framework, Minutes of meetings, training.. Face to face verification to be done.

		Select Yes/No from the Drop Down List	Comments
TEST 4.3	Check that a training programme for all relevant staff is in place for risk management and includes:		
	• Risk Identification	Yes	Range of training provided includes: induction, in house core. User guide, information on intranet, customised training offered. Use of Datix to record , review and report on risks.
	• Recording of Risks	Yes	
	• Risk Assessment	Yes	
	• Risk Tolerance & appetite	No	Work is in progress SEE RACES 1 - 22. . When complete, a planned programme of communication and education will be implemented. n
	• Risk Responses	No	This terminology is not used
	• Risk Response Monitoring	No	This terminology is not used

		Select Yes/No from the Drop Down List	Comments
TEST 4.4	Obtain details of number of staff trained to date and check that:		
	• risk management is included in Board development events	Yes	
	• all corporate risk owners and managers have received appropriate training	Yes	Training has been provided in accordance with need.
	• For a sample of other risk owners, training has been provided	Yes	
	• risk management is included in induction training	Yes	As part of In house core programme

		Select Yes/No from the Drop Down List	Comments
TEST 4.5	Check that there is adequate risk management support available including:		
	• A Risk Management department / manager or Champion who can provide competent advice on risks and controls	Yes	NHS Fife Risk manager and team. Acute Services Division Directorates and Health & Social Care (H&SCP) have staff with a remit for risk
	• A support function available for risk register owners and managers e.g. web site, support team available to advise	Yes	Support available from 'central' NHS Fife Risk Management Team, Divisional & H&SCP teams, e health support, Intranet, learn pro modules, study guides, Datix User Group,.DatxWeb newsletter, face to face teaching
	Assessing if the risk register support arrangements are adequate and identify any potential improvements		Needs to be objectively determined.

		Select Yes/No from the Drop Down List	Comments
TEST 4.6	Benchmark project / support resource across other clients using the same risk register system.		Would need to be determined

		Select Yes/No from the Drop Down List	Comments
TEST 4.7	Determine whether 'business units' or departments:		
	• are aware of the organisation's risk priorities	Yes	Should be clearer now that referenced in Strategic Framework
	• have a local risk register in place and carry out risk assessments in line with organisational guidance	Yes	Widespread operational use of risk registers and ongoing demand for support in their development. Can be evidenced by e.g. minutes and registers in Datix
	• monitor projects and risk improvements and report up to appropriate committee which co-ordinates risk management activity	Yes	As above.
	• have an embedded risk culture	Yes	From evidence above. Also walk rounds, safety huddles, included in clinical governance domain of performance reviews. Other tests: e.g. safety culture, incident reporting and response

		Select Yes/No from the Drop Down List	Comments
TEST 4.8	From discussion with management and consideration of KPI outcomes determine whether the risk register system requires development to ensure it meets the needs to the organisation and determine the process for progressing developments.		System development is ongoing. Always striving for improvement. To be gauged following implementation of KPIs. Intention to further develop the use of Datix. Considerable investment in Datix system upgrades and improved functionality.

RISK AND CONTROL EVALUATION (RACE) 5

RISK
Risks with partner organisations may not be appropriately managed ('the extended enterprise').

TEST DETAILS ***(Testing section of guidance)***

		Select Yes/No from the Drop Down List	Comments
TEST 5.1	Check that HSCI/partnership working has been considered as a corporate risk	No	Has been discussed. Referenced in IJB risk registers and in BAF .

		Select Yes/No from the Drop Down List	Comments
TEST 5.2	Check that the Board has agreed with partner organisations an appropriate approach to management of joint risks.	Yes	As above. The extent to which the approach, scope, and accuracy of risk is considered appropriate requires to be assessed. EDG and

		Select Yes/No from the Drop Down List	Comments
TEST 5.3	Check there is a system in place to identify, evaluate, record and monitor joint risks.	Yes	As above

		Select Yes/No from the Drop Down List	Comments
TEST 5.4	Check that a joint risk register has been established which accurately records joint risks.	Yes	As above.

		Select Yes/No from the Drop Down List	Comments
TEST 5.5	Check that joint risks are regularly and openly discussed with partner organisations.	Yes	As above

		Select Yes/No from the Drop Down List	Comments
Test 5.6	Obtain evidence that joint risks are appropriately reported and monitored at Board and operational level.	Yes	As above