Audit and Risk Committee

13 March 2020, 14:00 to 16:00
Board Room, Staff Club, Victoria Hosptial

Agenda

1. Apologies for Absence

2. Declaration of Members' Interests

3. Minutes of Previous Meeting held on 9 January 2020

Martin Black

Item 3 - Audit and Risk Minutes - 9 January 2020.pdf (10 pages)

4. Action List

Martin Black

Item 4 - A&R Action List 0320.pdf (1 pages)

5. Matters Arising

5.1. Assurance Mapping Process

Tony Gaskin/Gillian MacIntosh

5.2. IFRS 16 Update

Margo Mcgurk

Item 5.2 - SBAR IFRS 16 Leases accounting standard implementation.pdf (3 pages)

6. GOVERNANCE - GENERAL

6.1. Model Standing Orders for NHS Boards

Gillian MacIntosh

Item 6.1 - Model Standing Orders.pdf (18 pages)

6.2. New Meeting Paper Template for NHS Boards

Gillian MacIntosh

Item 6.2 - SBAR Meeting Paper Template.pdf (2 pages)

Item 6.2 - Meeting Paper Template & Guidance.pdf (13 pages)

6.3. Annual Committee Workplan 2020/21

Gillian MacIntosh

Item 6.3 - SBAR Annual Workplan ARC.pdf (1 pages)

Item 6.3 - ARC Annual Workplan 2020-21.pdf (2 pages)

6.4. Annual Review of Committee's Terms of Reference

Gillian MacIntosh

Item 6.4 - SBAR Committee ToR A&R.pdf (2 pages)

Item 6.4 - Committee ToR A&R.pdf (8 pages)

6.5. Committee Self-Assessment Report

Gillian MacIntosh

Item 6.5 - SBAR Committee SA report A&R.pdf (8 pages)

7. GOVERNANCE - INTERNAL AUDIT

7.1. Internal Audit - Progress Report

Barry Hudson

Item 7.1 NHSF March 2020 Progress Report Final.pdf (9 pages)

7.2. Internal Audit Report - B19/20 Adverse Events

Barry Hudson

Item 7.2 SBAR Adverse Events Management.pdf (5 pages)

Item 7.2 B19-20 - Adverse Event Management.pdf (16 pages)

7.3. Internal Audit - Follow Up Report

Barry Hudson

Item 7.3 Audit Follow Up Report.pdf (14 pages)

8. GOVERNANCE - EXTERNAL AUDIT

8.1. Annual Accounts – Progress Update on Audit Recommendations

Margo Mcgurk

Item 8.1 - SBAR cover Annual Audit Report Recommendations.pdf (2 pages)

Item 8.1 - Annual Audit Report Recommendations Update March 2020 FINAL.pdf (12 pages)

9. RISK

9.1. Board Assurance Framework

Helen Buchanan

Item 9.1 -SBAR Update on Board Assurance Framework to NHS Fife Audit and Risk Committee on 130320 V1.0.pdf (5 pages)

Item 9.1 - NHS Fife Board Assurance Framework (BAF) - Strategic Planning - CGC 160120.pdf (1 pages)

Item 9.1 -NHS Fife Board Assurance Framework (BAF) - Integration Joint Board.pdf (1 pages)

Item 9.1 -NHS Fife Board Assurance Framework (BAF) - Strategic Planning - FPR 160120.pdf (1 pages)

Item 9.1 -NHS Fife Board Assurance Framework (BAF) eHealth - CGC 160120.pdf (1 pages)

Item 9.1 -NHS Fife Board Assurance Framework (BAF) Environmental Sustainability - FPR 140120.pdf (1 pages)

Item 9.1 -NHS Fife Board Assurance Framework (BAF) Financial Sustainability - FPR 140120.pdf (2 pages)

Item 9.1 -NHS Fife Board Assurance Framework (BAF) Quality & Safety - CGC 160120.pdf (1 pages)

Item 9.1 -NHS Fife Board Assurance Framework (BAF) Workforce Sustainability - SG 170120.pdf (2 pages)

9.2. Risk Management Framework / Policy

Helen Buchanan

10. OTHER

10.1. Issues for escalation to NHS Board

Martin Black

11. Any Other Competent Business

12. Date of Next Meeting - Thursday 14 May 2020 at 2.00pm within the Boardroom, Staff Club, Victoria Hospital.

MINUTES OF THE NHS FIFE AUDIT AND RISK COMMITTEE HELD AT 10:00AM ON THURSDAY 9 JANUARY 2020 IN THE STAFF CLUB, VICTORIA HOSPITAL, KIRKCALDY

Present:

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

In Attendance:

Mrs H Buchanan, Director of Nursing
Mr T Gaskin, Chief Internal Auditor
Mr P Hawkins, Chief Executive
Mr B Howarth, Audit Scotland
Mr B Hudson, Regional Audit Manager
Dr G MacIntosh, Head of Corporate Governance & Board Secretary
Mrs C Potter, Director of Finance
Ms L Stewart, PA to Director of Finance

ACTION

01/20 WELCOME / APOLOGIES FOR ABSENCE

The Chair welcomed to the meeting Mr Brian Howarth, from Audit Scotland, and Ms Laura Stewart, who was attending in the capacity as an observer as part of her induction as PA to the Director of Finance. There were no apologies for absence.

02/20 DECLARATION OF MEMBERS' INTERESTS

There were no declarations of interest.

03/20 MINUTES OF PREVIOUS MEETING HELD ON 5 SEPTEMBER 2019

The Minutes of the previous meeting held on 5 September 2019 were **approved** as an accurate record.

04/20 ACTION LIST

Members of the Audit and Risk Committee **noted** that all the outstanding actions on the Committee's rolling Action List were complete, as per the update given.

05/20 MATTERS ARISING

There were no matters arising.

ACTION

06/20 GOVERNANCE – GENERAL

(a) Performance & Accountability Review Framework

Mrs Potter acknowledged that this report had previously been submitted to the other governance committees and was now presented to the Audit and Risk Committee for review. The new process is a key element of improved governance around Operational performance, Finance, Workforce and Quality, and the paper detailed the new framework that has been put in place in support.

Initial performance and accountability review meetings had taken place with individual directorates, which would be built upon going forward. Between the present date and the end of the financial year, there will be a further round of meetings. Next year, the intention is to build on the process and use it as part of strengthening the connection between discussions at an operational level (through EDG) and the different governance committees of the Board. It was noted that the timing of review meetings, particularly as aligned to the publication of the Integrated Performance & Quality Report, was important, so that this fed in to the Board reporting structure. It was anticipated that the Director of Finance & Performance, supported by the Medical Director, Director of Nursing, and Director of Workforce, would be able to take an overarching perspective of the operational activities of the organisation, which could enhance the systems of assurance that exist operationally and with the Board and its committees.

A query was raised about the formal performance review of the Health and Social Care Partnership. Mrs Potter noted that the Director of Health and Social Care has newly been appointed to her post and there is a new Interim Chief Operating Officer for Acute. The expectation is that, before we get into the formal performance review process, at an operational level the Chief Operating Officer and the Director of Health and Social Care have a similar process in place for their respective areas, with regular discussions on performance, as part of the operational management of these services.

The Audit and Risk Committee **noted** the Performance & Accountability Framework to be implemented for 2019/20, in support of enhanced assurance on all aspects of performance.

It was recommended that an update be brought back in terms of the review process for next financial year, which would expand on how these meetings align with existing day-to-day operational

performance management.

(b) Assurance Mapping Process

Dr MacIntosh explained that, aligned to the NHS Scotland Blueprint for Good Governance, there is work ongoing on the potential development of a common set of general principles around risk assurance that can be applied consistently to all Boards. This will also seek to cover existing guidance published by HM Treasury and the Scottish Government in the form of the Scottish Public Finance Manual.

A small working group has been established to discuss establishing an assurance mapping process, the membership including the four Health Boards covered by the FTF Internal Audit Service, with representation from Board Secretaries and Risk Managers. The paper outlined the early work of the group in discussing potential options for a workable process.

It was agreed that members would be kept up-to-date with progress, and it was noted an Internal Audit report would be issued in due course at the conclusion of the work.

The Audit and Risk Committee **noted** the present update.

(c) A Blueprint for Good Governance Update: Template Governance Documentation

In support of the implementation of the Good Governance Blueprint, Dr MacIntosh highlighted that that the NHS Scotland Board Secretaries' Group is leading on a number of supporting workstreams, including the creation of various 'Once for Scotland' templates for key governance documentation. As an example, a new induction process has been set up for Non-Executive Directors, based on the NHS Fife approach, and this also includes a new website that can be used for future development and further training.

A new version of model Standing Orders was released to NHS Boards in mid-December 2019. Work will begin in January 2020 to consider how the various changes to practice will be introduced in NHS Fife and an update provided to the Committee's next meeting in March 2020.

A reporting template for Board papers has also been designed and has been circulated for comment. The template remains based on the present SBAR format, but is intended to be simpler, more streamline and accessible to all. The current draft awaits the Steering Group's consideration, following initial scrutiny by Board

secretaries. Dr MacIntosh added that this will be trialled initially with EDG, with the intention that the new template is adopted across the whole organisation. Early discussion with the Health & Social Care Partnership has taken place about alignment with their existing template, to ensure that papers which come forward to the Board are similar in content.

Work has also begun around crafting standard Terms of Reference for governance committees. The proposed draft Terms of Reference for Audit and Risk is the most complete and this was discussed recently at the Board Secretaries' meeting. The revised draft now awaits feedback from Directors of Finance and Chief Internal Auditors.

Cllr Graham asked that Fife Council are included in the template discussions going forward, to ensure common areas of practice are identified. Dr MacIntosh agreed to take this action forward. **GM**

The Audit and Risk Committee **noted** the update.

07/20 GOVERNANCE - INTERNAL AUDIT

(a) Internal Audit Progress Report

Mr Hudson advised that eight internal audits reports have been competed since the last meeting of the Audit and Risk Committee, which are summarised in the report provided.

The completion of B08/20 - Internal Control Evaluation - was a substantial piece of work and will be discussed as a separate item on the agenda.

B09/20 - Audit Follow Up - was also a lengthy piece of work. There is now an enhanced system of follow up undertaken, with an updated protocol, which is also on the today's agenda.

Proposed amendments to the Internal Audit plan were detailed in the report. It was agreed at the June 2019 Audit and Risk Committee meeting that the plan would be revisited to ensure that it was still fit for purpose for 2019/20. The changes outlined in the report were being put to the Committee for approval, to allow the plan to go forward.

The External Quality Review assessment was presented to the Audit and Risk Committee originally in May 2019. The action plan is included in the report. There was one outstanding action, which the report details as now being complete.

ACTION

Ms Braiden referred to page 12 of the paper, in reference to the audit of transport of medicines. She noted that it was suggested that "electronic and automated solutions should be explored to mitigate against the issues highlighted..." and barcode scanning was mentioned. She referred to a recent Board presentation on Hospital Electronic Prescribing & Medicines Administration (HEMPA) and queried whether this would fully address this weakness in control. Mr Gaskin agreed that this would have some benefits, but there were wider implications that could be improved by generally automating and making more efficient the processes around medicines management.

Ms Potter noted that the audit opinion on transport of medicines is given as "Limited Assurance". She asked members if they would find it useful in future to have the Lead Director present for any reports where there is "limited" or "no assurance", to allow the Committee to query the area and receive reassurance on the actions being taken to improve controls.

The Committee agreed that, for future meetings, when a report is categorised as providing only "limited" or "no assurance", the Lead Director will attend the meeting, with a copy of the full report (rather than a summary) being added to the agenda. **BH/CP**

The Audit and Risk Committee:

- Noted the ongoing delivery of the 2018/19 and 2019/20 NHS Fife internal audit plan;
- Approved the proposed changes and revision of the 2019/20 Internal Audit Plan; and
- Noted the progress of actions in the External Quality Assessment.

(b) Interim Evaluation of Internal Control Framework

Mr Gaskin reported that the key issues arising from the report, with detailed findings and actions against progress deadlines, are included in Section Two. The action plan has been agreed with management to address the identified weaknesses. A follow-up of implementation of the agreed actions will be undertaken in accordance with the audit reporting protocol.

He highlighted that, in light of the Section 102 Report for Fife IJB, Internal Audit are of the opinion that the NHS Fife IJB BAF risk needs to be fundamentally reviewed and updated. He added that he had also recently received clarity in the key governance issues from the Scottish Government around Integration principles and advised that Nicky Connor, Director of Health and Social Care,

would be addressing these issues in the planned review of the Integration Scheme. Mr Hawkins gave assurance that there would be a resolution to the integration governance concerns in this planned review.

Mrs Potter noted that the Section 102 report for the Fife IJB is a first for any integration authority within Scotland. She gave background to the process and noted that it was applicable to Local Authorities and Integration Authorities, but not NHS Boards. Mr Howarth also explained the scope of the report and how the draft would be issued.

Ms Braiden queried whether a standalone BAF on Transformation would be taken forward. Mrs Buchanan noted that, in terms of integration, throughout the Board Assurance Framework there were elements covered in many of the organisational risks, since transformation was a thread that ran through many areas. Within the Financial Sustainability BAF, for instance, there is a section about the transformation programme and new ITB group included.

The Audit and Risk Committee **noted** the progress reported in the Interim Report of the Internal Control Evaluation.

(c) Audit Follow-Up Protocol

Mr Hudson explained that the previous version had come to the Committee for approval and this version has been updated to reflect feedback and comments in relation to the updated follow-up process.

The Audit and Risk Committee **noted** the reviewed protocol; and **approved** the changes and revision of the document.

(d) Follow-Up Report on Audit Recommendations

Mr Hudson highlighted that this is the first full audit follow up report in the new format. As reported to the May 2019 Audit and Risk Committee, Internal Audit have agreed to take responsibility for NHS Fife Audit Follow Up. An exercise recently was undertaken to identify outstanding actions.

Notifications were raised and sent to relevant responding officers for all recommendations that remained outstanding for final reports issued in 2017/18 and 2018/19.

In relation to using Datix to automate the follow-up process, it has been decided that, at the present time, the Internal Auditors will continue to progress the Audit follow up of recommendations manually.

Overall, 55% of due actions have been implemented as at 10 December 2019. This percentage is set to increase substantially as Internal Audit take forward the audit follow-up process on an ongoing, rolling basis.

The Audit and Risk Committee:

- **noted** and considered the current status of Internal Audit recommendations recorded within this report;
- **noted** the ongoing work to enhance the audit follow-up system and the reporting to Audit and Risk Committee.

08/20 GOVERNANCE – External Audit

(a) Annual Accounts – Progress Update on Audit Recommendations

Mrs Potter noted that this report provides an overview of the recommendations emerging from both the Internal Audit Annual Report and the Audit Scotland Annual Report for 2018/19.

A series of recommendations were included in the attached appendices, along with actions taken. Some due dates were still to occur, particularly those aligned to the year-end process.

The Audit & Risk Committee **noted** the actions taken to date.

(b) Audit Scotland Annual Audit Plan

Mr Howarth took members through the External Audit Annual Plan for 2019/20, outlining the following significant risks for NHS Fife. The risks have been categorised into financial statements risks and wider dimension risks. These were:

Financial Statements Risks

- Risk of material misstatement caused by management override of controls.
- Risk of material misstatement caused by fraud in expenditure.
- Risk of material misstatement caused by estimation and judgements.
- Risk of material presentation error in Note 3 – operating expenses.

Wider Dimension Risk

- Financial Management
- Financial Sustainability

Exhibit 1 in the report gave details of the planned audit work.

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

(c) Audit Scotland Report - NHS Scotland in 2019

Mrs Potter highlighted that the report sets out a number of key facts and messages, a series of recommendations and a supplementary checklist for Non Executive Directors. The report had been circulated to the Board, with the accompanying checklist, on its original publication in October 2019.

The Audit and Risk Committee **noted** the key messages and recommendations set out in the *NHS Scotland in 2019* report.

09/20 RISK

(a) Board Assurance Framework (BAF)

Mrs Buchanan provided an update to the Committee on the various components of the Board Assurance Framework, as follows:

Mrs Buchanan highlighted that:

- Financial Sustainability - remains at High, which recognises the ongoing financial challenges facing Acute Services in particular, as well as the pressures notable within the Health & Social Care Partnership.

- Environmental Sustainability – issues raised around water safety issues that were highlighted at the Clinical Governance Committee around a post that was required to be filled. This post has now been filled and the risk reduced.

- Quality & Safety - one of the risks has been closed. There had been some issues around monitoring water temperature etc. This project has been completed and the risk has been removed.

- Strategic Planning – four priorities have been identified in terms of strategic planning:
    1. Acute Transformation Programme
    2. Joining Up Care
    3. Mental Health Redesign
    4. Medicines Efficiencies

This is all being taken under the umbrella of the Transformation Programme Board, which has been reinvigorated.

- Integration Joint Board – A range of work has been carried out to improve the governance arrangements for the IJB.

- eHealth – The eHealth BAF has been approved by the Clinical Governance Committee and is the subject of review as part of the Assurance Mapping work discussed earlier in the agenda.

The Audit and Risk Committee **noted** the BAF and **noted** the developments to risk ratings.

(b) Risk Appetite

Mrs Buchanan gave a brief update, highlighting that specific responsibilities and processes relating to all aspects of the Board's risk appetite and tolerance will be described in the updated version of the Risk Management Framework, to be presented to the Committee and the Board for approval in March 2020.

The Audit and Risk Committee **noted** the paper.

(c) Update on Risk Management Workplan 2018-19

The Audit and Risk Committee **noted** the update to the Workplan for 2018/19.

(d) Risk Management Key Performance Indicators

Mrs Buchanan reported that work had taken place with Internal Audit for advice and support around creating KPIs in terms of Risk Management. Seven KPIs have now been developed, which have been submitted to the Executive Directors Group for discussion and approval.

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

10/20 OTHER

(a) There were no matters of escalation to the NHS Board from this meeting's agenda.

ACTION

11/20 Any Other Competent Business

There was no other competent business.

12/20 DATE OF NEXT MEETING: Friday 13 March 2020 at 14.00pm, within the Boardroom, Staff Club, Victoria Hospital, Kirkcaldy.

ACTION LIST FROM AUDIT & RISK COMMITTEE – 2019-20

	Title	Action	Lead	Outcome
1	Board Paper Template	Consult with colleagues at Fife Council on their covering paper template, to ensure that common areas of practice are identified where possible.	GM	Complete
2	Internal Audit reporting	When an internal audit report is categorised as providing only “limited” or “no assurance”, the Lead Director will attend the meeting, with a copy of the full report (rather than a summary) being added to the agenda.	BH / CP	In place for March meeting, with Adverse Events report given in full and Lead Director invited.

Completed Updated

Audit & Risk Committee

DATE OF MEETING:	13 March 2020
TITLE OF REPORT:	IFRS 16 Leases
EXECUTIVE LEAD:	Margo McGurk, Director of Finance & Performance
REPORTING OFFICER:	Mark Doyle, Assistant Director of Finance

Purpose of the Report (delete as appropriate)

~~**For Decision**~~	~~**For Discussion**~~	**For Information**

SBAR REPORT

Situation

IFRS 16 is applicable for accounting periods beginning or after 1 January 2019. For NHS bodies applying the HM Treasury's Financial Reporting Manual (FReM) the application of the standard has been deferred to 1 April 2020 (the 2020/21 financial year). NHS Fife will adopt the standard from 1 April 2020. There is no financial impact of IFRS 16 changes in the 2019/20 financial year.

Background

The new standard IFRS 16 replaces IAS 17 and was introduced by the International Accounting Standards Board (IASB) because of criticisms of the distinction between operating and finance leases, and the failure to fully recognise assets and liabilities arising from operating leases. The new standard contains more guidance on interpreting and identifying leases.

IFRS 16 removes the distinction between operating and finance leases, such that all leases will be capitalised, with corresponding lease liabilities accounted for through the statement of financial position from 1 April 2020.

IFRS 16 applies to:

- Leases previously classified as operating leases (excluding low value leases)
- Leases previously classified as finance leases (excluding leases of less than 12 months)
- Peppercorn Lease arrangements which should be valued at current or fair value.
- The right to use a specific asset within a contract that is not termed a "lease".

IFRS 16 does not apply to service concession arrangements and licences of intellectual property.

NHS Fife set up a SLWG to set out the planning and implementation requirements of IFRS 16. This included a review of: existing arrangements under IAS17 and IFRIC 4, the requirements of IFRS 16, NHS Fife planning, application and implementation timetables and the responsible officers, intended outcomes and timeframes.

Assessment

In December 2019 SG Health Finance and Infrastructure issued a template along with a request to confirm 2020-21 budget requirements under IFRS 16 Lease reclassification. The purpose of quantifying the lease reclassification changes was to ensure that sufficient budget cover could be provided to all NHS Boards and to set Scottish Government's leasing estimate for 2020-21.

SG confirmed that the Budgetary impact of IFRS 16 Lease reclassification implementation, in Financial year 2020/21, for all NHS Boards is:

- RDEL – removal of resource for operating lease annual payments
- RDEL - addition of resource for interest and depreciation charges associated with leases.
- CDEL – addition of capital budget for capitalisation of leases in the year they commence

HM Treasury indicated that adjustments to the reclassification figures submitted in the 10th January 2020 template would only be granted in exceptional circumstances. A response was sent by NHS Fife to SG for the 10th January 2020 deadline.

Next Steps

At the start of the 2020-21 Financial year:

- All leases identified in the December 2019 exercise will be added to the Board's Lease Register.
- All existing operating leases (including those under managed services contracts) which have been identified as leases under IFRS 16 will be capitalised as assets in the Statement of Financial Position (SOFP). The asset will be recognised at an amount equal to the lease liability (adjusted for accrued or prepaid lease payments recognised in 2019/20 also recognised in the SOFP).
- Depreciation will be charged in the Statement of Comprehensive Net Expenditure (SOCNE) against these assets from 1 April 2020 onwards.
- Interest charges will be charged in the SOCNE for these assets from 1 April 2020 onwards.
- A lease liability will be recognised in the SOFP in 2019/20, measured as the present value of the remaining lease payments. The discount rate will be either the interest rate implicit in the lease (if available) otherwise using the incremental borrowing rate.
- For existing finance leases classified under IAS 17 the carrying amount of the asset and the lease liability as at 31 March 2020 will become the carrying amount of the lease asset and lease liability under IFRS 16 as at 1st April 2020.
- Revised process identified and implemented to ensure that the all new leases that meet the conditions in IFRS 16 are identified and treated correctly, including the determination of the appropriate discount factor. The Financial Operating Procedures (FOP) to be updated accordingly.
- A revised process implemented to ensure that an up to date lease register is maintained. The Healthcare Financial Management Association identified this as an area of concern for all NHS bodies in their March 2019 "Application of IFRS 16 (updated) Briefing".
- A process implemented for capturing the disclosure requirements for expense of short term leases and low value leases (which are not taken into the SOFP).
- A process implemented to ensure that the qualitative and quantitative disclosure requirements of IFRS 16 are met. Including: the nature of leasing activities, future cash outflows (that are not measured in the lease liabilities) and residual value guarantees.

Qualitative and quantitative accounts disclosures explaining the difference between the operating commitments disclosed applying IAS 17 as at 31 March 2020 (discounted using the incremental borrowing rate) and the lease liabilities recognised in the SOFP at 1st April 2020 will also be required for the 2020/21 Financial Statements.

Recommendation

Members of the Audit & Risk Committee are asked to

- **note** the update on the application of the IFRS 16 Leases accounting standard.

Objectives: (must be completed)	
Healthcare Standard(s):	n/a
HB Strategic Objectives:	Financial sustainability
Further Information:	
Evidence Base:	n/a
Glossary of Terms:	n/a
Parties / Committees consulted prior	n/a

to Committee Meeting:	
Impact: (must be completed)	
Financial / Value For Money	Potential financial loss which must be recorded in statutory accounts
Risk / Legal:	n/a
Quality / Patient Care:	n/a
Workforce:	n/a
Equality:	n/a

Audit & Risk Committee

DATE OF MEETING:	13 March 2020
TITLE OF REPORT:	Model Board Standing Orders
EXECUTIVE LEAD:	Margo McGurk, Director of Finance
REPORTING OFFICER:	Gillian MacIntosh, Board Secretary

Purpose of the Report
For information

SBAR REPORT

Situation

The Scottish Government issued a Director's Letter (DL(2019)24) on 13 December 2019 advising of new model Standing Orders that all NHS Boards in Scotland are required to adopt, replacing any other local versions presently in place. This workstream is related to the implementation of NHS Scotland's 'A Blueprint for Good Governance', as previously detailed to the Committee in earlier updates.

This paper provides the new text of the model Standing Orders and highlights potential areas of change in practice for the Board to note, prior to the adoption of the Standing Orders in NHS Fife from 1 April 2020. The new text will thence be reflected in the annual update to the Code of Corporate Governance, to be considered by the Board, as scheduled, at its meeting in May 2020.

Background

Practical implementation of the Blueprint and its supporting suite of documents is being overseen through the NHS Scotland Chairs' sub-group, the Corporate Governance Steering Group, on which the NHS Fife Chair, Tricia Marwick, serves as a member. One of the first workstreams has been the creation of a model set of Standing Orders, based on a 'Once for Scotland' approach. Board Secretaries were consulted initially in their development and the final document has since been endorsed by NHS Chairs.

Standing Orders detail the formal procedures in place for Board meetings, outline key roles and responsibilities, and regulate the conduct of Board business in the context of its formal meetings. The text provided in the new version of the model Standing Orders (given in full in Appendix 1) has been kept simple and non-legalistic, whilst reflecting modern practice in the expected conduct of Board meetings.

The role of an NHS Board, as detailed in the Blueprint for Good Governance, has been included as a preamble to the document. All matters relating to Board Members' conduct (i.e. the model code of conduct, declaration of interests and receipt of gifts and hospitality) are collated together for ease. Further detail has been given on the matters reserved to the Board and those agenda items that should be considered in private session, which provides greater clarity on these matters and improved consistency in practice across Scotland. Guidance is

also given on agenda management, voting and member roles and responsibilities.

Assessment

To assist a more detailed consideration of the changes, a comparison between NHS Fife's existing Standing Orders (last reviewed as part of the Code of Corporate Governance update in May 2019) and the model document is included as Appendix 2 to this paper.

In summary, there are a small number of amendments that will require a change to current practice, and these are detailed below:

(i) (clause 4.9 of model Standing Orders) - final minutes of Committees (i.e. those formally approved at the subsequent Committee meeting) are to be tabled to a Board meeting, potentially introducing a significant lag in reporting unless a separate mechanism is introduced to cover the draft business discussed at the meeting immediately prior to the Board meeting date. In the new model text, Boards are free to 'determine [their] own approach for committees to inform it of business which has been discussed in committee meetings for which the final minutes are not yet available'. Other Boards already adopt the above procedure, with the majority allowing the respective Committee Chair to give a verbal update to the Board on the most recent committee meeting. Alternatively, some Boards have created a short (i.e. one to two page) report on the business considered at the most recent meeting (for an example in practice, see a Committee report from NHS Borders).

As Boards are able to decide on their own local procedure, it is proposed that draft minutes continue to be supplied to Board meetings, in addition to approved copies of minutes from the preceding meeting, in order to ensure that the Board continues to have the most up-to-date information on Committee deliberations and discussions. An amended cover sheet will be produced to clearly indicate the draft nature of the accompanying minute.

(ii) (clause 9.5 of model Standing Orders) - Board Committee meetings should not be held in public nor their papers published on the Board's website, unless the Board specifically requests otherwise. This is contrary to current practice, whereby we make available publicly all Committee dates and their full meeting papers (apart from any private sessions) in advance of the meeting, as per the normal publication schedule for the full Board papers. To reflect the updated guidance, it is proposed that Committee papers continue to be published on the NHS Fife website, but only after the Board meeting has taken place to which each Committee subsequently reports. This will, in practice, introduce a short lag in publication of around three to four weeks.

(iii) (schedule of optional text to be included in Standing Orders, see p.15 of this paper) – it is recommended that optional additions to both Sections 4 and 5 are included in the new Standing Orders for Fife, to mirror existing coverage. Both optional clauses have equivalents within the current Standing Orders and are therefore not new additions. For the additional items to be reserved to the Board, to be included in Section 6 of the new text, it is proposed we adopt the majority of the wording given in the model text, again to mirror existing coverage and present practice.

Recommendation

The Audit & Risk Committee is invited to:

- **note** the update given in this paper on the content of the new model Standing Orders that have been prepared for adoption nationally on a 'Once for Scotland' basis;
- **note** the anticipated changes to current Board administrative practice as detailed above; and
- **agree** to recommend to the Board at its 25th March meeting the adoption of the model Standing Orders, to be effective from the start of the new financial year, 1 April 2020.

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

Further Information:	
Evidence Base:	DL(2019) 24 – NHS Boards: Standing Orders
Glossary of Terms:	N/A
Parties / Committees consulted prior to Meeting:	Board Chair; Finance Director

Impact:	
Financial / Value For Money	There are no financial implications.
Risk / Legal:	Implementing the model Standing Orders will mitigate any risks of non-compliance with the Blueprint's requirements. Compliance evidences that NHS Fife has robust corporate governance practices in place that help deliver and support organisational objectives.
Quality / Patient Care:	Delivering improved governance across the organisation is supportive of enhanced patient care and quality standards.
Workforce:	The implementation of any of the recommendations from this paper will be met from existing resource.
Equality:	There are no specific Equality and Diversity issues arising from undertaking this work.

STANDING ORDERS FOR THE PROCEEDINGS AND BUSINESS OF [FIFE] NHS BOARD

1 General

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

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

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

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

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

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

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

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

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

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

Board Members – Ethical Conduct

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

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

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

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

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

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

2 Chair

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

3 Vice-Chair

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

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

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

4 Calling and Notice of Board Meetings

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

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

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

responsibility to discharge which requires that member to present a report to the Board, then that report will be included in the agenda.

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

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

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

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

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

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

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

receive the meeting papers for those items, unless the person presiding agrees that others may receive them.

5 Conduct of Meetings

Authority of the Person Presiding at a Board Meeting

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

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

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

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

Quorum

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

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

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

committee meeting when the item is under consideration, and should not be counted as participating in that meeting for quorum or voting purposes.

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

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

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

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

Adjournment

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

Business of the Meeting

The Agenda

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

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

Decision-Making

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

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

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

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

5.19 Where the Chair concludes that there is not a consensus on the Board's position on the item and/ or what it wishes to do, then the Chair will put the decision to a vote. If at least two Board members ask for a decision to be put to a vote, then the Chair will do so. Before putting any decision to vote, the Chair will summarise the outcome of the discussion and the proposal(s) for the members to vote on.

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

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

Board Meeting in Private Session

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

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

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

Minutes

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

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

6 Matters Reserved for the Board

Introduction

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

6.2 This section summarises the matters reserved to the Board:

a) Standing Orders
b) The establishment and terms of reference of all its committees, and appointment of committee members
c) Organisational Values

d) The strategies for all the functions that it has planning responsibility for, subject to any provisions for major service change which require Ministerial approval.
e) The Annual Operational Plan for submission to the Scottish Government for its approval. (Note: The Board should consider the draft for submission in private session. Once the Scottish Government has approved the Annual Operational Plan, the Board should receive it at a public Board meeting.)
f) Corporate objectives or corporate plans which have been created to implement its agreed strategies.
g) Risk Management Policy.
h) Financial plan for the forthcoming year, and the opening revenue and capital budgets.
i) Standing Financial Instructions and a Scheme of Delegation.
j) Annual accounts and report. (Note: Note: This must be considered when the Board meets in private session. In order to respect Parliamentary Privilege, the Board cannot publish the annual accounts or any information drawn from it before the accounts are laid before the Scottish Parliament. Similarly the Board cannot publish the report of the external auditors of their annual accounts in this period.)
k) Any business case item that is beyond the scope of its delegated financial authority before it is presented to the Scottish Government for approval. The Board shall comply with the Scottish Capital Investment Manual.
l) The Board shall approve the content, format, and frequency of performance reporting to the Board.
m) The appointment of the Board's chief internal auditor. (Note: This applies either when the proposed chief internal auditor will be an employee of the Board, or when the chief internal auditor is engaged through a contract with an external provider. The audit committee should advise the Board on the appointment, and the Board may delegate to the audit committee oversight of the process which leads to a recommendation for appointment.)

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

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

7 Delegation of Authority by the Board

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

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

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

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

8 Execution of Documents

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

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

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

9 Committees

9.1 Subject to any direction issued by Scottish Ministers, the Board shall appoint such committees (and sub-committees) as it thinks fit. NHS Scotland Board Development website will identify the committees which the Board must establish. (https://learn.nes.nhs.scot/17367/board-development)

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

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

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

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

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

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

Appendix 1

MODEL STANDING ORDERS

SCHEDULE OF OPTIONAL TEXT

Section 4 – Calling and Notice of Board Meetings: Deputations and petitions

[**Suggested inclusion after Clause 4.9**]
Any individual or group or organisation which wishes to make a deputation to the Board must make an application to the Chair's Office at least 21 working days before the date of the meeting at which the deputation wish to be received. The application will state the subject and the proposed action to be taken.

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

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

Section 5 - Business of the Meeting: Consent agenda technique

[**Suggested inclusion after Clause 5.14**]
For Board meetings only, the Chair may propose within the notice of the meeting "items for approval" and "items for discussion". The items for approval are not discussed at the meeting, but rather the members agree that the content and recommendations of the papers for such items are accepted, and that the minutes of the meeting should reflect this. The Board must approve the proposal as to which items should be in the "items for approval" section of the agenda. Any member (for any reason) may request that any item or items be removed from the "items for approval" section. If such a request is received, the Chair shall either move the item to the "items for discussion" section, or remove it from the agenda altogether.

Section 6 – Additional matters which may be reserved for the Board

[**Suggested inclusion as part of Clause 6.2, excluding text that is struck out**]

- The contribution to Community Planning Partnerships through the associated improvement plans.
- Health & Safety Policy
- Arrangements for the approval of all other policies.
- The system for responding to any civil actions raised against the Board.
- The system for responding to any occasion where the Board is being investigated and / or prosecuted for a criminal or regulatory offence.

~~Within the above the Board may delegate some decision-making to one or more executive Board members.~~

Comparison with existing Standing Orders

	Current Standing Orders	**New Standing Orders**
Section 1.1 **General provisions**	-	New section added to reflect the Blueprint's description of the function of an NHS Board.
Clauses 1.5 to 1.10 **Board Members – Ethical Conduct**	Covered largely in existing clause 9 of current text.	This section brought to the front of new text, clearly setting out members' personal responsibility for compliance with Code of Conduct and collating guidance on declaration of interests, gifts and hospitality.
Clause 3.1 **Appointment of Vice-Chair**	In current text 'the Board' appoints the Vice-Chair. Limited detail on the actual appointment process and role.	Provides full details on the appointment process for Vice-Chair, including the nomination / approval sequence to be followed in consultation with the Cabinet Secretary.
Clauses 4.2 and 4.3 **Contents of the Agenda / AOCB**	No specific reference.	Full details given on determining the content of the agenda and the Chair's approval role on items of business to be included. Clarification that AOCB can only be used for business which the Board is being informed of, i.e. for awareness, rather than for matters where the Board is being asked to make a decision.
Clause 4.6 **Minimum notice period for meetings**	Current text states 'five clear days', but this presently includes non-working days.	Instructed to be 'three clear days', *excluding weekends and public holidays*, so in effect no change in practice.
Clause 4.9 **Meetings to be held in public**	No change.	
Clause 4.9 **Committee minutes included in Board meeting papers**	No specific detail.	Meeting papers have to include the approved minute of Board committees (i.e. those minutes that have been finalised at the subsequent committee meeting). Text notes that 'the Board may determine its own approach for committees to inform it of business which has been discussed in committee meetings for which the final minutes are not yet available'. Note, Remuneration Committee minutes are to be excluded from any published version of the Board papers.

Clause 4.10 (optional) **Deputations & Petitions**	Included in current version (Clause 6), but with less detail on process included.	Provides further details on the process to be followed, and increases the timeframe for submission of such applications from 'five clear days' in current text to '21 working days'.
Clauses 5.1 to 5.4 **Authority of the Chair**	Less detail provided in current text.	Detailed outline of the authority of the person presiding at a Board meeting, including how inappropriate behaviour by a member is to be dealt with.
Clause 5.5 to 5.11 **Quorum**	In current version, one-third required, with at least five Non-Executive members; for Committees, at least three Non-Executive or Stakeholder members.	One third required, with 'at least two members who are not employees of the Board'; for Committees, at least 'two Board members'. Further detail given on course of action when a quorum is not achieved.
Clause 5.12 **Adjournment**	No change.	
Clauses 5.13 and 5.14 **Business of the Meeting: Agenda**	If a member wishes to add an item of business, they may make such a request to the Chair 'at the start of the meeting'. A majority of members present must agree to its inclusion.	Any such requests to add an item should be made 'ideally in advance of the day of the meeting and certainly before the start of the meeting'. The Chair will determine if the proposed addition is urgent and should be included.
Clauses 5.15 to 5.21 **Business of the Meeting: Decision-Making**	Specific detail included on motions.	Detail on motions removed from new text. Replaced with instructions on how discussions should proceed, how discussions should be concluded when consensus has been reached, and on when voting should be used. If at least two Board members ask for a decision to be put to a vote, the Chair is required to do so.
Clause 5.22 **Board meeting in Private Session**	Covered in current clause 5.22.	Removes local text as to who also is permitted to be present in the private session (i.e. in addition to Board members), though replacement text does not prohibit that. Clarifies that the meeting minutes will clearly reflect when the Board has resolved to meet in private.

Clauses 5.24 and 5.25 **Minutes**	Additional clause given in current version - 'Minutes of governance committees shall be submitted as soon as it is practicable to the Board'.	This is not present in new text, as approved minutes only are to be considered by the Board (see clause 4.9 above).
Clause 6.2 **Matters reserved for the Board**	Present text reflects local terminology (such as IPQR, BAF etc.) and further detail around reporting.	Less detail provided but largely similar content overall.
Clauses 7.1 to 7.4 **Delegation of Authority**	No change.	
Clauses 8.1 to 8.3 **Execution of Documents**	Use of common seal detailed.	Detail on use of common seal removed from new text – regulations do not require this to be in Standing Orders and its use is limited in practice.
Clauses 9.2 to 9.4 **Committee membership**	'The Chair' shall appoint committee chairs and members. Substitutes permitted from Non-Executive membership.	'The Board' shall appoint committee chairs and members. Substitutes continue to be permitted from Non-Executive membership.
Clause 9.5 **Committee meetings and publication of papers**	No specific detail included.	Recommended practice is that a Committee's meetings '*shall not be held in public and the associated committee papers shall not be placed on the Board's website, unless the Board specifically elects otherwise*'.
Clause 9.7 **Co-option**	Not included in current version.	In order to address particular skill requirements, the Board may authorise committees to co-opt members for a period of up to one year, subject to the approval of the Board and the Accountable Officer. Such an appointee is not to be counted when determining the quorum.

Audit & Risk Committee

DATE OF MEETING:	13 March 2020
TITLE OF REPORT:	New Meeting Paper Template for NHS Boards
EXECUTIVE LEAD:	Margo McGurk, Director of Finance
REPORTING OFFICER:	Gillian MacIntosh, Board Secretary

Purpose of the Report
For Information

SBAR REPORT

Situation

Members are asked to review the new national template produced for Board and Committee meeting papers, which has been developed on a 'Once for Scotland' basis by the Board Secretaries' Group, with input from the Chairs' Corporate Governance Steering Group (on which NHS Fife's Chair serves as a member).

Background

As part of the suite of work accompanying the implementation of the Model NHS Scotland Blueprint for Good Governance, a new template for Board-level meeting papers has been produced, along with accompanying guidance. The template remains based on the SBAR format that is currently in use; however, the revised version aims to be more streamlined and cleaner in format, and has been accessibility checked by the source Board, Golden Jubilee.

Boards are encouraged to adopt the template fully, but there is scope for minimal revision to suit local circumstances.

Assessment

Attached to this paper is a copy of the meeting paper template and accompanying guidance document to support its introduction. Some minor tweaks have been made to both to reflect our local administration arrangements, but in general we propose adopting the template and guidance largely as issued.

In order to ensure that papers which progress through the internal governance structure are properly formatted, it would be important to mandate the use of the new template for other key groups, such as EDG. The template has been shared with colleagues at the Fife H&SCP and Fife Council, with the request that (particularly for the IJB) we aim to use as similar a format as possible. Some minor changes have been made to the current draft to reflect their feedback.

A review is currently underway of the minute format for the Board and its committees, to ensure greater consistency between committees (since some variation has crept in since the

last review). This also has the aim of streamlining and simplifying format, to enhance readability and clarity, aligning the minute format to that of meeting papers.

Recommendation

The Audit & Risk Committee is invited to:

- **consider** the attached template with a view to adoption in NHS Fife at the start of the new financial year 2020/21; and
- **note** the ongoing review of other template documentation for the Board and its committees (for instance, minute format) to align with the adoption of the new template.

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

Further Information:	
Evidence Base:	DL(2019) 02 - NHS Scotland Health Boards and Special Health Boards - Blueprint for Good Governance
Glossary of Terms:	N/A
Parties / Committees consulted prior to Meeting:	Board Chair; Committee Chairs; EDG

Impact:	
Financial / Value For Money	There are no financial implications.
Risk / Legal:	Compliance with the 'Once for Scotland' governance work evidences that NHS Fife has robust corporate governance practices in place that help deliver and support organisational objectives.
Quality / Patient Care:	Delivering improved governance across the organisation is supportive of enhanced patient care and quality standards.
Workforce:	The implementation of any of the recommendations from this paper will be met from existing resource.
Equality:	There are no specific Equality and Diversity issues arising from undertaking this work.

NHS Fife

Meeting:	**Meeting name**
Meeting date:	**1 January 2020**
Title:	**Name of report**
Responsible Executive/Non-Executive:	**Full name and title of responsible lead**
Report Author:	**Full name and title of report author**

1 Purpose

Please select one item in each section and delete the others.

This is presented to the Board for:

- Awareness
- Decision
- Discussion

This report relates to:

- Annual Operational Plan
- Emerging issue
- Government policy/directive
- Legal requirement
- Local policy
- NHS Board / Integration Joint Board Strategy or Direction
- National Health & Well-Being Outcomes

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

Provide a concise statement of the situation. Why is this being brought to the meeting's attention? What is the strategic context? What is the Board being asked to do? (Cross-reference with Recommendation Section below).

2.2 Background

Provide pertinent information relating to the situation. Summarise issues of significance, any National / Local objectives involved and relevant legislative / Healthcare Standards.

2.3 Assessment

Provide analysis of the situation and considerations. Assess the current position, identifying any organisational risks, stakeholder considerations and evidence base to help inform decision-making. This should be the bulk of the paper.

2.3.1 Quality/ Patient Care

Describe any positive and negative impact on quality of care (and services).

2.3.2 Workforce

Describe any positive and negative impact on staff, including resources, staff health and wellbeing.

2.3.3 Financial

Describe the financial impact (capital, revenue and efficiencies) and how this will be managed.

2.3.4 Risk Assessment/Management

Describe relevant risk assessment/mitigations.

2.3.5 Equality and Diversity, including health inequalities

State how this supports the Public Sector Equality Duty, Fairer Scotland Duty, and the Board's Equalities Outcomes.

An impact assessment has been completed and is available at… or
An impact assessment has not been completed because…

2.3.6 Other impact

Describe other relevant impact.

2.3.7 Communication, involvement, engagement and consultation

If relevant, the Board has carried out its duties to involve and engage external stakeholders where appropriate:

State how his has been carried out and note any meetings that have taken place.

- Stakeholder/Group Name, date written as 1 January 2020
- Stakeholder/Group Name, date written as 1 January 2020

2.3.8 Route to the Meeting

This has been previously considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

- Committee/Group/Meeting Name, date written as 1 January 2020
- Committee/Group/Meeting Name, date written as 1 January 2020

2.4 Recommendation

State the action being requested. Use one of the following directions for the meeting. No other terminology should be used.

- **Awareness** – For Members' information only.
- **Decision** – Reaching a conclusion after the consideration of options.
- **Discussion** – Examine and consider the implications of a matter.

3 List of appendices

The following appendices are included with this report:

- Appendix No, Document title
- Appendix No, Document title
- Appendix No, Document title

Report Contact
Author Name
Author's Job Title
Email ***@nhs.net

NHS Scotland

Model Meeting Paper Template
Completion Guidance

	Date	Detail of change	Author
Draft Version 0.1	Dec-19	-	National Board Secretaries Group

1 NHS Scotland Meeting Paper Guidance

These instructions have been prepared to help the authors of all reports and explain how to use the Model Meeting Paper Template for reports to the Board, its committees and senior management meetings.

They provide guidance on:

- issues to consider when deciding whether and how to submit a paper to a meeting,
- achieving the desired result,
- format and structure of papers including protective markings, and
- timing of submission of papers.

2 Introduction

For any decision-making group to be effective, it needs to be given information in a form and of a quality that is appropriate to enable members to carry out their duties.

A Board performing to its full potential needs sufficient, timely, accurate and relevant information. A good set of Board or Committee papers is essential for effective governance. A well-constructed set of papers gives an overall picture of the organisation at a point in time and highlights the decisions that need to be made at a particular meeting.

Board, Committee or group members rely on these papers to provide them with the right information so they can make informed decisions. The papers are also a formal record of the decision-making process.

To ensure papers are fit for the purpose of any meeting, they should be appropriate for the audience, not overly lengthy or too detailed and are well laid out.

A well written paper will be structured appropriately within major template headings, read like a written conversation, and anticipates and answers Board members' questions.

The author should write with the audience in mind, so the purpose of the report and the issue for the organisation is clear at the beginning.

The author's discussion may include a summary of actions that have occurred, not a step by step account.

3 Issues to consider when deciding whether and how to submit a paper

3.1 Purpose of the report

The purpose of a report for the Board or one of its committees will be concerned with corporate governance, and should aim to either:

1) **Provide assurance*** on something, or
2) **Provide information and/or options** so that the Board or committee may make a decision on something, e.g. approval of a strategy or a business case.

*Assurance is “confidence based on sufficient evidence that internal controls are in place, operating effectively and objectives are being achieved.”

The Model Meeting Paper Template will prompt you to tell members that the paper is for:

- Awareness;
- Decision; or
- Discussion.

3.2 Achieving the desired result

In order to achieve a desired result, please think carefully about the decision(s) the meeting is being asked to take.

3.3 Is the report ready to come?

Appropriate involvement and engagement must have taken place, and appropriate group approvals secured, before the paper reaches the Board or a Committee.

3.4 For managers preparing papers, has your Director seen and approved the paper?

A Board member or an Executive Director should approve a report before it is presented to the Board or a committee.

3.5 What other issues should be considered?

The Board is responsible for taking forward the strategic aims and objectives agreed by Scottish Ministers, to ensure that its services are safe, effective and person centred.

It provides effective leadership, direction, support and guidance to the organisation and ensures that the policies and priorities of Scottish Ministers are implemented.

One of the key roles of every Board member is to provide a strong 'challenge function', carefully scrutinising plans and underlying assumptions before decisions are taken.

When deciding whether to submit a paper, please consider the following questions:

- **Why the issue is being brought to the meeting?**

  It is important to have a clear idea of why an issue needs to come to a particular meeting. What corporate risk or strategy objective is being addressed? Are you confident that the purpose of the report will be a governance issue, or is it a matter which executive management should decide?

- **Is it of significance to merit the group's time?**

  For example, is it an issue which has significance across the Board? Does it change service policy? Does it have significant cost or reputational implications? Is the issue relevant to the remit of the committee, or appropriate for discussion at the Board?

- **Does the issue need to be decided by the Board or another group?**

  Some decisions have to be made by the Board as set out in the Standing Financial Instructions' Scheme of Delegation (e.g. contract awards over £1m in value). However, for other decisions it will be more appropriate to be considered by someone else (Governance Committee or Executive Director)?

- **Is the matter urgent?**

  If the matter is urgent, please seek advice from the Board Secretary. It is helpful to discuss a proposed paper with the Executive lead or Chair of the meeting at an early stage in order to establish whether it is suitable for inclusion on the agenda and how it should be presented.

- **What other areas should be considered?**

  Where a paper is coming to the Board or to a committee for decision, discussion, or awareness, the Board requires "assurance" that:

  - there are sufficient processes to fulfil the requirements of the Public Sector Equality Duty, Fairer Scotland Duty and that these have been carried out properly,
  - there are processes to gather and use evidence such as data or engagement with people from different protected characteristics groups, and
  - there is a procedure for publication of the impact assessments associated with this.

Where a paper is coming to the Board or Committee for approval.

- As well as the assurance described above, the Board has to demonstrate that it has paid due regard to Equality Impact Assessment. These are a mandatory and legal function of any Public Sector organisation. In tandem with the Fairer Scotland Duty 2019, this requires all public sector organisations to 'give due regard' and 'actively consider' what the impact of strategic decisions would be on those people who experience socio-economic disadvantage and inequalities of outcome.

  The information required must be sufficient for members to understand the impact on equality and the actions taken, to be assured about evidence including engagement as well as plans for monitoring impact.

  It is unlikely to be sufficient for the Impact Assessment or similar to be attached. Whilst this supports the assurance element, it does not necessarily ensure the Board or Committee has its attention drawn to the relevant information for decision-making.

- **Stakeholder engagement**

  It is a legal duty to encourage public involvement, as per the legislation below:

  National Health Service (Scotland) Act 1978
  Community Empowerment (Scotland) Act 2015

  The Scottish Health Council's participation toolkit provides guidance on best practice of participation and engagement.

  Reports should outline what involvement and engagement has taken place (or will take place) with key stakeholders. This will highlight and give assurance that specific stakeholders are aware of the plan or project, as well as ensure there is strong and widespread understanding of the direction of travel, aims and priorities set out.

4 Format and structure of papers

4.1 Model Meeting Paper Template

The "Once for Scotland" Model Meeting Paper Template can be used in one of two ways:

- as a report document in its own right; or
- as a cover paper/Executive Summary to a larger document.

This will provide Boards with the flexibility needed to effectively use the template to meet local needs.

Logos

The NHSScotland logo is included as standard as it applies to all Boards. Where Boards wish to use their own logo, the Board Secretary should change the logo before circulating the template for use.

Populating the template

Adapted from the original version developed by the United States Navy, the SBAR communication tool is widely used in healthcare.

S = Situation (a concise statement of the problem)
B = Background (pertinent and brief information related to the situation)
A = Assessment (analysis and considerations of options)
R = Recommendation (action requested/recommended)

The SBAR tool:

- Is easy to use.
- Enables information to be communicated accurately,
- Encourages assessment skills,
- Prompts provision of the right level of detail,
- Ensures thinking has happened before the message is communicated.
- Ensures the recipient knows what to expect.

Further information on the SBAR Communication Tool is available at:
https://improvement.nhs.uk/documents/2162/sbar-communication-tool.pdf

4.2 Report writing guidance

Plan your writing

- Be clear about why you are writing.
- What do you want to achieve?
- What action do you want your reader to take?
- Before you begin writing, ask yourself ‘who is my audience?’ Your audience will influence the way you write.
- Picture your readers if you can – try and put yourself in their shoes.
- Organise all the information your reader needs in logical order that will make sense.

Structure your writing

- Keep to the essentials. What message do you want to get across? Make your purpose clear to the reader early on.
- Get to the point quickly. The first few paragraphs should summarise the key points. For example: who, what, why, where, when and how.
- Think carefully how to present the information.
- If there is a lot of information, use headings to break up your writing into sections.
- Careful use of illustrations and flow charts can help your reader sort out complex information.
- Lists can help to simplify complex information. Bullet points can help to make information stand out.
- Remember – be consistent in the way you lay out information.
- The average sentence length should be around 15 to 20 words. Vary the length. Very short sentences are good for making punchy points. Each sentence should contain one main idea.
- Paragraphs should be made up of a group of sentences with a common theme.
- Before submitting your report, re-read it, or ask someone else to do so, to ensure the information is clear and easy to understand.

Your writing style

- Imagine you are talking to your reader. Your writing style will immediately become more warm, personal and conversational. Refer to the reader as you and the organisation as we.
- Do not use gender specific words such as manpower (use workforce or employees).
- Use everyday English. Remember you are writing to inform, not to impress.
- Avoid legalistic and pompous words.
- Do not use jargon that your reader might not understand. Explain any technical terms that you may need to use.
- If you use acronyms, write them out in full and put the acronym in brackets. For example: Senior Management Team (SMT)
- Use simple words to make things clear for your reader, such as “near” rather than “in the vicinity, ” “use” instead of “utilise” etc

5 Timing of submission of papers

The Board Secretary will establish arrangements within your Board for you to submit your final reports for Board and committee meetings. It is essential that you submit your reports by the required deadline. This gives the chair of the meeting the opportunity to review the reports in advance of the meeting before the reports are issued. The secretary can also distribute the meeting pack to the members in good time for them to prepare for the meeting.

Please let the Board Secretary know as soon as possible if there are any issues meeting the deadlines.

6 Further guidance

For further guidance or advice, contact:

((Name))
Board Secretary (or other title)
NHS xxxx

Appendix one - **Content checklist**

Does the issue need to be decided by the group?	
Is the paper ready to come to the group?	
Is there enough information that members can make a decision with confidence?	
Are the key messages clear so that everyone understands the same message?	
Is there enough information to support the key messages?	
Is all the information relevant or does it include 'nice to know' information as well?	
Is there enough analysis?	
Is the language suitable, i.e. is it clear and simple without any jargon?	
Where options are presented, are there clear reasons for the preferred option(s)? Are the risks clearly identified? Are the finances and facts accurate?	
Are fact and opinion clearly differentiated?	
Is the proposal in line with the Board's strategy?	
What communication and engagement has taken place or is needed with stakeholders?	

Appendix two – **Formatting checklist**

Font	Arial	
Headings	Size 14 bold and sentence case	
Sub headings	Size 12 bold and sentence case	
All other text	Size 12 regular and sentence case	
Line Spacing	Single	
Justification	Left (ragged margin)	
Text colour	Select automatic colour. Colour text should only be used where it significantly adds to understanding (i.e. graphs)	
Version Control	All documents should be in line with Document Control and Naming Conventions guidance, which includes the format for page numbers.	
Acronyms	Spell these out in full the first time and follow up with the shortened version in brackets. Thereafter the acronym should be used.	
Abbreviations (add local information to bullet list)	Spell these out in full the first time and follow up with the shortened version in brackets. Thereafter the acronym should be used. The following should never be abbreviated: • NHSScotland	
Tense	Stick to the same tense and keep it simple.	
Postholders	Refer to job titles and not by personal name.	
Dates	For consistency across papers, the following format for dates should be used in all papers: 1 January 2016.	
Terminology	Ensure that a glossary is included or provide an explanation on first use in Board paper.	
Changes	Generally, tracked changes should not be included on any papers but you should highlight any changes made to the original paper presented in the cover paper. In some circumstances it may be relevant to include changes in this way.	
Protective markings	All Board papers are public and do not need to be protectively marked. Boards with a private session should classify papers by using a header message on every page as follows: • Board Official or • Board Sensitive	
Patient / Personal / Sensitive information	If you have any questions in respect of patient/personal information, to ensure that all information is treated appropriately and confidentially, advice should be sought from the Caldicott Guardian.	

Audit & Risk Committee

DATE OF MEETING:	13 March 2020
TITLE OF REPORT:	Audit & Risk Committee Workplan 2020/21
EXECUTIVE LEAD:	Margo McGurk, Director of Finance
REPORTING OFFICER:	Gillian MacIntosh, Board Secretary

Purpose of the Report (delete as appropriate)		
		For Assurance

SBAR REPORT

Situation

The NHS Fife Code of Corporate Governance states that all Committees *"will draw up and approve, before the start of each year, an annual work plan for the Committee's planned work during the forthcoming year".*

Background

The annual workplan for the Audit & Risk Committee for 2019/20 was last formally approved in March 2019. The attached workplan gives the forward plan for the new financial year 2020/21.

Assessment

The purpose of this report is to seek approval for the Committee workplan for 2020/21.

Committee members should note that no major changes have been made to the workplan or the overall schedule of expected business.

Recommendation

The Committee is asked to:

- **approve** the updated workplan for 2020/21.

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:	N/A
Parties / Committees consulted prior to Committee Meeting:	N/A
Impact: (must be completed)	
Financial / Value For Money	The review and approval of an annual workplan for Committee business will ensure appropriate governance across all areas and that effective assurances are provided
Risk / Legal:	
Quality / Patient Care:	
Workforce:	
Equality:	

AUDIT & RISK COMMITTEE – ANNUAL WORKPLAN 2020/21

	Lead	May	June	September	December	March
General						
Minutes of Previous Meetings	**Chair**	√	√	√	√	√
Annual Workplan	**Board Secretary**					√
Corporate Calendar	**Board Secretary**			√		
Escalation of Issues to NHS Board	**Chair**	√	√	√	√	√
Review of Terms of Reference	**Board Secretary**					√
Annual Review of Code of Corporate Governance	**Board Secretary**	√				
Governance – General						
Committee Self Assessment	**Board Secretary**					√
Annual Assurance Statement	**Board Secretary**	√				
Annual Assurance Statements from Standing Committees	**Board Secretary**		√			
IJB Annual Assurance Statement	**Board Secretary**			√		
Draft Governance Statement	**Chief Executive**	√				
Property Transactions Report	**DoE&F**	√				
Review of Property Transactions	**Chief Internal Auditor**			√		
Review of Payment Verification Process (FHS/PMS)	**DDoF**	√				
Governance – Internal Audit						
Internal Audit Progress Report	**Chief Internal Auditor**	√	√	√	√	√
Annual Internal Audit Report	**Chief Internal Auditor**		√			
Internal Audit – Follow Up Report on Audit Recommendations	**DoF**	√		√	√	√
Annual Internal Audit Plan	**Chief Internal Auditor**	√				
FTF Shared Service Agreement / Service Specification	**Chief Internal Auditor**	√				
External Quality Assessment (5 yearly)	**Chief Internal Auditor**	√				
Governance – External Audit						
Interim Management Report	**External Audit**	√				
Annual Audit Report	**External Audit**		√			
Annual Audit Plan	**External Audit**				√	
Audit Planning Memorandum – Patients Private Funds	**External Audit**	√				
External Audit – Follow Up Report on Audit Recommendations	**DoF**			√	√	√
Service Auditor Reports on Third Party Services	**DoF**		√			

Annual Accounts						
Annual Accounts & Financial Statements	**DoF / External Auditor**		√			
Patients Funds Accounts	**DoF / External Auditor**		√			
Annual Statement of Assurance to the NHS Board	**Board Secretary**		√			
Letter of Representation	**DoF**		√			
Risk						
Annual Risk Management Report	**DoN**	√				
Risk Management Report	**DoN**			√		√
Board Assurance Framework (BAF)	**DoN**	√	√	√	√	√
Counter Fraud						
Counter Fraud Service – Update on Referrals	**ADoF**	√		√	√	√
Counter Fraud Service – Update on Intelligence Alerts	**ADoF**	√		√	√	√
Counter Fraud Service – NHS Scotland Quarterly Report	**DoF**	√		√		√
Partnership Agreement Between Health Boards and CFS	**DoF**	√				
Other / Adhoc						
Appointment of Statutory Auditor	**DoF**	**As required**				
Appointment of Patients Funds Auditor	**DoF**					
Progress on National Fraud Initiative (NFI)	**ADoF**					
Private Meeting with Internal / External Auditors	**Committee**					
Legal & regulatory updates (e.g. Audit Scotland reports; Technical Bulletin etc)	**DoF**					

Audit & Risk Committee

DATE OF MEETING:	13 March 2020
TITLE OF REPORT:	A&R Committee Terms of Reference
EXECUTIVE LEAD:	Margo McGurk, Director of Finance
REPORTING OFFICER:	Gillian MacIntosh, Board Secretary

Purpose of the Report
For Decision

SBAR REPORT
Situation All Committees are required to regularly review their Terms of Reference, and this is normally done in March of each year. Any changes are then reflected in the annual update to the NHS Fife Code of Corporate Governance, which is reviewed in full by the Audit & Risk Committee and then formally approved by the Board in May of each year.
Background The current Terms of Reference for the Committee were last reviewed in March 2019, as per the above cycle.
Assessment An updated draft of the Committee's Terms of Reference is attached for members' consideration, with all changes 'tracked' for ease. Proposed amendments largely relate to clarifying the current wording relating to risk, to reflect present practice. Following review and approval by the Committee, an amended draft will be considered by the Committee as part of a wider review of all Terms of Reference by each standing Committee and other aspects of the Code. Thereafter, the final version of the Code of Corporate Governance will be presented to the NHS Board for approval.
Recommendation Members of the Committee are asked to: • **consider and approve** the updated Terms of Reference.

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:	N/A
Parties / Committees consulted prior to Health Board Meeting:	N/A

Impact: (must be completed)	
Financial / Value For Money	The update of Committee Terms of Reference will ensure appropriate governance across all areas and that effective assurances are provided.
Risk / Legal:	
Quality / Patient Care:	
Workforce:	
Equality:	

AUDIT AND RISK COMMITTEE
CONSTITUTION AND TERMS OF REFERENCE

Date of Board Approval: ***

1. PURPOSE

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

2. COMPOSITION

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

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

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

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

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

- Chief Executive
- Director of Finance
- Chief Internal Auditor or representative
- Executive Lead for Risk Management
- Statutory External Auditor
- Board Secretary

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

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

3. QUORUM

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

4. MEETINGS

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

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

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

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

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

5. REMIT

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

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

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

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

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

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

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

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

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

Internal Control and Corporate Governance

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

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

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

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

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

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

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

- Annual Statements of Assurance from the main Governance Committees and the conclusions of the other sub-Committees, confirming whether they

have fulfilled their remit and that there are adequate and effective internal controls operating within their particular area of operation;

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

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

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

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

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

Internal Audit

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

5.10 To monitor audit progress and review audit reports.

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

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

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

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

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

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

External Audit

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

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

5.18 To consider all statutory audit material, in particular:

- Audit Reports;
- Annual Reports;
- Management Letters

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

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

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

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

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

Risk Management

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

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

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

- The Board has clearly defined its risk appetite (i.e. the level of risk that the Board is prepared to accept, tolerate, or be exposed to at any time), and

that the executive's approach to risk management is consistent with that appetite;

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

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

- Receive and review a quarterly report summarising any significant changes to the Board's Corporate Risk Register, and what plans are in place to manage them. ~~The Committee may also elect to occasionally request information on significant risks held on any risk registers held in the organisation~~;

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

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

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

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

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

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

- The Committee shall seek assurance on the overall system of risk management for all risks and risks pertinent to its core functions. ~~This will include biannual updates from the other Standing Governance Committees, of the corporate risks assigned to each Committee for scrutiny.~~

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

Standing Orders and Standing Financial Instructions

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

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

Annual Accounts

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

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

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

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

Other Matters

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

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

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

5.34 The Committee shall review regular reports on Fraud and potential Frauds.

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

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

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

5.38 The Committee shall provide assurance to the Board on achievement and maintenance of Best Value standards, relevant to the Committee's area of

governance as set out in Audit Scotland's baseline report "Developing Best Value Arrangements".

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

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

6. AUTHORITY

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

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

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

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

7. REPORTING ARRANGEMENTS

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

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

Audit & Risk Committee

DATE OF MEETING:	13 March 2020
TITLE OF REPORT:	Committee Self-Assessment Report 2019-20
LEAD:	Martin Black, Chair of the Audit & Risk Committee
REPORTING OFFICER:	Gillian MacIntosh, Board Secretary

Purpose of the Report
For Discussion

SBAR REPORT

Situation

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

Background

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

Following the comprehensive review undertaken in early 2019 of the format and range of self-assessment questions previously used, a more light-touch review was undertaken this year, taking account of members' feedback on the length and clarity of the previous iteration of the questionnaire. Board Committee Chairs each approved a revised set of questions for their respective committee in October 2019.

To conform with the requirement for an annual review of their effectiveness, all Board Committees were invited to complete a self-assessment questionnaire in late December 2019 / early January 2020. The survey was undertaken online, following overwhelmingly positive feedback on the move to a non-paper system of completion, and took the form of a Chair's Checklist (which sought to verify that the Committee is operating correctly as per its Terms of Reference) and a second questionnaire (to be completed by members and regular attendees) comprising a series of effectiveness-related questions, where a scaled 'Agree/Disagree' response to each question were sought. Textual comments were also encouraged, for respondents to provide direct feedback on their views of the Committee's effectiveness.

Assessment

As previously agreed, Committee chairs have received a full, anonymised extract of the survey responses for their respective committee. A summary report assessing the composite

responses for the Audit & Risk Committee is given in this paper. The main findings from that exercise are as follows:

Chairs' Checklist (completed by Chair only)

It was agreed that the Committee was operating as per its Terms of Reference, and there were no particular issues flagged for attention.

Self-Assessment questionnaire (completed by members and attendees)

In total, all four members (excluding the Chair) and four regular attendees completed the questionnaire. In general, the Committee's current mode of operation received a positive assessment from its members and attendees who participated, with no areas of major concern flagged. Some initial comments identified for further discussion include:

- improving the training opportunities available to members, on an ongoing basis;
- ensuring that there is an understanding about any potential areas of overlap with the IJB Audit & Risk Committee;
- enhancing the financial expertise amongst the Committee's Non-Executive members;
- further improving the reporting on risk, particularly around the area of information governance.

Recommendation

The Audit & Risk Committee is asked to:

- **note** the outcome of the Committee's recent self-assessment exercise, as detailed in the attached; and
- **discuss** what actions members would wish to see implemented to address those areas identified for improvement.

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:	N/A
Parties / Committees consulted:	Committee Chairs

Impact: (must be completed)	
Financial / Value For Money	The use of a comprehensive self-assessment checklist for all Board committees ensures appropriate governance standards across all areas and that effective assurances are provided.
Risk / Legal:	
Quality / Patient Care:	
Workforce:	
Equality:	

		Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Comments
A. Committee membership and dynamics							
A1.	The Committee has been provided with sufficient membership, authority and resources to perform its role effectively and independently.	4 (50%)	4 (50%)	-	-	-	Identified member with finance experience would enhance scrutiny.
A2.	The Committee's membership includes appropriate representatives from the organisation's key stakeholders.	4 (50%)	4 (50%)	-	-	-	It may be helpful to invite lead Directors to speak to specific Audit reports as and when the Committee consider there are issues of concern. The organisation's senior auditors are regular attendees. Director of Nursing regularly attends and presents on board assurance framework. CEO regularly in attendance.
A3.	Committee members are clear about their role and how their participation can best contribute to the Committee's overall effectiveness.	4 (50%)	4 (50%)	-	-	-	It may be worth considering a refresh of the Audit Committee training held in the previous financial year.
A4.	Committee members are able to express their opinions openly and constructively.	4 (50%)	4 (50%)	-	-	-	From being an attendee all members express opinions when required. Discussion at the committee.
A5.	There is effective scrutiny and challenge of the Executive from all Committee members, including on matters that are critical or sensitive.	4 (50%)	4 (50%)	-	-	-	It may be helpful to invite lead Directors to speak to specific Audit reports as and when the Committee consider there are issues of concern.
A6.	The Committee has received appropriate training / awareness-raising in relation to the areas applicable to the Committee's areas of business.	4 (50%)	4 (50%)	-	-	-	Recent training has been provided. It may be worth considering a refresh of the Audit Committee training held in the previous financial year. Access to appropriate training is made available to board members and strongly encouraged.

A7.	Members have a sufficient understanding and knowledge of the issues within its particular remit to identify any areas of concern.	3 (38%)	4 (50%)	1 (12%)	-	-	But finance identified as an area to be enhanced.
B. Committee meetings, support and information							
B1.	The Committee receives timely information on performance concerns as appropriate.	4 (50%)	4 (50%)	-	-	-	-
B2.	The Committee receives timely exception reports about the work of external regulatory and inspection bodies, where appropriate.	3 (38%)	4 (50%)	1 (12%)	-	-	Audit Scotland reports are presented as an example. External regulatory reports are available and discussed.
B3.	The Committee receives adequate information and provides appropriate oversight of the implementation of relevant NHS Scotland strategies, policy directions or instructions.	2 (25%)	5 (63%)	-	1 (12%)	-	When required. For example CIA produced paper on Audit committee handbook. Signposting to relevant policy documentation might be a useful inclusion for the future.
B4.	Information and data included within the papers is sufficient and not too excessive, so as to allow members to reach an appropriate conclusion.	3 (38%)	4 (50%)	1 (12%)	-	-	Always asking the members if information presentation can be enhanced.
B5.	Papers are provided in sufficient time prior to the meeting to allow members to effectively scrutinise and challenge the assurances given.	5 (63%)	3 (37%)	-	-	-	-
B6.	Committee meetings allow sufficient time for the discussion of substantive matters.	4 (50%)	4 (50%)	-	-	-	Agenda provides time. Discussion takes place on substantive matters.
B7.	Minutes are clear and accurate and are circulated promptly to the appropriate people, including all members of the Board.	6 (75%)	2 (25%)	-	-	-	-

B8.	Action points clearly indicate who is to perform what and by when, and all outstanding actions are appropriately followed up in a timely manner until satisfactorily complete.	6 (75%)	2 (25%)	-	-	-	-
B9.	The Committee is able to provide appropriate assurance to the Board that NHS Fife's policies and procedures (relevant to the Committee's own Terms of Reference) are robust.	4 (50%)	3 (38%)	1 (12%)	-	-	Links with IJB Audit and Risk Committee need to be clarified.
B10.	Committee members have confidence that the delegation of powers from the Board (and, where applicable, the Committee to any of its sub-groups) is operating effectively as part of the overall governance framework.	4 (50%)	4 (50%)	-	-	-	-
C. The Role and Work of the Committee							
C1.	The Committee reports regularly to the Board verbally and through minutes and makes clear recommendations on areas under its remit when necessary.	4 (50%)	3 (38%)	1 (12%)	-	-	Chair reports.
C2.	In discharging its governance role, the focus of the Committee is at the correct level.	4 (50%)	4 (50%)	-	-	-	-
C3.	The Committee's agenda is well managed and ensures all topics within the Committee's Terms of Reference are appropriately covered.	5 (63%)	3 (37%)	-	-	-	Workplan in place.
C4.	Key decisions are made in a structured manner and can be publicly evidenced.	5 (63%)	3 (37%)	-	-	-	Minutes clear of what discussed.
C5.	What actions could be taken, and in what areas, to further improve the effectiveness of the Committee in respect of discharging its remit?	Nothing to add. We need to ensure that the diaries of the respective organisations continue to be in sync as difficulties in the past have been due to diary clashes between Fife Council and NHS Fife. Clarification of governance role and remit across Board and IJB as appropriate.					

D. Audit & Risk Committee specific questions							
AR1.	At least one of the Audit & Risk Committee members has sufficient relevant and recent financial experience.	2 (25%)	4 (50%)	1 (12.5%)	1 (12.5%)	-	Important to acknowledge that attendees include independent financial expertise in the form of both internal and external audit.
AR2.	All members, including the chair, are suitably independent of the Executive function.	5 (63%)	3 (37%)	-	-	-	-
AR3.	Members are sufficiently independent of the other key committees of the Board.	2 (25%)	4 (50%)	2 (25%)	-	-	-
AR4.	The Audit & Risk Committee annual schedule of meetings is suitable for NHS Fife's business and governance needs, as well as the requirements of the financial reporting calendar.	4 (50%)	3 (38%)	1 (12%)	-	-	Meets all the required reporting schedule. This has improved over time but I have had issues due to the direct conflict of the council diary with the NHS one.
AR5.	The Audit & Risk Committee appropriately satisfies itself that the arrangements for risk management, control and governance have operated effectively throughout the reporting period.	4 (50%)	3 (38%)	1 (12%)	-	-	Risk has been in transition for a while but huge steps have been made recently. BAF taken to Audit and Risk. Risk annual plan and updates taken to each meeting
AR6.	The Audit & Risk Committee effectively considers how accurate and meaningful the Governance Statement is.	3 (38%)	4 (50%)	1 (12%)	-	-	-
AR7.	The Audit & Risk Committee appropriately considers how it should coordinate with other Committees that may have responsibility for risk management and corporate governance.	3 (38%)	4 (50%)	1 (12%)	-	-	Risk reporting clear that other Standing Committees have considered the relevant risks. Enhancements to the oversight of information governance might be considered to ensure the Audit and Risk Committee has greater awareness.
AR8.	The Audit & Risk Committee has satisfied itself that NHS Fife has adopted appropriate arrangements to counter and deal with fraud.	5 (63%)	3 (37%)	-	-	-	Good CFS / Fraud reporting to Committee.

AR9.	The Audit & Risk Committee has been made aware of the role of risk management in the preparation of the internal audit plan.	4 (50%)	4 (50%)	-	-	-	Paper on plan is clear that plan is mapped to risk.
AR10.	The Audit & Risk Committee's role in the consideration of the annual accounts is clearly defined.	6 (75%)	2 (25%)	-	-	-	-
AR11.	The Audit & Risk Committee has gained an appropriate understanding of management's procedures for preparing NHS Fife's annual accounts.	3 (37%)	5 (53%)	-	-	-	-
AR12.	The Audit & Risk Committee approves, annually and in detail, the internal audit plans, including consideration of whether the scope of internal audit work addresses NHS Fife's significant risks.	4 (50%)	4 (50%)	-	-	-	Close link from plan to risks, with input to plan from both executive and non executives.
AR13.	Outputs from follow-up audits by internal audit are appropriately monitored by the Audit & Risk Committee and the Committee considers the adequacy of implementation of recommendations.	4 (50%)	4 (50%)	-	-	-	Revised process led by IA to Jan 2020 Audit committee.
AR14.	There is appropriate co-operation between the internal and external auditors.	3 (37%)	5 (63%)	-	-	-	-
AR15.	The Audit & Risk Committee reviews the adequacy of internal audit staffing and other resources.	4 (50%)	3 (38%)	1 (12%)	-	-	Role of Partnership board which Director of Finance represents Fife.
AR16.	Internal audit performance measures are appropriately monitored by the Audit & Risk Committee.	4 (50%)	4 (50%)	-	-	-	Within each progress report to Audit committee.
AR17.	The external auditors effectively present and discuss their audit plans and strategy with the Audit & Risk Committee (recognising the statutory duties of external audit).	4 (50%)	4 (50%)	-	-	-	-

AR18.	The Audit & Risk Committee appropriately reviews the external auditor's annual report to those charged with governance.	5 (63%)	3 (37%)	-	-	-	-
AR19.	The Audit & Risk Committee adequately ensures that officials are monitoring action taken to implement external audit recommendations.	3 (38%)	4 (50%)	1 (12%)	-	-	-
AR20.	The Audit & Risk Committee assesses effectively the performance of external audit.	4 (50%)	-	4 (50%)	-	-	A more formalised arrangement might be considered; however there is limited scope given that the Board and Audit Committee do not appoint the external auditor. I personally feel that the External Auditor does an excellent job. However, I'm not sure whether it's our role to assess the performance of the External Auditor. My impression is that it should be more about working with them to ensure good practice prevails across the organisation.
AR21.	Agenda papers are circulated timely in advance of the meeting, to allow adequate preparation by Audit & Risk Committee members.	5 (63%)	3 (37%)	-	-	-	-
AR22.	Reports to the Audit & Risk Committee communicate relevant information at the right frequency, time and in a format that is effective.	4 (50%)	4 (50%)	-	-	-	-

DATE OF MEETING:	13 March 2020
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

Progress Report

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 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 (AFU) system which is included separately on the agenda.

As of 28 February 2020 actual input against the 2019/20 NHS Fife plan stood at 428 days (79%) of the 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.

Recommendation

The Audit and Risk Committee is asked to:

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

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 February 2020.

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 9 January 2020. 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
Financial Governance				
B25/19 – Financial Management	Moderate Assurance	1 Significant 1 Merits Attention	29 August 2019	3 March 2020

Audit 2019/20	Opinion on Assurance	Recommendations	Draft issued	Finalised
Corporate Governance				
B09/20 – Audit Follow Up	N/A	N/A	N/A	Report provided to each Audit and Risk Committee
Clinical Governance				
B19/20 - Adverse Event Management	Limited Assurance	2 Significant 2 Merits Attention	28 January 2020	3 March 2020

Information Governance				
B32/20 – Waiting Times Methodology	N/A – Follow Up Review of B29/18	4 Significant 6 Merit Attention	18 December 2019	3 March 2020

NHS Fife Draft Reports Issued

Audit 2019/20	Draft issued
B13/20 – Risk Management Report to be finalised by the Lead Executive Officer for risk management w/c 9 March 2020 and issued to all members. Full report to be presented to the May 2020 Audit and Risk Committee.	17 December 2019

NHS Fife Work in Progress and Planned:

Audit 2019/20		Status	Target Audit Committee
B01/20	Audit Risk Assessment and Planning	Planning	16 May 2020 for Draft and June 2020 for approval
B10/20	Governance Blueprint	Fieldwork	16 May 2020
B11/20	Assurance Mapping	Fieldwork	16 May 2020
B15 and 16/20	Strategic and Operational Planning – Transformation Programme	Fieldwork	16 May 2020
B17/20	Organisational Performance Management	Fieldwork	16 May 2020

Audit 2019/20		Status	Target Audit Committee
B24/20	Management of Savings Programme	To be Risk Assessed as part of planning for 2020/21 – linked review to B15/20 and B16/20	TBC
B25/20	Capital Management – Orthopaedic Project	Planning	16 May 2020
B22/20	Staff Governance – Workforce Strategy	Fieldwork	16 May 2020
B31/20	eHealth Strategic Planning and Governance	Fieldwork	16 May 2020
B34/20	Recruitment and Retention	To be Risk Assessed as part of planning for 2020/21	TBC

Audit Follow Up

An Audit Follow Up Report has been produced by Internal Audit and is included separately on the agenda.

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.

B25/19 Financial Management

Audit Opinion – Moderate Assurance - Adequate framework of key controls with minor weaknesses present.

Link to strategic / operational risk – Financial Sustainability BAF

Executive Summary & Agreed Management Action:

The review encompassed whether: revenue budgets/ allocations were effectively delegated to budget holders; Budget monitoring reports provided to budget holders are relevant, reliable, complete, accurate, timely, clear and aligned with best practice; Budget variations are adequately investigated on a timely basis, explained and remedial action taken when necessary and monitoring information related to the financial position of the Board is complete, relevant, sufficient and reliable. The main issues identified from the review were:

- We reviewed a random sample of three virements, and concluded that they were authorised by the relevant budget holders and recorded appropriately. Of the three virements, two were authorised by the Associate Director of Nursing. This designation is not included within the FOP and the Head of Finance advised Internal Audit that this would equate to the authorisation levels of Corporate Directors/ Divisional General Managers. The third virement, which was greater than £20,000 was authorised by a Service Manager and there was no evidence provided that this was reported to the Chief Executive, Chief Operating Officer or Director of Health and Social Care as required.

  Management agreed to the following: ***"The Head of Finance advised that they will report the virements appropriately and review the FOP's in relation to the financial limits, designations and process of reporting virements to the Chief Executive, Chief Operating Officer and Director of Health and Social Care and update these areas within the next reiteration of the FOP**. "*

- We reviewed a sample of monthly budget reports and we noted that Planned Care and Health & Social Care West Division current Whole Time Equivalent (WTE) exceeds the funded WTE. The Finance Business Partner advised that this is due to the outcome of the comprehensive workforce review that has taken place across all H&SCP Inpatient Wards in June 2019. The review was completed in line with CEL 32 (2011) using the national Nursing and Midwifery Workload Workforce Planning (NMWWP) tools. This has the effect of increasing the current WTE and there has been a delay in obtaining approval for the virements required to align these budgets.

  Management agreed to the following: "***Evidence of approval will be sought in line with Section 5 of FOPs 9.2 and 9.3 and we will take steps to highlight and explain the budget position."***

B09/20 Audit Follow Up

Separate agenda item for 13 March 2020 Audit and Risk Committee.

B19/20 Adverse Event Management

Audit Opinion – Limited Assurance - Satisfactory framework of key controls but with significant weaknesses evident which are likely to undermine the achievement of objectives.

Link to strategic / operational risk Quality and Safety BAF

As report is Limited Assurance, this is included as a separate agenda item.

B32/20 Waiting Times Methodology – Follow Up Review of B29/18

Audit Opinion – Due to the limited nature of the scope of this audit, no audit opinion is provided. Our review was mainly a follow up to ensure appropriate implementation of the recommendations in audit report B29/18 NHS Scotland Waiting Times Methodology.

Executive Summary & Agreed Management Action:

B29/18 – NHS Scotland Waiting Times Methodology report included 10 findings with an associated 16 recommendations which were all due. This included 4 priority 2 recommendations and 12 priority 3 recommendations with management actions agreed to address these

There was a backlog of monthly audit checks to be undertaken when the current member of staff took over this responsibility in January 2019. The monthly audits are not yet up to date, with the August 2019 sample being reviewed in October 2019, however we note that performance is improving with the aim of completing the audit monthly in arrears.

We re-performed the monthly check for August 2019. We found that the audit was being undertaken in line with the NHS Scotland Waiting Times Monthly Audit Methodology.

A review of the NHS Fife Patient Access Policy GP/P8 found that an out of date version of the policy is available on the intranet (last reviewed 10/11/17). The current updated policy (last reviewed 29/06/18) is not available to staff on the intranet.

Overall we have concluded that of the 16 agreed recommendations, 2 were completed, 4 were partly completed and 10 were outstanding. Internal Audit have revised all the recommendations within B32/20, and will be actively reporting the status of these revised actions and providing validation in future Audit Follow Up reports.

Key Performance Indicators 2019/20

Performance against service specification as at 13 December 2019:

	Planning	Target	05 Sep 2019	9 Jan 2020	13 March 2020
1	Audit assignment plans for planned audits issued to the responsible Director at least 2 weeks before commencement of audit	75%	100%	100%	95%
2	Draft reports issued by target date	75%	100%	83.3%	69%
3	Responses received from client within timescale defined in reporting protocol	75%	100%	67%	54%
4	Final reports presented to target Audit Committee	75%	100%	100%	77%
5	Number of days delivered against plan	100% at year-end	145 – 27%	361 – 67%	428 – 79%
6	Number of audits delivered to planned number of days (within 10%)	75%	100%	60%	70%

Audit and Risk Committee Meeting

DATE OF MEETING:	13 March 2020
TITLE OF REPORT:	Internal Audit Report – Adverse Event Management (B19/20) – Item 7.2
EXECUTIVE LEAD:	C McKenna, Medical Director
REPORTING OFFICER:	Barry Hudson , Regional audit Manager Helen Woodburn, Head of Quality and Clinical Governance

Purpose of the Report (delete as appropriate)		
~~For Approval~~	~~For Discussion~~	For Assurance

SBAR REPORT

Situation

At the January 2020 Audit and Risk Committee it was agreed that any audit report which is categorised as Limited Assurance or No Assurance will be reported in full to the Audit and Risk Committee.

The Internal Audit review of Adverse Events – B19/20 has been categorised as Limited Assurance.

Background

This review evaluated the design and operation of the controls relating to the implementation of actions to address the issues identified from Adverse Event reviews and specifically considered whether:

- ◊ Procedures are in place to implement actions to address the issues identified from Adverse Event reviews and there is cross-learning throughout NHS Fife, so that such actions are fully implemented in all wards/departments that they are relevant to.
- ◊ There is ongoing monitoring of the actions implemented from Adverse Event reviews to confirm that they remain in operation as effective measures.

Assessment

In summary the following topics were identified as good practice or were identified from audit testing as requiring further consideration:

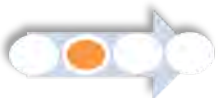
- ◊ A review of the GP/I9 – Adverse Events Policy and other supporting guidance available on the intranet shows that procedures are in place to address the issues identified from Adverse Event reviews and allow cross-learning throughout NHS Fife. The guidance fully describes the process to be followed from initiation and approval of action plans to address the issues identified, to the completion and subsequent sign off of individual actions and approval of fully completed action plans.
- ◊ There is a robust process documented to identify and learn from the issues arising from adverse events. This process was seen to be applied for a sample of 10 Significant Adverse Event Reviews (SAERs) and 10 Local Adverse Event Reviews (LAERs) checked, with action plans being prepared in accordance with standard procedures and guidance notes.
- ◊ The Internal Audit review of the implementation of a sample of the actions within the 10 SAERs and 10 LAERs referred to above indicates that appointed officers are not fully

implementing actions by the set due dates, with a number still being open. This applied to 11 out of 31 SAER actions and 1 out of 10 LAER actions reviewed. These results also indicate that nominated leads are not following up completion of action plans to ensure actions are implemented by the respective due dates.

- ◊ In a large number of instances, no information was recorded on DATIX to confirm what steps had been taken to implement completed actions. The date the action was completed (closed) was noted in DATIX, but no other detail was provided. This was seen to apply to 12 out of 31 SAER actions and 1 out of 10 LAER actions reviewed. Confirmation of the steps taken to implement actions was provided for 7 out of the 31 SAERs and 7 out of the 10 LAERs reviewed. It is the view of Internal Audit that such details should be provided in all instances.
- ◊ Currently no key performance indicators (KPIs) are being reported within the Performance Review reports on overdue actions arising from adverse events, but arrangements are now being made to introduce meaningful key performance indicators to strengthen governance and give additional assurance on actions being implemented. Once implemented the KPI will be included in the Integrated Performance and Quality report (IPQR). An update will be provided to the Executive Directors Group and through IPQR to NHS Fife Adverse Events & Duty of Candour Group and the NHS Fife Clinical Governance Committee on a bi-monthly basis.
- ◊ Ongoing monitoring of actions forms an integral part of the adverse event review process as described in the GP/I9 – Adverse Events Policy and other supporting guidance available on the intranet. In testing compliance with procedural guidance, this is not being completed for the actions which are overdue and may result in cross-learning not being completed throughout NHS Fife to address the issues identified from adverse event reviews in all the wards/departments that they are relevant to. This applied to 11 out of 31 SAER actions and 1 out of 10 LAERs actions reviewed, all of which are overdue completion.

This review highlights that the internal controls implemented by managements are not fully functioning as intended. Management has agreed to take action to address the issues identified. Due to the time available for this review, audit testing did not include a review of whether actions are being implemented, but their completion is not being recorded on DATIX. A further audit review will be completed and reported on in 2020/21 to consider whether there is evidence that this applies.

The Internal Audit opinion regarding the area under review expressed in the report is:

Limited Assurance		Satisfactory framework of key controls but with significant weaknesses evident which are likely to undermine the achievement of objectives.	Controls are applied but with some significant lapses.

The eight findings in the report were risk assessed as follows:

Risk Assessment		Definition	Total
Fundamental		Non Compliance with key controls or evidence of material loss or error. **Action is imperative to ensure that the objectives for the area under review are met.**	None

Significant		Weaknesses in control or design in some areas of established controls. **Requires action to avoid exposure to significant risks in achieving the objectives for area under review.**	Two
Merits attention		There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**	Two

Recommendation

The Audit and Risk Committee is asked to consider the report and note the agreed management actions within the report.

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:	N/A
Parties / Committees consulted prior to meeting:	Medical Director and 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

Adverse Event Management

Report No. B19/20

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

C McKenna, Medical Director
H Buchanan, Director of Nursing

H Woodburn, Head of Quality & Clinical Governance
P Cumming, Risk Manager

G MacIntosh, Head of Corporate Governance & Board Secretary
Follow-Up Co-ordinator

Audit and Risk Committee
External Audit

Contents

Draft Report Issued	28 January 2020
Management Responses Received	24 February 2020
Target Audit & Risk Committee Date	13 March 2020
Final Report Issued	**04 March 2020**

CONTEXT AND SCOPE

1. The NHS Fife Strategic Objectives 2019/20 approved at the 29 May 2019 Board meeting has clinical excellence as a strategic objective, which includes the continuing development of NHS Fife's approach to the management of adverse events. This incorporates the review and update where required of the systems and processes for reporting and investigating on adverse events to ensure robust procedures exist for remedial action to be taken.

2. The NHS Fife Board Assurance Framework (BAF) presented to the September 2019 Clinical Governance Committee meeting describes the following quality and safety risk (BAF 1416) which could threaten the achievement of the above strategic objective:

   ◊ *'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*'.

3. To mitigate this risk, as it relates to adverse event management, NHS Fife has a Clinical Strategy in place as supported by a defined Clinical Governance structure and specific operational governance arrangements for adverse event management. Further mitigating actions relevant to adverse event management include the ongoing review of reporting to ensure an accurate and current picture of clinical quality and performance in priority areas is provided.

4. NHS Fife has detailed organisational procedures within GP/19 – Adverse Events Policy to deal with adverse events in accordance with Healthcare Improvement Scotland guidance, 'Learning from adverse events through reporting and review – A national framework for Scotland, July 2018'.

5. The above mitigation system has been identified within the strategic internal audit planning process as a **Medium** audit risk rating. There are no risks recorded within the NHS Fife corporate risk register relating to adverse event management.

6. This audit is a continuation of Internal Audit's review of adverse event management arrangements, which were initially considered in 2018/19 and reported in audit report B16/19 – Management of Significant Adverse Events. This review evaluated the design and operation of the controls relating to the implementation of actions to address the issues identified from Adverse Event reviews and specifically considered whether:

   ◊ Procedures are in place to implement actions to address the issues identified from Adverse Event reviews and there is cross-learning throughout NHS Fife, so that such actions are fully implemented in all wards/departments that they are relevant to.

   ◊ There is ongoing monitoring of the actions implemented from Adverse Event reviews to confirm that they remain in operation as effective measures.

AUDIT OPINION

7. The Audit Opinion of the level of assurance is as follows:

Level of Assurance		System Adequacy	Controls
Limited Assurance		Satisfactory framework of key controls but with significant weaknesses evident which are likely to undermine the achievement of objectives.	Controls are applied but with some significant lapses.

A description of all definitions of assurance and assessment of risks are given in Section 4 of this report.

8. In summary the following topics were identified from audit testing (see page 14 for full details of test results) as requiring further consideration:

- ◊ A review of the GP/I9 – Adverse Events Policy and other supporting guidance available on the intranet shows that procedures are in place to address the issues identified from Adverse Event reviews and allow cross-learning throughout NHS Fife. The guidance fully describes the process to be followed from initiation and approval of action plans to address the issues identified, to the completion and subsequent sign off of individual actions and approval of fully completed action plans.
- ◊ There is a robust process documented to identify and learn from the issues arising from adverse events. This process was seen to be applied for a sample of 10 Significant Adverse Event Reviews (SAERs) and 10 Local Adverse Event Reviews (LAERs) checked, with action plans being prepared in accordance with standard procedures and guidance notes.
- ◊ The Internal Audit review of the implementation of a sample of the actions within the 10 SAERs and 10 LAERs referred to above indicates that appointed officers are not fully implementing actions by the set due dates, with a number still being open. This applied to 11 out of 31 SAER actions and 1 out of 10 LAER actions reviewed. These results also indicate that nominated leads are not following up completion of action plans to ensure actions are implemented by the respective due dates.
- ◊ In a large number of instances, no information was recorded on DATIX to confirm what steps had been taken to implement completed actions. The date the action was completed (closed) was noted in DATIX, but no other detail was provided. This was seen to apply to 12 out of 31 SAER actions and 1 out of 10 LAER actions reviewed. Confirmation of the steps taken to implement actions was provided for 7 out of the 31 SAERs and 7 out of the 10 LAERs reviewed. It is the view of Internal Audit that such details should be provided in all instances.
- ◊ Currently no key performance indicators (KPIs) are being reported within the Performance Review reports on overdue actions arising from adverse events, but arrangements are now being made to introduce meaningful key performance indicators to strengthen governance and give additional assurance on actions being implemented. Once implemented the KPI will be included in the Integrated Performance and Quality report (IPQR). An update will be provided to the Executive Directors Group and through IPQR to NHS Fife Adverse Events & Duty of Candour Group and the NHS Fife Clinical Governance Committee on a bi-monthly basis.
- ◊ Ongoing monitoring of actions forms an integral part of the adverse event review process as described in the GP/I9 – Adverse Events Policy and other supporting guidance available on the intranet. In testing compliance with procedural guidance, this is not being completed for the actions which are overdue and may result in cross-learning not being completed throughout NHS Fife to address the issues identified from adverse event reviews in all the wards/departments that they are relevant to. This applied to 11 out of 31 SAER actions and 1 out of 10 LAERs actions reviewed, all of which are overdue completion.

9. This review highlights that the internal controls implemented by management are not fully functioning as intended. Management has agreed to take action to address the issues identified. Due to the time available for this review, audit testing did not include a review of whether actions are being implemented, but their completion is not being recorded on DATIX. A further audit review will be completed and reported on in 2020/21 to consider whether there is evidence that this applies.
10. Detailed findings/information is included at Section 3.

ACTION

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

ACKNOWLEDGEMENT

12. 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:

Responsibility for completing actions arising from SAERs and LAERs lies with service management and, although there previously was, there is currently no regular reporting to relevant committees on the SAER and LAER actions implemented and those still outstanding. This prevents follow-up of overdue actions and because there is no reporting on such, it prevents the standing committees from fully discharging their responsibilities as outlined in GP/I9 – Adverse Events Policy to ensure action plans have been completed and contribute to organisational learning by sharing and adopting key learning points.

Arrangements are now being progressed to re-introduce meaningful KPIs to strengthen governance and give additional assurance on risk management activity. This includes reporting on the percentage of SAER and LAER actions completed by target date. The intention is to report this to the EDG, NHS Fife Adverse Events & Duty of Candour Group and the NHS Fife Clinical Governance Group on a bi-monthly basis.

We were advised that DATIX is not currently configured to send out reminders to staff/management, advising of actions which are overdue completion. Outstanding actions now appear on the user front page of Datix in the 'To Do list' and work is underway to introduce a standardised functionality within 'My Reports' in Datix to enable the services to run off their own reports. These actions should enable easier identification of outstanding and overdue actions.

Audit Recommendation:

As part of the intended KPIs and additional standardised reporting templates, consideration should be given to including the number of actions overdue completion, so that the committees and groups receiving such reports have full details on the numbers still to be finalised and so that management action can be taken as necessary to minimise and prevent any back log arising.

Once the KPIs and standardised reporting templates are introduced, the revised reporting arrangements functioning centrally and within the services should be reported to the NHS Fife Adverse Events & Duty of Candour Group for approval. The reporting arrangements introduced should be sufficient to enable the standing committees to ensure actions contained within action plans are being implemented as outlined in GP/I9.

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 KPIs are in development with the intention to introduce in Quarter 2 of 2020. Consideration will be given to reporting on the number of actions overdue, and creating monthly reports of overdue actions for completion. This will be discussed on 27 February 2020 at NHS Fife Adverse Event Group.

Action by:	Date of expected completion:
Helen Woodburn	**June 2020**

Action Point Reference 2

Finding:

A review of actions still open for 2018 and 2019 revealed there to be 70 SAER actions and 95 LAER actions still open and overdue completion. A review of these overdue actions, indicated that most of the 2018 actions were overdue completion by more than four months from their set due date (42 SAER actions and 69 LAER actions) and out of the 2019 actions a large number were overdue completion by more than two months from their set due date (14 SAER actions and 7 LAER actions).

The above results indicate that in a large number of instances, officers to whom actions are being assigned to are not fully completing them by the respective due dates. Also, Lead Officers responsible for ensuring all actions are implemented are not fully completing follow-up reviews as required by GP/I9 – Adverse Events Policy and the additional guidance provided.

Audit Recommendation:

An action plan should be drawn up to enable steps to be taken to finalise the backlog of actions currently outstanding and ensure greater effort is made to have actions completed by the respective due date. This should initially include all officers with responsibility for implementing actions and those overseeing their completion being reminded of their responsibilities for doing so and thereafter relevant reminder information (in the form of the additional standardised reporting templates) being sent to the appropriate level of management in future. The action plan should be approved by the NHS Fife Adverse Events & Duty of Candour Group, to which an appropriate KPI on clearing the backlog of the actions awaiting implementation should be reported.

Assessment of Risk:

Significant		Weaknesses in control or design in some areas of established controls. **Requires action to avoid exposure to significant risks in achieving the objectives for area under review.**

Management Response/Action:

Divisions and Directorates will be provided with a monthly report on number of actions overdue. This will be a standing item on the agenda of the NHS Fife Adverse Event/Duty of Candour Group.

A 'My Report' will be configured for all services to utilise for managing overdue actions.

Reporting of overdue actions will be reported through local governance committees/groups.

Action by:	Date of expected completion:
Helen Woodburn	**June 2020.**

Action Point Reference 3

Finding:

A review of the actions within the SAER and LAER samples selected for all stages of audit testing indicated that sufficient explanation is not being provided within DATIX on the steps taken to implement the actions. As an example, within a sample of 31 SAER actions reviewed, 12 of those completed did not have sufficient detail to confirm the steps taken to complete the action. A further 6 of those overdue, but being progressed, did not having sufficient information detailing the initial action taken to implement the requirements of the action. These results also applied to any actions relating to shared learning, with it not therefore being possible to establish what shared learning had taken place.

The reason why the final actions may not be noted in all instances is that the information fields in DATIX only require progress information to be noted, rather than the final outcome and final steps taken to close the action. There is therefore currently no concluding note on the action taken in all instances. In those instances where the final outcome is not noted, this will cause difficulty for the lead officer overseeing the action being implemented from confirming what steps have actually been taken to complete it without having to contact the relevant officer. It also provides no audit trail confirming what action has been taken. It is the view of Internal Audit that details of the actual action taken should be provided in all instances.

Audit Recommendation:

Staff should be reminded to fully note on DATIX what steps have been taken to implement actions; including what shared learning has actually taken place.

Additionally, a review of the fields on DATIX for recording details of the steps taken to implement actions should be completed, so that staff can be more readily directed to note the final outcome, thereby enabling it to be confirmed that the initial action requirements have been met for all actions. This will enable the lead officer overseeing each action to more easily confirm that they have been completed as required.

Assessment of Risk:

Significant		Weaknesses in control or design in some areas of established controls. **Requires action to avoid exposure to significant risks in achieving the objectives for area under review.**

Management Response/Action:

The proposal for all evidence pertaining to the completion of actions from reviews is to be logged in the documents for incidents section within the incident record.

Action by:	Date of expected completion:
Helen Woodburn	**June 2020.**

Action Point Reference 4		
Finding:		
In completing audit testing a small number of matters were identified for further review by management: ◊ Actions can be closed on DATIX without the name of the officer doing so being noted in the 'Completed By" field. This potentially results in a full audit trail not being provided for each completed action. ◊ The requirement for officers monitoring completion of action plans to sign these off on a paper copy of action plans is not being completed as described in guidance notes. ◊ A small number of learning summaries were not prepared for the sample of LAERs reviewed.		
Audit Recommendation:		
A review of the control implications highlighted by the above matters should be completed with controls strengthened as necessary.		
Assessment of Risk:		
Merits attention		There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**
Management Response/Action:		
An extra field to the action form in Datix will be added, this will prompt the user to confirm if an action is complete. If answer Yes, it will trigger 3 mandatory questions of Completed by, the date and the evidence to be logged. **Minimum documents will include reports, learning summaries and evidence from completed actions.**		
Action by:		**Date of expected completion:**
Helen Woodburn		**June 2020.**

Risk/Control 1

Procedures are in place to implement actions to address the issues identified from Adverse Event reviews and there is cross-learning throughout NHS Fife, so that such actions are fully implemented in all wards/departments that they are relevant to.

Procedures and guidance on implementing actions

The following are appropriately documented within the procedures/guidance:

- ◊ A review of the GP/I9 – Adverse Events Policy and other supporting guidance available on the intranet shows that procedures are in place to address the issues identified from Adverse Event reviews and allow cross-learning throughout NHS Fife. The guidance fully describes the process to be followed from initiation and approval of action plans to address the issues identified from Adverse Event reviews, to the completion and subsequent sign off of individual actions and approval of fully completed action plans.
- ◊ Action plans arising from all SAERs and LAERs are approved by Executive Directors and/or Senior Management depending on the particular classification of each incident. A lead officer is nominated with responsibility for overseeing all actions being implemented.
- ◊ The GP/I9 – Adverse Events Policy stipulates that in completing adverse incident reviews there is a responsibility for ensuring there is cross-learning and improvement arising from adverse events. One of the purposes being to prevent the recurrence of adverse events.

Support in managing adverse events and recording actions on the DATIX incident reporting and risk management system is provided by the Risk Management Team.

A comparison of the GP/I9 – Adverse Events Policy with the Healthcare Improvement Scotland (HIS) guidance 'Learning from adverse events through reporting and review: A national framework for NHSScotland September 2018', indicated that NHS Fife's policy on actioning and learning from adverse events has been prepared in accordance with the HIS national framework.

Review of steps being taken to implement actions and comply with procedural guidance

Internal Audit completed a review of outstanding actions for both SAERs and LAERs and it was noted that there are still 70 overdue SAER actions and 95 overdue LAER actions for 2018 and 2019. There are still some actions open for previous years, but due to changes in the procedures for managing adverse events it is not possible to easily identify those relating to SAERs and LAERs.

The above review of 2018 and 2019 actions still open indicates that for both SAERs and LAERs, appointed officers are not fully implementing actions by the due dates and nominated leads are not fully following up completion of action plans.

In further reviewing the operation of the NHS Fife's policy on adverse event management, Internal Audit selected a sample of 10 SAERs and 10 LAERs completed in 2019 to consider in more detail whether the procedures outlined above are being followed in practice. The results of our review revealed the following:

- ◊ The procedures in place to record and manage adverse events and prepare action plans for learning and improvement, are functioning as intended. All SAER and LAER reviews within the sample selected were authorised by Executive Directors and/or Senior Management.
- ◊ For the sample of SAER and LAERs selected, the standard adverse event review reports and action plans were prepared with a nominated lead being appointed to oversee

completion of individual actions.

- ◊ Learning summaries were prepared for all 10 SAERs reviewed, but not for 2 of the 10 LAERs reviewed.
- ◊ All the actions included within the action plans for all SAERs and LAERs were entered on DATIX for implementation with leads being appointed to implement actions and separate leads to oversee completion of individual actions. This included actions to arrange for shared learning.

The above indicates that there is a robust process in place to initially identify actions learned from adverse events, with the procedures and the guidance notes being followed to arrange for the actions identified to be implemented. Further review indicated that after entry of individual actions onto the DATIX incident reporting system, implementation of individual actions is not being fully completed as intended, with, as noted above for 2018 and 2019, a significant number being overdue completion. Follow-up by nominated leads overseeing completion of action plans is also not being completed as intended or described in the guidance notes, through signing of original action plans.

From the Internal Audit review of the individual actions within the sample of 2019 SAER and LAERs selected, plus a further review of 2018 open actions on DATIX, the following detail arose on the completion of individual actions:

- ◊ Out of the sample of 31 2019 SAER actions reviewed, 11 of the actions remain open and are overdue, not having been completed by the set due date. This only applied to 1 of the 10 LAER actions reviewed.
- ◊ The DATIX system includes a field to record progress in implementing actions, but 6 of the 11 overdue SAER actions had no, or insufficient information, to determine what initial action had been taken. In addition, 12 of the 19 completed SAER actions had no information to confirm what steps had been taken to implement and complete the actions. Overall such information was seen to be recorded for the 10 LAER actions reviewed.
- ◊ Although there are fields in DATIX to record that the action has been completed and the date it occurred, as all actions are not necessarily straightforward and involve different stages, Internal Audit consider it appropriate that the final outcome should be recorded to inform the nominated leads of satisfactory implementation of the action and provide an audit trail. Final actions may not be getting noted on DATIX as the fields available only require progress information to be recorded rather than the final outcome. There is therefore no concluding information field for noting the final outcome of the action taken.
- ◊ The information recorded on DATIX detailing the action taken was reviewed to determine if sufficient detail was provided on the final outcome to indicate whether the initial action requirements were fulfilled. Sufficient details on the final outcome was recorded for 7 of the 8 completed LAER actions tested, but the final outcome was only recorded for 7 of the 19 completed SAER actions tested. These results also indicate that it is not always possible to confirm that shared learning has actually taken place.
- ◊ Further review of progress in completing a sample of 5 of the overdue SAER actions (47) and 5 of the overdue LAER actions (79) for 2018 indicated that none of those selected had any information recorded on the progress being made in implementing the required actions, suggesting no action may yet have been taken.

Reporting

As detailed in Audit Report B16/19 – Management of Significant Adverse Events, there is currently no analytical review data relating to the implementation of actions arising from adverse events included in the Integrated Performance Quality Report. Only the number of

major and extreme adverse events occurring is being reported and although these initiate action plans, such reporting does not cover the closure of actions arising from adverse events.

Arrangements are now being made to introduce meaningful key performance indicators to strengthen governance and give additional assurance on actions being implemented. This reporting will include the percentage of SAER and LAER actions completed by target dates. Such reporting will enable the Executive and Non-Executive Directors and relevant committees to more fully monitor the implementation of actions as outlined in GP/I9 – Adverse Events Policy, to ensure where necessary the quality of service is improved and learning is shared and implemented across NHS Fife.

As it is the responsibility of local management to ensure actions are implemented, the above reporting should also be directed to relevant committees within the different services to overcome the backlog in clearing outstanding actions. Previously outstanding actions were reported on a directorate basis, but a review of the most recent Performance Reports for both Emergency Care and Planned Care revealed that although the finalisation of SAERs and LAERs by respective due dates is completed, there is no reporting on the completion of actions arising from such reviews.

It was noted from the samples of actions reviewed that consideration needs to be given to the adequacy of existing functional controls on DATIX, as a number of actions within the samples selected were seen to be signed off as completed without the officer doing so being named in the "Completed By" field. Although not a significant problem it could compromise control over the correct completion of actions.

Risk/Control 2

There is ongoing monitoring of the actions implemented from Adverse Event reviews to confirm that they remain in operation as effective measures.

Procedures and guidance for ongoing monitoring

Ongoing monitoring of actions forms an integral part of the adverse event review process as described in the GP/I9 – Adverse Events Policy and other supporting guidance available on the intranet. As part of these procedures ongoing monitoring requirements are considered as part of the initial process in addressing the issues identified from adverse event reviews and implementing resulting actions plans. Initial monitoring is completed as part of the completion and subsequent sign off of individual actions and approval of fully completed action plans. Subsequent monitoring is dependent upon the individual action and will either involve subsequent actions being raised on DATIX or arrangements being made as part of the original action to install monitoring arrangements as part of revised operational procedures.

From the review completed and described in Risk/Control 1 above, the procedures and guidance notes are being followed to arrange for the actions identified, including ongoing monitoring to be implemented with all actions being entered onto DATIX. This ensures ongoing monitoring is fully incorporated into the action completion process.

Review of ongoing monitoring

The results of the sample of SAER and LAER actions tested within Risk/Control 1 above indicate that initial review of action completion is not being fully monitored. This will impact on the completion of any ongoing monitoring requirements.

Within the sample of SAER and LAER actions tested the majority of actions only required an initial action to be completed to implement changes to operational procedures, with no

further monitoring being required after the initial changes were implemented, as they then became the new ongoing procedures. Further testing on the actions where additional ongoing monitoring was required indicated that, where the full details of the steps taken to implement the action and the final outcome were noted on DATIX, it could be ascertained that ongoing monitoring arrangements were installed into operational procedures. Where actions were overdue and/or progress information was not noted on DATIX it could not be established if ongoing monitoring of the learning identified from SAER and LAER actions is being completed.

Summary of test results

SAER/LAER	SAERs No.	SAERs %	LAERs No.	LAERs %
SAER/LAER sample selected	**10**		**10**	
Action Plans raised and fully entered on DATIX	10	100	10	100
Executive/Senior Management sign off	10	100	10	100
Learning summary prepared	10	100	8	80
Incident actions fully completed or not yet due	6	60	9	90
Incidents with overdue actions	4	40	1	10
Total number of actions within SAER/LAERs	47	-	27	-

Progress/completion details recorded within DATIX for sample of actions	No.	%	No.	%
Sample of SAER/LAER actions selected	**31**		**10**	
Not yet due	1	3	1	10
Overdue - but noted that in progress	5	16	0	0
Overdue - no update provided on progress in completing	6	19	1	10
Completed - with sufficient detail on final outcome	7	23	7	70
Completed - only date noted with no note on final outcome	12	39	1	10
	31	100	10	100

Actions outstanding on DATIX for 2018 and 2019 (as at December 2019)*	No.	%	No.	%
2018				
Total actions outstanding	51		82	
Actions overdue >4 months	42	82	69	84
2019				
Total Actions outstanding	33		28	
Actions overdue > 2 months	14	42	7	25

* Due to time constraints this audit did not consider actions outstanding prior to 2018.

Section 4 Definition of Assurance and Recommendation Priorities

Definition of Assurance

To assist management in assessing the overall opinion of the area under review, we have assessed the system adequacy and control application, and categorised the opinion based on the following criteria:

Level of Assurance		System Adequacy	Controls
Comprehensive Assurance		Robust framework of key controls ensure objectives are likely to be achieved.	Controls are applied continuously or with only minor lapses.
Moderate Assurance		Adequate framework of key controls with minor weaknesses present.	Controls are applied frequently but with evidence of non-compliance.
Limited Assurance		Satisfactory framework of key controls but with significant weaknesses evident which are likely to undermine the achievement of objectives.	Controls are applied but with some significant lapses.
No Assurance		High risk of objectives not being achieved due to the absence of key internal controls.	Significant breakdown in the application of controls.

Section 4 Definition of Assurance and 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.**	None
Significant		Weaknesses in control or design in some areas of established controls. **Requires action to avoid exposure to significant risks in achieving the objectives for area under review.**	Two
Merits attention		There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**	Two

FTF Internal Audit Service

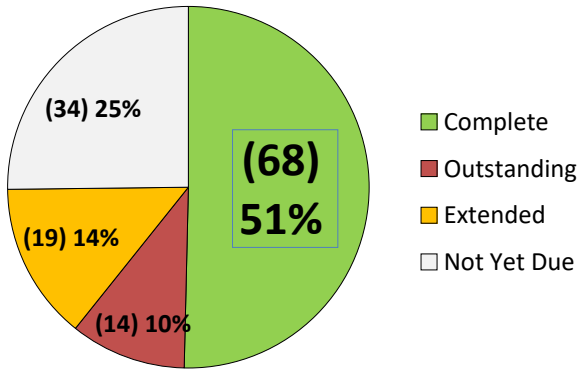
DATE OF MEETING:	13 March 2020
TITLE OF REPORT:	Internal Audit Progress Audit Follow Up Report – Item 7.3
EXECUTIVE LEAD:	Tony Gaskin, Chief Internal Auditor
REPORTING OFFICER:	Barry Hudson, Regional Audit Manager

Purpose of the Report (delete as appropriate)		
		For Assurance

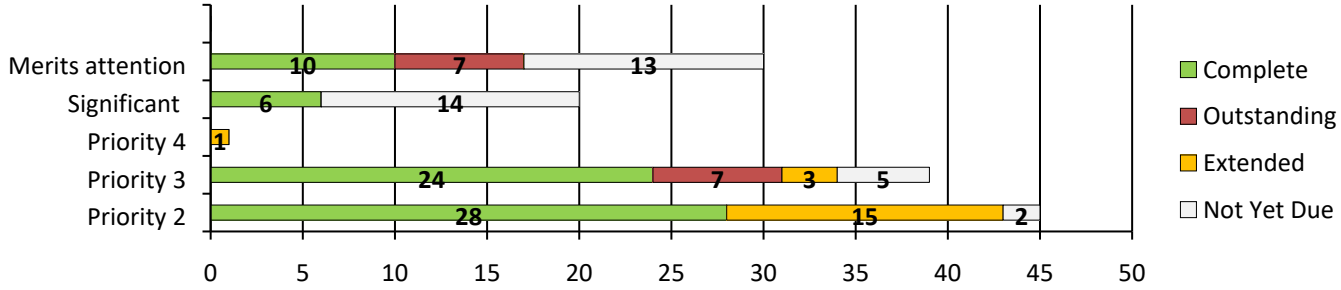
SBAR REPORT
Situation and Background Good practice guidance, as laid out in the Audit Committee Handbook, emphasises the importance of effective follow up processes to ensure that the actions agreed by management to address control weaknesses identified by the work of Internal and External Audit are actually implemented. A revised Audit Follow Up Protocol was approved at the January 2020 Audit and Risk Committee and Internal Audit will continue to undertake the follow up of the recommendations within our audit reports. External Audit recommendations will continue to be followed up through NHS Fife Finance Directorate. Internal Audit will continue to review progress against external audit recommendations where relevant to internal audit fieldwork.
Assessment The appendices to this paper report overdue recommendations only. Internal Audit has obtained management responses to assure the Audit and Risk Committee that recommendations reported as complete have been appropriately actioned and evidenced. Internal audit will undertake a separate exercise around validating the responses to ensure the action taken mitigates the original issue, and will include this within future audit follow up reports. Where we have issues around progress for outstanding recommendations, in particular where no response is received from the responsible officer, we will liaise with the Director of Finance to escalate and progress with an expectation that performance will improve over the coming months.

Summary of Audit Follow Up Progress for 2017/18, 2018/19 and 2019/20 Audits

Status of Internal Audit actions at 27 February 2020



Status of Internal Audit Actions by priority at 27 February 2020



Overall, 51% of due actions have been implemented. We would expect this percentage to increase substantially as Internal Audit take forward the Audit Follow Up process on an ongoing basis.

Since the January 2020 Audit and Risk Committee a further 27 actions have been completed.

14 action points are still outstanding for which updates on progress have not yet been received.

Revised dates have been agreed with Responsible Officers for a further 19 action points.

Appendix 1 shows the action status by report of **all** internal audit action points for 2017/18, 2018/19 and 2019/20 at 27 February 2020.

Appendix 2 shows the status of all **outstanding** internal audit action points for 2017/18, 2018/19 and 2019/20 at 27 February 2020 and also shows the detailed position of **overdue** actions, based on information received from Responsible Officers, at 27 February 2020.

Appendix 3 shows the position of one **historic** action which is outstanding for audits prior to 2017/18. We are liaising with the Clinical Services Manager for Older Adult Mental Health who was not in post at the time of the audit to bring the remaining outstanding historic action to conclusion.

Recommendation

The Audit and Risk Committee is asked to:-

- note and consider the current status of Internal Audit recommendations recorded within this report

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.

	Date of Issue	Total Recs.		Complete	Outstanding	Extended	Superseded	Not Yet Due
2017/18								
B10/18 Transformation Programme	Dec-18	4		3	0	1	0	0
B18/18 Clinical Governance Strategy	Dec-17	17		5	0	12	0	0
B19/18 Patient Safety Programme	Jan-18	2		0	0	2	0	0
B21B/18 Remuneration Sub-Committee	May-18	2		2	0	0	0	0
B24/18 Property Transaction Monitoring	Aug-17	3		2	1	0	0	0
B26/18 Ordering, Requisition & Receipt of Goods	Feb-18	6		3	0	3	0	0
B27B/18 Service Contract Expenditure	Jul-18	4		1	3	0	0	0
B28/18 Service Contract Income	Oct-17	2		2	0	0	0	0
B31A/18 Departmental Review: Podiatry	Mar-19	7		7	0	0	0	0
B31B/18 Departmental Review: Muirview	Nov-18	11		11	0	0	0	0
2018/19								
B11/19 Mandatory Training	Aug-19	3		0	0	0	0	3
B16/19 Adverse Event Management	Mar-19	1		1	0	0	0	0
B18/19 Medical Equipment & Devices	Mar-19	1		1	0	0	0	0
B22/19 Losses & Comps	Apr-19	8		3	3	0	0	2
B23&24/19 Savings & Financial Planning	Sep-19	2		1	0	0	0	1
B27/19 Property Transaction Monitoring	Aug-18	2		2	0	0	0	0
B29/19 Service Contract Expenditure	Aug-19	4		4	0	0	0	0
B31&32/19 IS Assurance & eHealth Strategic Planning	Aug-19	6		5	0	1	0	0
B33/19 Endowment Funds	Jun-19	4		3	0	0	0	1

	Date of Issue	Total Recs.		Complete	Outstanding	Extended	Superseded	Not Yet Due
2019/20								
B08/20 Internal Control Evaluation	Jan-20	15		0	4	0	0	11
B14/20 Staff & Patient Environment	Dec-19	3		0	0	0	0	3
B21/20 Medicines Management	Dec-19	18		8	0	0	0	10
B22b/20 Staff Lottery Follow up	Aug - 19	3		2	0	0	0	1
B23a/20 Workforce Planning – Attendance Management	Jan -20	4		0	3	0	0	1
B26/20 Property Transaction Monitoring	July-19	1		1	0	0	0	0
B27/20 Financial Process Compliance	Jan-20	2		1	0	0	0	1
		135		**68**	**14**	**19**	**0**	**34**

Report / Action Point / Responsible Officer	Issue Date	Audit Finding & Recommendation	Original Management Response	Priority	Original Due Date	Revisions to Due Date	Latest Position – 27 Feb 2020
B24/18 – Post Transaction Monitoring Action point 3 Property Services Manager/ Head of Procurement	16-Aug-17	Clarification should be sought within NHS Fife and documented within the SFIs on the exact protocol that should be followed in future when capital receipt tenders are opened.	It has been agreed with the Director of Estate, Facilities and Capital Services that in future the Property Advisor and Marketing Agent will be asked to be present when tenders are opened. A request will also be made to Financial Services to have this included within the SFIs.	3	Aug-18	Feb-20	**As notified by Responsible Officer 30 October 2019:** **Ongoing** There is national work ongoing at present to develop standard governance documentation and I believe the SFIs will be part of that. I suggest that we simply note the recommendation at this time and confirm that this will be taken into account when we have more clarity on the national guidance/template. **26 February 2020** Further correspondence between Director of Estates, Facilities and Capital Services and the Head of Procurement has confirmed the request to amend the SFIs to reflect current practice to note that the property advisor will be present at the tender opening stage.
B27B/18 – Service Contract Expenditure Action Point 2,3a &3b	13-Jul-18	Virgin Media The revised contract with Virgin Media is for a minimum of three years and as its annual value exceeds the £10,000 limit specified in the FOPs section	Financial Services will be contacted to determine the correct manner in which to progress the Virgin Media contract payments in future.	3	Sep-18		**As notified by Responsible Officer 03 March 2020:** **Ongoing**

eHealth Business & Resource Manager		11(a) ii, tendering arrangements should have been applied, with single tender authorisation being obtained in accordance with FOP 11 (a) 10.1.4. If this contract is renewed it should be ensured that the tendering arrangements specified in the FOPs are followed. This will also ensure that there is appropriate segregation of duties between the contract and subsequent payments being authorised. The Virgin Media contract should also have had a purchase order raised to authorise the annual charge and enable quarterly payments to be processed through PECOS.					Discussions with the responsible officer confirmed that they have only been in post since November 2019 and this recommendation was not included within the handover. They confirmed that, the ITProcurement team are linking in with the central procurement team to confirm the status and processes followed with regard to the Virgin Media contract. A response will be provided by 20 March 2020. For information, ITProcurement are currently working with central procurement to ensure consistency across the organisation, to better understand the work of each other's teams, improve clarity of assignment and encourage a supportive, productive network
B22/19 – Losses & Comps Action point 1a	11-Apr-19	Our testing of 4 losses incidents categorised as losses on the Datix risk management system indicated that one of these losses should have been	a. A communication to managers will be issued reminding them of their responsibilities under FOP 16a Losses and	3	Jul-19		**No information received since further pro-active notification and subsequent reminder sent.**

Assistant Director of Finance (Financial Services)		recorded as a loss and FOP16a should have been followed, regarding the reporting and recording of this loss, but was not followed. Managers responsible for recording incidents should be reminded of the requirement to follow FOP16a for all cases where property is lost, damaged or written off. As per action point 2 below the Datix system should be amended to remind/prompt managers, recording incidents related to losses on Datix, that FOP16a should be followed for all cases where property is lost, damaged or written off.	Compensations. This will specifically remind managers of the following: • FOP 16a should be followed in all cases where property is lost, damaged or written off • Losses forms should be completed and forwarded without delay to the appropriate Directorate/Department Head • The appropriate Directorate/Department Head should acknowledge receipt of the form and record the date of this acknowledgement on the form • The current version of the losses and compensations form should be used • The section of the losses and compensations form related to further investigation and recommendations should be completed for all losses and should record actions identified to prevent recurrence of				

			the loss • Where applicable a cross reference to the related Datix incident should be recorded on the losses and compensations form				
B22/19 – Losses & Comps Action point 3 Assistant Director of Finance (Financial Services)	11-Apr-19	From a sample of five losses and compensations forms tested, one was forwarded to the appropriate Directorate/ Department Head within 2 days but the others were forwarded 18, 12, 57 and 44 days after completion. We also noted that only two of the five recorded acknowledgement of receipt by the by the Directorate Manager/Department Head and that one of the forms used was of an older style than included in the current version of the FOPs and did not include provision for the acknowledgement to be recorded. The relevant managers should be reminded of the requirements in FOP16a 3.2 for the completed forms to be forwarded without delay and Directorate Manager/ Department Heads should be reminded of the need to sign the forms to acknowledge receipt as per FOP16a 4.	As above	3	Jul-19		**No information received since further pro-active notification and subsequent reminder sent.**

B22/19 – Losses & Comps Action point 6 Assistant Director of Finance (Financial Services)	11-Apr-19	For the 5 losses forms sampled: • 3 out of 5 had details of further investigation recorded • None of the 5 included details of action taken to prevent recurrence. [Failure to request patients to sign a disclaimer on admission was recorded on 3 of the 5 forms so a logical action to prevent recurrence was to remind staff to request patients to sign a disclaimer form on admission but this was not recorded] • One of the 5 had been completed on an older version of the losses form than the version included in FOP16a. Managers responsible for completing losses forms should be reminded to use the current version of the form included as an appendix to FOP16a and to complete the section of the form related to recording further investigation in a manner that details the investigation that took place and actions identified to prevent recurrence of the loss.	As per action point 1 part a	3	Jul-19		**No information received since further pro-active notification and subsequent reminder sent.**

B08/20 – Internal Control Evaluation Action point 5 Director of Workforce	6 -Jan- 20	Executive Directors should be asked to leave Remuneration Committee meetings when any discussion takes place with regard to any individual Directors performance.	Arrangements will be made to remind all Remuneration Committee members of this requirement at this time and at future meetings when any discussion takes place with regard to any individual Director's performance. In relation to the meeting on 11 July 2019, the CE and DoW did leave the room at the appropriate point; however the minutes omitted this detail.	Merits attention	Feb 2020		**As Notified by the responsible director 28 February 2020:** An update will be provided by 6 March 2020
B08/20 – Internal Control Evaluation Action point 6 Director of Workforce	6 -Jan- 20	An update on the status of the implementation/action plan for the NHS Fife Workforce Strategy 2019-2022 should be scheduled to the NHS Fife SGC in its 2020/21 workplan	This recommendation is supported and will be built into the NHS Fife SGC Workplan for 2020/21.	Merits attention	Jan 2020		**As Notified by the responsible director 28 February 2020:** An update will be provided by 6 March 2020

B08/20 – Internal Control Evaluation Action point 13	6 -Jan- 20	The identity of the SIRO has not been communicated to staff since the change of post holder (from the ASD COO to the NHS Fife Director of Finance) The change of SIRO should be communicated to staff.	A notification will be issued to staff via Dispatches.	Merits attention	Dec 2019		**No information received since further pro-active notification**
B08/20 – Internal Control Evaluation Action point 14	6 -Jan- 20	The NHS Fife Information Security Policy [GP/I5] has a lapsed review date of 01 May 2019. The status of IG&S Policies is reported to each meeting of the IG&SG and the latest updated informed the group that this policy should have been reviewed by the IG&S Team. The NHS Fife Information Security Policy should be reviewed as a matter of urgency.	The Data Protection Officer will review the policy and report back to the first meeting of the IG&SG in 2020.	Merits attention	Feb 2020		**No information received since further pro-active notification**
B23a Workforce Planning – Attendance management Action point 1 Director of Workforce	16-Jan-20	We recommend that the SGC use this sickness absence data to form a view on whether the overall approach is effectively mitigating the risk and utilise the existing escalation route to the Board appropriately.	Agreed	Merits attention	Dec 2019		**As Notified by the responsible director 28 February 2020:** An update will be provided by 6 March 2020

B23a Workforce Planning – Attendance management Action point 2 Head of Human Resources	16-Jan-20	We recommend that a communication is disseminated to all Managers to raise awareness of the importance of the timeliness of the return to work discussion.	This recommendation is supported and further communication will be disseminated to all Managers to raise awareness of the importance of the timeliness of the return to work discussion. This will also be re-iterated within all of the relevant groups involved in progressing work in respect of promoting Attendance Management within the Board.	Merits attention	Dec 2019		**As Notified by the responsible director 28 February 2020:** An update will be provided by 6 March 2020
Planning – Attendance management Action point 3 Head of Human Resources	16-Jan-20	If NHS Fife have input to the Return to Work Form, cognisance of the recently published Once for Scotland Workforce Policies should be considered to include prompts for discussion, trigger levels and tick boxes.	The national work in respect of the paperwork associated with the Management of Attendance has been concluded therefore the ability to influence the design of the Return to Work Form may be limited. Once the national guidance is received this will be implemented within the Board.	Merits attention	Jan 2020		**As Notified by the responsible director 28 February 2020:** An update will be provided by 6 March 2020

Report / Action Point / Responsible Office	Issue Date	Audit Finding & Recommendation	Original Management Response	Priority	Original Due Date	Expected Complet-ion Date	Latest Position as at 27 Feb 2020
B40a/16 – Departmental Review QMH – Ward 4 Action point 1 Clinical Services Manager (Mental Health)	4-May-16	As yet the protocol on ward mergers required by the EDG has not been prepared to specify the authorisation and management arrangements that should be followed in completing future ward mergers. As Mental Health management has recent experience of completing a merger, it should lead a working group made up of all relevant NHS Fife departments, to prepare a protocol for the benefit of future ward mergers, extending to cover ward closures/relocations as applicable. Once approved, the protocol should be presented to the EDG for approval and thereafter advised to all appropriate levels of management and put on the internet for reference. A post-completion review should be a standard feature of the protocol so lessons learned can be factored into future decisions on ward mergers, closures and relocations.	A paper will be presented to the Mental Health Strategic Management Team to arrange for a short-term working group to be set up to prepare a protocol for future NHS Fife ward mergers. The working group will include representation from Finance and Estates. Once protocol for ward closure has been completed it will be presented to EDG.	2	Aug-16		**We are liaising with the Clinical Services Manager for Older Adult Mental Health who was not in post at the time of the audit to bring the remaining outstanding historic action to conclusion.**

Audit & Risk Committee

DATE OF MEETING:	13 March 2020
TITLE OF REPORT:	Annual Accounts – Progress Update on Audit Recommendations
EXECUTIVE LEAD:	Margo McGurk, Director of Finance
REPORTING OFFICER:	Gillian MacIntosh, Head of Corporate Governance

Purpose of the Report
For Information

SBAR REPORT
Situation The purpose of this report is to provide an update on actions taken, in response to the recommendations emerging from both the Internal Audit Annual Report and the Audit Scotland Annual Report for 2018/19.
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 **Audit Recommendations:** 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 1 and 2 to this paper, with updates of specific actions taken to end of February 2020.
Recommendation The Audit & Risk Committee is asked to: • **note** the actions taken to date to close off issues in advance of the year end.

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; Board Committees

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	Relevant Governance Committee	Update on Progress as at 29 February 2020
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**	Audit & Risk	In progress. 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**	Audit & Risk	Complete. Amended letter used for recent departures of Director of Health & Social Care, Director of Workforce and Chief Operating Officer. For future years, work ongoing at creating new questionnaire to support the production of year-end assurance statements.
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**	All	Complete. Template developed for use with audit reports tabled to other governance committees.
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**	Audit & Risk	Complete. Final Risk Management Framework will be taken to Audit & Risk Committee and NHS Fife Board in March 2020.

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**	Staff Governance	In progress. An update was provided to Staff Governance Committee in January 2020 detailing the intention to review and publish the Workforce Strategy in line with the revised National Workforce strategy timetable. Updates on Workforce Strategy performance will be provided to the Committee on an annual basis and are built into the Staff Governance Committee annual work plan. The Terms of reference for the Strategic Workforce Planning Group will be amended to reflect the recommendations.
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**	Remuneration	Complete. Agreed that no retrospective self-assessment for Remuneration Committee for years 2017/18 and 2018/19 would be undertaken, due to limited use of this exercise. Self-assessment report for present year completed, to be considered at March 2020 meeting, using the same template as in use with other governance committees. As part of this process, the Audit Scotland case studies will be reviewed with Committee members.
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**	Clinical Governance	In progress. Since Audit B08/19 was compiled, there have been a further two audits - B06/20 and B08/20 - which now supersede. B06-20 Annual Internal Report has been completed and covers all the recommendations from B08/19. Any outstanding actions that remain will be followed up through the usual Internal Audit Follow-Up process.

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**	Audit & Risk	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	Relevant Governance Committee	Update on Progress as at 29 February 2020
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*** ***30 September 2019***	Audit & Risk	In progress. A short life working group is being established with colleagues from eHealth, HR and also Financial Management, to ensure that support is available to Procurement staff with regards to appropriate permissions being granted / available within the system. An operational procedure will produced to confirm the process before the next update is due.
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***	Audit & Risk	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***	Finance, Performance & Resources	In progress. Discussions ongoing within the IJB in relation to delivery of savings. Reviewed the Deloitte recommendations and operationalised the improvements identified. These will be monitored through the ASD Performance Reviews within each Directorate.
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.		Finance, Performance & Resources	Delivery of savings, within the context of the overall financial position, is a high risk on the BAF. A financial recovery plan is an essential component of the Annual Operational Plan for 2020/21.

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***	Finance, Performance & Resources	In progress. Procurement and tender process completed. External agency appointed in December 2019 to host and develop the new NHS Fife website. Redesign of the website structure and navigation has begun and the first phase of the new website development due to go live on 1st April 2020. This first phase will include a dedicated "Governance" area to host information about NHS Fife Committees and Groups, NHS Fife Board membership, meetings and associated papers.
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***	All	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***	Audit & Risk	Update given to the Board in November 2019 on completion of the current Blueprint Action Plan, and this reported externally to the Scottish Government. Revised committee self-assessment questionnaire agreed with Committee chairs and completed by members in Dec 19/Jan 20.

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***	All	In progress. 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. Meetings are also currently underway with Integration Partners to review the present Integration Scheme, which will take into account existing governance structures and reporting lines, with the intention to bring a revised version of the Scheme for Partners' approval in Spring 2020.
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***	Clinical Governance	Attrition and flux within the technical teams and delays lining up the supplier (Service Catalogue and BIA assessment) has pushed this work back. The expected date of completion is now **30 June 2020**. February 2020 - no update to add.

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***	Clinical Governance	Complete. An action plan has been approved and delivery thereof is well underway. Scottish Government have responded to our initial self-assessment and a further progress update to SG will be prepared for submission in April 2020. An update in the meantime will be given to Clinical Governance and the Board in January 2020.
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***	Clinical Governance	A change of Cyber Security Manager (who was assigned this work) has caused a delay. However, a Cyber Resilience Plan has now been drafted and this will drive the reporting based on the key deliverables. Full report path expected to be in place by **30 March 2020**. February 2020 - no update to add.
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***	Clinical Governance	Complete. The 12 areas in the GDPR Business Plan have now been addressed and implemented. The quarterly Information Governance & Security (IG&S) Group (which is the ISMS under its Terms of Reference) is kept appraised of the status of GDPR compliance via the reports submitted. The NHS Fife SIRO chairs the IG&S Group and is a Director who sits on the Board and therefore is able to raise any appropriate GDPR risks or issues as they deem necessary. The Information Governance department has implemented principle of Plan, Do, Check, Act (PDCA) to ensure that appropriate responses to changes to the organisation or its operations that raises the risk of GDRP non-compliance.

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***	Staff Governance	Complete. 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***	All	In progress. The need for focus on joint transformation has been recognised and the outcomes from the summer Joint Transformation Workshop has informed the savings plans of the Health Board and IJB, with further work underway.
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		All	The refresh of the governance arrangements for transformation across Fife has resulted in the establishment of the Integrated Transformation Board (ITB). Further support is available via the Interim Director of the Project Management Office for a six-month period.

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***	Clinical Governance	In progress. As the Clinical Strategy is in its fourth year, the proposal is to undertake a full review of the recommendations of the Clinical Strategy by May 2020, with a revised Clinical Strategy 2021-26 being approved by the Board by the end of the 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***	Audit & Risk	Timetable for 2019/20 annual accounts has been agreed as part of External Audit Annual Plan, and internal support will be aligned appropriately.

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***	Audit & Risk	In progress. The routine annual template to capture untaken annual leave for AFC and Executive Manager staff groups has been distributed to budget holders for their completion (early February 2020). This year a representative sample of untaken medical and dental staff will be collected in conjunction with Service Managers to inform the overall holiday pay accrual.
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***	Finance, Performance & Resources	See update provided for items 3 & 4 above.

NHS Fife Audit and Risk Committee

DATE OF MEETING:	13 March 2020
TITLE OF REPORT:	Update on NHS Fife Board Assurance Framework (BAF)
EXECUTIVE LEAD:	Helen Buchanan
REPORTING OFFICER:	Pauline Cumming

Purpose of the Report (delete as appropriate)		
For information		

SBAR REPORT

Situation

This report updates the Committee on the BAF since the last report on 9 January 2020.

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

Further to previous reports to the Committee, the BAF now has 7 components. These are:

- Financial Sustainability
- Environmental Sustainability
- Workforce Sustainability
- Quality & Safety
- Strategic Planning
- Integration Joint Board (IJB)
- e Health - Delivering Digital and Information Governance & Security

Table 1 - Risk Level and Rating over time

Risk ID	Risk Title	Initial Risk Level & Rating LxC	Likelihood (L)	Consequence (C)	Current Level & Rating June/July 2019	Current Level & Rating Aug/ Sept 2019	Current Level & Rating Oct/Nov 2019	Current Level & Rating Dec2019-2020
1413	**Financial Sustainability**	High 16	Likely 4	Major 4	16 (4x 4) High	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	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	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	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	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	12 (3x4)) Mod
1683	**eHealth - Delivering Digital and Information Governance & Security**	High 20	Possible 3	Major 5	N/A	N/A	15 (3x5) High	15 (3x5) High

The risks are reported bi monthly to the standing committee to which they are aligned. Each BAF is supported by a complementary SBAR report. These reflect the Executive Lead's review and assessment of the risk. The reports also highlight key issues and questions the committee must consider as part of its scrutiny 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 considered at the appropriate standing committees, most recently in January 2020. The BAFs are provided separately.

Key points are summarised below.

Financial Sustainability

On14 January 2020, the Director of Finance provided assurance to the Finance, Performance & Resources Committee that systems and processes are in place to monitor the financial

performance and sustainability of NHS Fife, including the impact of the financial position of the Integration Joint Board.

She reiterated the responsibilities of directors and managers for financial management within the related accountability framework.

The current BAF score remains at High which reflects the ongoing financial challenges facing Acute Services and the Health & Social Care Partnership (HSCP).

Linked operational risks:

Risk 1364 - Efficiency Savings - failure to identify level of savings to achieve financial balance

As a result of the consequence score increasing from major to extreme, the overall risk level has risen from 16 to 20.

Environmental Sustainability

On14 January 2020, the Director of Estates, Facilities and Capital Planning advised the Finance, Performance & Resources Committee, that work continues to address the risks as and when funding allows.

Linked operational risks:

Risk 1252 - Flexible PEX hoses in Phase 3 - Victoria Hospital
Risk 1207 - Water system Contamination - St Andrews Community Hospital

He reported that with regard to the above water safety related risks, the replacement programme for flexible hoses on those sites has started. Only when these projects have been are complete, will the risks be closed on the BAF.

Workforce Sustainability

On 17 January 2020, the Director of Workforce assured the Staff Governance Committee that systems and processes are in place to ensure the right staff composition and capability to deliver new clinical and care and delivery models set out in the Clinical and Workforce Strategies.

Linked operational risks:

Risk 90 - national shortage of Consultant Radiologists remains at high.

Quality & Safety

On 16 January 2020, the Director of Nursing reported to the Clinical Governance Committee that there are systems and processes in place to support the quality and safety of care.

Key updates included the setting up of a short life working group to assess the Board's position and state of readiness against the Quality of Care Framework.

In terms of assurance sources, she specifically cited accreditation systems such as the UNICEF Baby Friendly award for which NHS Fife achieved the gold standard.

Linked operational risks:

Risk1502 - 3D Temperature Monitoring System – South Labs - Blood Transfusion Fridges and Freezers.

In January 2020, the risk had reduced from high to moderate and was no longer linked to the BAF. Since then a new operational system has been installed and the risk has been closed.

Strategic Planning

On 14 and 16 January 2020, the Medical Director reported to the Finance, Performance & Resources and Clinical Governance Committees respectively, that the Annual Operational Plan (AOP) for 2019/20 re-identifies the 4 strategic priorities for NHS and Health & Social Care as:

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

These priorities are aligned to the 19 Clinical Strategy recommendations.

He reported that the Integrated Transformation Board (ITB) now provides oversight of all of the transformation programmes. The governance will continue to be with the 4 committees; 2 from the NHS and 2 from the IJB.

An interim PMO is in place to provide oversight and continuity of support to programmes across acute and health and social care. The challenges associated with delivery of strategic objectives and work plans for NHS Fife, the HSCP and the region are unchanged.

At present, no operational risks have been linked to this BAF. This will be kept under review.

Integration Joint Board (IJB)

A review of the Governance arrangements for the IJB, including a review of the Integration Scheme is underway. Pending any developments, the risk level is unchanged.

At present, no operational risks have been linked to this BAF. This will be kept under review.

eHealth - Delivering Digital and Information Governance & Security

On 16 January 2020, the Medical Director reported to the NHS Fife Clinical Governance Committee that systems and processes are in place to monitor eHealth performance and risks. A review of this BAF has started as part of the risk assurance mapping work reported to the Committee in January 2020. The outputs of this work will be reported in due course.

There have been no changes in linked operational risks.

Developments

In parallel with the assurance mapping activity relating specifically to the eHealth BAF, the working group made up of the four Boards covered by the FTF Internal Audit Service (Fife, Forth Valley, Lanarkshire and Tayside), continues to work towards developing the process for assurance mapping in order to enhance each Board's risk management arrangements.

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
Strategic Planning																													
1417	Person Centred, Clinically Excellent, Exemplar Employer, Sustainable	17.12.2019	01.02.2020	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	4 - Likely - Strong possibility this could occur	4 - Major	16	High	4 - Likely - Strong possibility this could occur	4 - Major	16	High	Integrated Transformation Board now in place after the review of transformation in 2019. Reporting and processes currently being embedded. New programme management approach in place supported by a stage and gate methodology.	Chief Executive	Clinical Governance	*Ongoing actions designed to mitigate the risk including:* 1. Establishment of Integrated Transformation Board (ITB) in 2019 to oversee transformation programmes across NHS Fife, Fife IJB and Fife Council to drive the delivery of the H&SC Strategic Plan and the Clinical Strategy. 2. Establishment of programme management framework with a stage and gate approach. 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	JSTG not performing role adequately and replaced by the newly formed Integrated Transformation Board. but transformation 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. Establishment of ITB should provide assurance to the committees and Board that the transformation programme has strategic oversight and delivery. Senior Leadership for Transformation through the ITB is provided by CEOs of NHS Fife and Fife Council.	Chief Executive	31.03.2020	1. Minutes of meetings record attendance, agenda and outcomes. 2. New governance in place with newly formed Integrated Transformation Group meeting every 6 weeks. 3. Performance and Accountability Reviews now underway which will provide assurance to committees on performance of all	1. Internal Audit Report on Strategic Planning (no. B10/17) 2. SEAT Annual Report 2016 3.Governance committee oversight of performance assurance framework	That the ITB is overseeing and managing the impact of the various programmes on areas such as capital and revenue, worforce and facilities. Business cases have been developed in support of the transformation	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	Possible - May occur occasionally - reasonable chan	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)

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Integration Joint Board																													
1418	Sustainable	21.08.2019	31.10.2019	There is a risk that the Fife Integration Scheme does not clearly define operational responsibilities of the Health Board, Council and Integration Joint Board (IJB) resulting in a lack of clarity on ownership for risk management, governance and assurance.	4 - Likely - Strong possibility this could occur	4 - Major	16	High	3 - Possible - May occur occasionally - reasonable chance	4 - Major	12	Moderate	Issues raised by auditors, acknowledged at year end 2016/17 that need to be addressed.	Director of Health & Social Care	NHS Fife Board Chair: Tricia Marwick	*Ongoing actions designed to mitigate the risk including:* 1. IJB has reviewed its Integration Scheme to ensure there is clarity around how decisions are made through its governance mechanisms, providing appropriate and efficient assurance to the parent bodies. NHS Fife asked for time to consider the proposals made. The governance working group is continuing to meet to further refine the wording of the Integration Scheme 2.. The revised NHS Fife Code of Corporate Governance was approved by the NHS Fife Board in March 2018. 3. A Code of Corporate Governance for the IJB has been developed and was submitted to the IJB Audit and Risk Committtree in March 2018 and then to the IJB on 21 June 2018 for approval. The IJB Code of Corporate Governance forms part of a consolidated governance framework, and will be supported by an annual action plan and Assurance Map, which are currently under development. This will ensure all risks, responsibilities and other appropriate matters are understood by all parties and considered effectively for ongoing assurance and the annual Governance Statement. 4. A Governance Manual, bringing all relevant governance information in to one reference document for all members and officers is currently	Nil	Nothing more to be done than the ongoing actions set out.	Director of Health & Social Care		1. Through regular updates to SLT and EDG about the progress of the reviews. 2. Updates to Audit & Risk Committees, the Integration Joint Board (IJB) and NHS Fife.	1. • The views of auditors will be the key independent assurance mechanism around this risk. We will involve them in the work to clarify governance arrangements as it progresses. 2. • Scottish Government will also provide useful advice and an independent perspective on the work to be carried out.	None	The problem should be largely resolved with the action taken.	1 - Remote - Can't believe this event would happen	4 - Major	4	Low	Once resolved and given effect to in IJB integration scheme and NHS Fife corporate governance arrangements, the issue should largely be resolved. But given maturity of relationships and dynamics around regional approaches a remaining risk will remain.

Linked Operational Risk(s)

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	Nil currently identified		

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Strategic Planning																													
1417	Person Centred, Clinically Excellent, Exemplar Employer, Sustainable	17.12.2019	01.02.2020	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	4 - Likely - Strong possibility this could occur	4 - Major	16	High	4 - Likely - Strong possibility this could occur	4 - Major	16	High	Integrated Transformation Board now in place after the review of transformation in 2019. Reporting and processes currently being embedded. New programme management approach in place supported by a stage and gate methodology.	Chief Executive	Clinical Governance	*Ongoing actions designed to mitigate the risk including:* 1. Establishment of Integrated Transformation Board (ITB) in 2019 to oversee transformation programmes across NHS Fife, Fife IJB and Fife Council to drive the delivery of the H&SC Strategic Plan and the Clinical Strategy. 2. Establishment of programme management framework with a stage and gate approach. 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	JSTG not performing role adequately and replaced by the newly formed Integrated Transformation Board. but transformation 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. Establishment of ITB should provide assurance to the committees and Board that the transformation programme has strategic oversight and delivery. Senior Leadership for Transformation through the ITB is provided by CEOs of NHS Fife and Fife Council.	Chief Executive	31.03.2020	1. Minutes of meetings record attendance, agenda and outcomes. 2. New governance in place with newly formed Integrated Transformation Group meeting every 6 weeks. 3. Performance and Accountability Reviews now underway which will provide assurance to committees on performance of all	1. Internal Audit Report on Strategic Planning (no. B10/17) 2. SEAT Annual Report 2016 3.Governance committee oversight of performance assurance framework	That the ITB is overseeing and managing the impact of the various programmes on areas such as capital and revenue, worforce and facilities. Business cases have been developed in support of the transformation	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	Possible - May occur occasionally - reasonable chan	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)

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eHealth - Delivering Digital and Information Governance & Security																													
	Person Centred, Clinically Excellent, An Exemplar Employee, Sustainable	**19.07.2019**	**01.07.2020**	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.	4 - Likely - Strong possibility this could occur	5 - Extreme	20	High	3 - Possible	5 -Extreme	15	High	Failure in this area could have a direct impact on patients care, organisational reputation and exposure to legal action. While it is recognised that several adverse events ranging from minor to extreme can occur daily, the proportion of these in relation to overall activity is very small and reporting to competent authorities is minimal.	Medical Director & DOF (SIRO)	Clinical Governance - Chair: Dr Les Bisset FP&R - Chair: Rona Laing	*Ongoing actions designed to mitigate the risk including:* 1. Implementation of the NHS Fife Strategic Framework and Clinical Strategy 2. Operational Governance arrangements 3. Risk Management Framework. The risk management framework is underpinned by Robust Policy & Process, Asset Management Controls, Monitoring and Detection, Defence in Depth security measures and technology; all of which are receiving a higher percentage of budget allocation. 4. Robust Internal and External Audit reports. 5. Working towards General Data Protection Regulation (GDPR), Directive on security of network and information systems (NIS) & Cyber Essentials Compliance 6. Corporate and eHealth policies & Procedures: GP/A4 Acceptable Use Policy GP/B2 eHealth Remote Access Policy GP/C10 Clear Screen Clear Desk Policy GP/D6 Data Encryption Policy GP/E7 Non NHS Fife Equipment GP/H6 eHealth Equipment Home Working Policy GP/I3 Internet Policy GP/I4 eHealth Procurement Policy GP/I5 Information Security Policy GP/M5 Mobile Device Policy GP/P2 Password Policy GP/M4 Media Handling Policy GP/E6 Email Policy GP/S8 eHealth Incident Management Policy GP/D3 Data Protection and Confidentiality Policy GP/I6 IT Change Management Policy GP/V2 IT Virus Protection Policy This is supported by the following: 7. eHealth Risk Register (incl Programme/project risks)	The organisation is not consistently fully compliant with the following key controls: GDPR/DPA 2018 NIS Directive Cyber Essentials Plus. Compliance is at 'a point in time' , Risks identified, linked and recorded. The organisation is also lacking in training resource to ensure our staff are digitally ready.	1. Improving and maintaining strong governance and procedures following Information Technology Infrastructure Library (ITIL) professional standards 2. Ensure new systems are not introduced without sufficient skilled resources to maintain on an ongoing basis. 3. Work to become fully compliant with GDPR, DPA 2018, NIS Directive, Information Security Policy Framework and thereafter maintain compliance.	Head of eHealth - Lesly Donovan	01.07.2020	Second Line of Defence 1. Reporting to eHealth Board, Information Governance & Security Group (IG&SG), clinical & clinical & care governance groups and committees. 2. Annual Assurance Statements for the eHealth Board and IG&SG. 3. Locally designed subject specific audits. 4. Compliance and monitoring of policies & procedures to ensure these are up to date. 5. Reporting bi annually on adequacy of risk management systems and processes to Audit & Risk Committee. 6. Monthly SIRO report 7. SGHSCD Annual review 8. SG Resilience Group Annual report on NIS & Cyber compliance 9. Quarterly performance report. 10. Accreditation systems. 11. Locally designed subject specific audits. 12. From June 2019	Third line of Defence: 1. Internal Audit reviews and reports on controls and process; including annual governance review / departmental reviews. 2. External Audit reviews. 3. Formal resilience testing / DR testing using an approved scope and measured success and mechanism for lessons learned and action plans. 4. Cyber Essentials/Plus Assessments. 5. NISD Audit Commissioned by the Competent Authority for Health.	1. Well developed reporting, which can highlight potential vulnerabilities and provide assurances (including assurances that confirm compliance with GDPR, DPA 2018, NIS Directive, the Information Security Policy Framework is being maintained). 2. Implementation of improvements as recommended in Internal and external Audit Reports and an internal follow-up mechanism to confirm that these have addressed the recommendations made 3. Improvements to SLA's (in line with 'affordable performance') 4. Output from national Digital maturity due late 2019	Overall, NHS Fife ehealth has in place a sound systems of 1. Governance 2. Reasonable security defences and risk management as evidenced by Internal Audit and External Audit reports 3. Attainment of the ISO27001 standard in the recent past and the Statement of Annual Assurance to the Board. 4. Investment has been made to support NIS, GDPR and Cyber resilience and some tools which will improve visibility of the Network.	2 - Unlikely	5 - Extreme	10	Moderate	1. Difficulty in securing investment in people, tools and maintaining systems that are resilient and always within support cycles. 2. Fully implementing resistance to attack through 'resilience by design', well practised response plans and recovery procedures. 3. Reduce the 'human factor' through ongoing 'user base education' and improving organisational digital readiness. 4. Enhanced controls and continuing improvements to systems and processes for improved usage, monitoring, reporting and learning are continually being put in place. Aim for Moderate Risk as target rather than Low Risk is due to the fact that likelihood whilst unlikely may still happen and consequence will be extreme due to level of fines that may be imposed, reputational damage and patient harm.

Risk ID	Risk Title	Current Risk Rating	Risk Owner
226	Lost of confidential or personal data	High 16	L Donovan
529	Information Security	High 16	C Potter
537	Failure of local Area Network causing loss of access to IT systems	High 15	A Young
1338	End of support for MS Office 2007	High 16	A Young
1393	Patch Management	High 16	A Young
1422	Unable to meet cyber essentials compliance	High 20	A Young
1424	End of support for MS Server 2003	High 16	A Young

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Reason for unlinking from BAF	Current Risk Rating	Risk Owner
913	MiDIS replacement	No longer High risk	Moderate 12	Lesly Donovan

NHS Fife Board Assurance Framework (BAF)

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Environmental Sustainability																													
1414	Sustainable, Clinically Excellent	18.12.2019	18.03.2020	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
1007	Theatre Phase 2 Remedial work		High 15	M Cross
1207	Water system Contamination STACH		High 15	A Fairgrieve
1252	Flexible PEX hoses Phase 3 VHK - Legionella Risk		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	Risk Closed		
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		
1384	Microbiologist Vacancy	Risk Closed		
1473	Stratheden Hospital Fire Alarm System	Risk Closed		

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Financial Sustainability																													
1413	Sustainable	31.12.2019	29.02.2020	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 is being developed by the Acute Services Division 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. For the purposes of reporting to SGHSCD, therefore, we continue to report a potential overspend at year end including the risk share impact of the shortfall in the opening IJB budget, noting the risk that this is likely to be higher due to the increased forecast cost pressures within social care packages. Within the Scottish Government monhtly reporting template we have highlighted that the impact of the social care overspend would require additional external funding and the overspend on the Health Board retained budgets might be managed through local management action (speficially non recurring financial flexibility).	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 20	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
1357	Financial Planning, Management & Performance	No longer a high risk	Moderate 12	C Potter

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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	05.12.2019	04.03.2020	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. Integrated Performance and Quality Report (IPQR), 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 Organisational 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 Integrated Performance and Quality (IPQR) 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 in line with national developments and HIS workshop on 09/12/19. 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. Establish a short life working group to begin assess our positon against the Quality of Care Framework and understand our state of readiness. 7.Further develop the culture of person centred appraoch to care. 8. Only Executive commissioning of reviews as appropriate e.g. internal audit, external peer and	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 eg. Unicef - Accredited Baby Friendly Gold. UKAS Inspection for Labs. 7. 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 11. Specific National reporting	1.Key performance indicators relating to corporate objectives e.g. person centred, clinically excellent, exemplar employer & sustainable.	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
43	Vascular access for haematology/Oncology	High 20	Shirley-Anne Savage
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	Scott Garden
1524	Oxygen Driven Suction	High 20	Dr Christopher McKenna
521	Capacity Planning	High 16	Miriam Watts
529	Information Security	High 16	Carol Potter
637	SAB HEAT TARGET	High 16	Julia Cook
1365	Cancer Waiting Times Access Standards	High 15	TBC
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
356	Clinical Pharmacy Input	Closed Risk		
528	Pandemic Flu Planning	No longer a high risk	Moderate 12	Dona Milne
1297	Obsolete Equipment In Use – No Replacement Plan In Place (Graseby 3000 Series)	Closed Risk		
1366	T34 syringe drivers in the Acute Division	Closed Risk		
1502	3D Temperature Monitoring System (South Lab)		Moderate 12	Ken Campbell

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
Workforce Sustainability																													
1415	Exemplar Employer	01.11.2019	17.01.2020	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. • Implementation of the Workforce Strategy to support the Clinical Strategy and Strategic Framework. 2. • Implementation of the Health & Social Care Workforce Strategy to support the Health & Social Care Strategic Plan for 2019 - 2022. 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 Assurance 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, SITREP Radiology Group 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. • NHS Fife Promoting Attendance 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 OH and Wellbeing	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. • Improvement to be 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	Risk Closed		
1375	Breast Radiology Service	No longer high risk	Moderate 12	M Cross
1420	Loss of consultants	No longer high risk	Moderate 12	H Bett