Audit & Risk Committee

16 May 2019, 09:30 to 11:30
The Boardroom, Staff Club, Victoria Hospital

Agenda

1. Apologies for Absence

2. Declaration of Members' Interests

3. Minutes of Previous Meeting held on 14 March 2019

Martin Black

Item 3 Minutes AR 14 March 2019.pdf (8 pages)

4. Action List

Martin Black

Item 4 AR Action List 0519.pdf (2 pages)

5. Matters Arising

5.1. Committee Workplan Update

Carol Potter

Item 5(a) - SBAR Committee Workplan ARC updated.pdf (1 pages)

Item 5(a) - ARC Annual Workplan 2019-20 updated.pdf (2 pages)

6. Governance - General

6.1. Annual Assurance Statement

Carol Potter

Item 6 - SBAR Annual Statement of Assurance.pdf (2 pages)

Item 6 - Annual Statement of Assurance 201819.pdf (15 pages)

7. Draft Governance Statement

Carol Potter

Item 7 - SBAR Draft Governance Statement.pdf (2 pages)

Item 7 - Draft Governance Statement.pdf (6 pages)

8. Property Transactions Report

Carol Potter

Item 8 - SBAR Property Transaction Report.pdf (2 pages)

9. Payments to Primary Care Practitioners

Item 9 - Payments to Primary Care Practitioners (SBAR) 240419.pdf (7 pages)

10. Annual Review of Code of Corporate Governance

Carol Potter

Item 10 SBAR Code of Corporate Governance A&R.pdf (2 pages)

Item 10 CodeofCorporateGovernanceApr2019.pdf (117 pages)

11. Governance - Internal Audit

11.1. Internal Audit Progress Report & Summary Report

Item 11 NHSF May 2019 Progress Report FINAL.pdf (11 pages)

12. Internal Audit Plan - 2019/20

Item 12 NHSFAnnual Plan SBAR and papers FINAL.pdf (4 pages)

Item 12 NHS Fife Internal Audit Plan 2019-20 Final.pdf (12 pages)

13. Internal Audit - Follow Up Report on Audit Recommendations

Carol Potter

Item 13 - SBAR Internal Audit Follow Up Monitoring.pdf (2 pages)

Item 13 - Action Plan Follow Up MAY (OVERDUE).pdf (2 pages)

14. External Quality Assessment

Item 14 External Quality Assessment.pdf (2 pages)

Item 14 Final - EQA Report for NHS Fife and NHS Forth Valley.pdf (12 pages)

15. Shared Service Agreement

To Follow

15.1. Service Specification

Item 15 Service Level Agreementr SSA Final.pdf (17 pages)

16. Governance - External Audit

16.1. Interim Management Report

Item 16 - 19_05_02_NHS_Fife_Management_Report.pdf (19 pages)

17. Audit Planning Memorandum - Patients Private Funds

Carol Potter

Item 17 - Patients' Private Fund Planning Memo 2019 - Copy.pdf (25 pages)

18. Risk

18.1. Board Assurance Framework

Helen Wright

Item 18 - SBAR Update on BAF to NHS Fife Audit and Risk Committee on 16 05 19 V 0 1.pdf (5 pages)

Item 18 - NHS Fife Board Assurance Framework (BAF) - Integration Joint Board.pdf (1 pages)

Item 18 - NHS Fife Board Assurance Framework (BAF) - Workforce Sustainability SGC 010319.pdf (2 pages)

Item 18 - NHS Fife Board Assurance Framework (BAF) - Environmental Sustainability FPRC 120319.pdf (1 pages)

Item 18 - NHS Fife Board Assurance Framework (BAF) - Financial Sustainability FPRC 120319.pdf (2 pages)

Item 18 - NHS Fife Board Assurance Framework (BAF) - Quality and Safety CGC 060319.pdf (1 pages)

Item 18 - NHS Fife Board Assurance Framework (BAF) - Strategic Planning CGC 060319.pdf (4 pages)

Item 18 - NHS Fife Board Assurance Framework (BAF) - Strategic Planning FPRC 120319.pdf (4 pages)

19. Other

19.1. Performance & Accountability Review Framework

Carol Potter

Item 19 - Performance Accountability Framework 2019-20.pdf (10 pages)

20. Technical Bulletin 2019-1

Item 20 - Technical Bulletin.pdf (35 pages)

21. Issues for escalation to NHS Board

Martin Black

22. Any Other Competent Business

23. Date of Next Meeting

23.1. Thursday 20 June 2019 at 9.30am within The Board Room, Staff Club, Victoria Hospital

MINUTES OF THE NHS FIFE AUDIT AND RISK COMMITTEE HELD AT 9:30AM ON THURSDAY 14 MARCH 2019 IN THE STAFF CLUB, VICTORIA HOSPITAL, KIRKCALDY.

Present:

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

In Attendance:

Mr P Hawkins, Chief Executive
Mr B Hudson, Regional Audit Manager
Dr G MacIntosh, Head of Corporate Planning & Performance
Mrs C Potter, Director of Finance
Ms P Tate, Audit Scotland
Ms H Wright, Director of Nursing

ACTION

01/19 APOLOGIES FOR ABSENCE

Apologies were received from Mr T Gaskin as a regular attendee.

02/19 DECLARATION OF MEMBERS' INTERESTS

Mr M Black, Ms S Braiden, Cllr D Graham, Ms J Owens and Mrs M Wells all declared their respective membership of other NHS Board Committees.

03/19 MINUTES OF PREVIOUS MEETING HELD ON 13 DECEMBER 2018

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

04/19 ACTION LIST

The Committee discussed the outstanding actions not otherwise covered in this meeting as follows:

Action 1 – Mrs Potter advised that the matter related the MoU with the IJB has been effectively overtaken by other work. She explained that a meeting will shortly be taking place looking at the conclusions of the recent Audit Scotland report on Integration and its recommendations for improved H&SCP governance and reporting.

Action 4 – Patients' Private Funds - Mrs Potter advised that this will be picked up in the Annual Accounts year-end process.

Action 9 – Audit Scotland report on Integration - Mrs Potter advised that this will be part of the "stock take" exercise as referred to under action 1.

ACTION

Action 10 – Mrs Potter stated that at the last meeting the progress update on the Annual Accounts recommendations didn't have the most up-to-date schedule attached to it. This has now been rectified.

05/19 MATTERS ARISING

There were no matters arising.

06/19 INTERNAL AUDIT

(a) Internal Audit Progress Report & Summary Report

Mr Hudson noted that the purpose of the report is to brief the Audit and Risk Committee on the audits completed since the last meeting.

Since the last meeting in December 2018, six reviews have been completed, with a further three at draft report stage. At this stage of the audit year the Committee can be assured that the plan will be substantially completed to allow any findings to be reflected in the year-end annual report.

Mr Hudson drew the Committee's attention to page 18 of the report and stated that, after discussions with the Director of Finance, two planned audits were to be removed from the plan, the reasons for which been provided within the report.

The Audit and Risk Committee **noted** the progress on the internal audit plan and **noted** the approach for the development of the Internal Audit Plan for 2019/20.

(b) Internal Audit Plan 2019/20

Mr Hudson stated that a brief summary was provided on the Internal Audit Plan for 2019/20 within the progress report. The overall aim for the plan next year is to ensure stronger links with the Board Assurance Framework (BAF) and making sure the risks are clearer and more closely aligned.

An initial meeting has taken place with the Chief Executive and the Director of Finance, where it was agreed that the Regional Audit Manager would meet the Chairs and Lead Officers of each of the Standing Committees to discuss any key concerns and identify any areas for review. These meetings are currently in progress.

All Directors have been informed of the plan's development and have been asked to input any operational risks that they feel may impact on the plan for next year. The plan will be submitted to the Executive Directors Group (EDG) for consideration before coming

to the May Audit and Risk Committee for approval.

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

(c) Interim Audit - Follow Up Report on Audit Recommendation

Mrs Potter advised that the report provided a summary of all outstanding actions arising from the recently completed Internal Audit reports. The number of outstanding actions has increased since the last report for a variety of reasons; the appendix provides a note of the reports that have the outstanding actions.

Ms Potter reported that another Health Board presently uses the Datix Risk Management system to automate and improve the follow-up of all internal audit recommendations. It is hoped that NHS Fife will start using this system for the new financial year. It was confirmed that the current outstanding actions will be closed off before the new system is implemented.

Ms Wells asked Mrs Potter for an update on the higher priority actions that were currently outstanding. Mrs Potter advised that she didn't have the detailed reports immediately at hand and would feed back to her via email. **CP**

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

(d) Information Sharing Protocol

Mr Hudson noted that this report has been prepared by the equivalent Chief Internal Auditor in Fife Council, who is the Lead Chief Internal Auditor for the IJB. The purpose of this report is to get approval from the Audit and Risk Committee for the Fife IJB Information Sharing Protocol. Fife Council Standards and Audit Committee approved the protocol on 28 February 2019 and it will now be presented to the IJB Audit and Risk Committee on 22 March 2019.

The overall aim of this protocol is to enable sharing of internal audit outputs in a controlled manner with Audit Committees, where it is considered recommendations apply to one or more of the other partners for assurance purposes.

In a response to a question by Ms Braiden around confidentially, Mrs Potter said that all the Internal Audit reports are presently accessible under FOI. If there were any matters that were confidential then they would be considered as private business. The Data Protection officers in each of the entities have been consulted on in the preparation of the protocol.

Mrs Wells asked about the next steps of the protocol, particularly how the audit plans of each entity begin to fit together and how they are being carried out. She stated that there had been an independent report that had some useful recommendations and asked how this will be taken into account across the parties.

Mr Hudson stated that the IJB audit plan will be small and will largely sit under the individual audit plans from the Health Board and the Council.

Mr Hawkins noted that there needs to be a conversation with the Council and the auditors to discuss who should be auditing it. He queried if it would be possible to share all the audit plans with each of the Committees, including those of the IJB, to identify any gaps for next year and address some of the work that has already been agreed.

Mrs Potter confirmed that the internal audit plan will be taken forward with the Lead Directors for each Committees and each of the respective Committee Chairs.

The Audit and Risk Committee **approved** the Internal Audit Output Sharing Protocol, subject to checking the confidentially clauses meet required needs across all parties (particularly where patient issues are involved) and encouraged further thought about seeking assurance around the internal audit plan.

07/19 RISK MANAGEMENT

(a) Update on Risk Management

Ms Wright gave an update on the Risk Management Work Plan. Since the last meeting, and following on from the recent Board Development Session, it was agreed that a Short Life Working Group would be set up to formalise the Board's appetite for risk, to develop a set of risk appetite statements and to define definitions of risk tolerance and risk appetite.

The updated report will be submitted to the Board for approval in due course.

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

b) Workplan Board Assurance Framework (BAF)

Mrs Wright advised that the six components contained within the BAF had recently been through all the relevant Governance Committees.

Following the recent Board Development Session it was agreed to look at creating a stand-alone eHealth BAF. This has since been developed and currently being considered by the eHealth Board and will be brought to the next meeting of Audit and Risk.

The Audit and Risk Committee **noted** the BAF and **noted** the developments with the creation of an eHealth report.

08/19 Annual Accounts - Progress Update on Audit Recommendations

Mrs Potter advised that this report was the final update on actions taken within this financial year.

Ms Braiden asked for clarity on the matter of "Prescribing advance" ... *NHS Fife appears to be the only health board showing the movement between the opening and closing prescribing advanc*e ...

Mrs Potter confirmed that this is a technical adjustment that came up in the accounts in the last financial year. It was very small value of around £30k, and thus low risk, but the auditors highlighted that our treatment of it through the balance sheet was inconsistent with practice at other Boards.

The Audit and Risk Committee **noted** the actions taken to close off issues in advance of the year end.

09/19 Annual Workplan

Mrs Potter presented the revised workplan detailing the schedule of Committee business for the new financial year 2019/20.

The Audit and Risk Committee **approved** the updated workplan for 2019/20.

10/19 Review of Code of Corporate Governance

Dr MacIntosh reported that the Code of Corporate Governance was last updated in March 2018, with a review cycle of every three years. However, it is the intention that an annual update be undertaken to ensure the information contained therein remains current. It was also reported that there is a potentially a new suite of Standing Orders and Standing Committee Remits coming out as part of national work around implementing the new NHS Blueprint for Good Governance, which will require further changes to be made to this document.

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

11/19 Review of Committee's Terms of Reference

Mrs Potter confirmed that a number of minor changes have been made to the Committee's Terms of Reference, to reflect title changes and

ACTION

also the requirements of the Scottish Government's Audit and Assurance Committee Handbook issued originally in March 2018. The Committee are asked to review the updated remit and confirm that it remains relevant and applicable.

The Audit and Risk Committee **reviewed** the terms of reference for the Audit and Risk Committee, confirming it remains relevant and applicable, and **approved** the suggested amendments to the Committee's remit, to reflect the requirements of the new Audit and Assurance Committee Handbook.

12/19 Self Assessment Checklist

Mr Black thanked members of the Audit and Risk Committee for taking part in completing the Committee's Self Assessment Checklist. Discussion followed on a number of the findings as below:

Section D - Audit and Risk Specific Questions

AR1 – At least one of the Audit and Risk Committee members has sufficient relevant and recent financial experience.

Discussing what counts as relevant and recent financial experience, the External Auditors confirmed that this would normally mean that at least one member came from a financial or accounting background. If that skill was missing across the Committee overall, they would then assess how that gap might be filled by a combination of members' other skills.

Mr Hawkins noted that such skills could be sought in the next round of Non-Executive recruitment, if there was an issue in that area. Mr Black added that he is presently assured that Non-Executives get ample opportunities to seek clarity on any areas that might be complex and receive appropriate information.

Dr MacIntosh also noted that if the Committee feels that there are potential areas that members need training on, this is something that can be arranged.

Section B - Committee meetings, support and information

B11 – The Committee provides clear direction to its sub groups or committees.

Mr Black asked if this question was applicable to the Audit and Risk Committee (which has no sub-committees), hence its relatively low-rating in the questionnaire report. Dr MacIntosh noted that the actual format of the checklist is the same for all the Standing Committees of

the Board, though Audit and Risk get an extra set of questions. It was noted that this feedback will help inform the next iteration of the questionnaire.

Section C - The Role and Work of the Committee

C4 – The Committee seeks effective feedback on its own performance from the Board and Accountable Officer.

Mrs Wells noted that support for more feedback for Committees from the Board had been raised by a number of the Committees, via the self-assessment exercise, and queried how this might be practically addressed. Dr MacIntosh agreed this had been a common theme across the Committee responses and thought would now be given as to how the Board might feed back appropriately. Mr Black noted that Committee Chairs meet regularly with the Chair of the Board as part of overall assurance mechanisms, and discussions from those meetings could cover Committee performance overall. Mr Hawkins noted that Committee workplans also provide assurance that each Committee is covering adequately the areas within its remit.

Mrs Potter added that this issue could be discussed at a future Board Development Session, and Dr MacIntosh noted the intention to cover this as part of our overall review of Governance. Separately, it was agreed that Mr Hawkins and Mr Black would also discuss with the Chair how such feedback to Committees in general could be delivered.

In relation to the Committee's self-assessment report, Cllr Graham passed on his thanks to the Board Secretary for ensuring future scheduled dates for Audit & Risk did not clash with any full meetings of Fife Council for the forthcoming year, thus allowing his regular attendance at meetings.

The Audit and Risk Committee **noted** the outcome of the recent self-assessment exercise.

13/19 Update from Brexit Assurance Group

Mr Black reported to the Audit and Risk Committee that the Brexit Assurance Group has met for the first time and are due to meet again on 2 April. Reporting input from the NHS Fife Resilience Forum has been agreed and Terms of Reference for the group established.

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

14/19 Issues for Escalation to the NHS Board

None.

ACTION

15/19 Any Other Competent Business

There was no other business.

16/19 DATE OF NEXT MEETING: Thursday 16 May 2019 at 9.30am, within the Boardroom, Staff Club, Victoria Hospital, Kirkcaldy.

ACTION LIST FROM AUDIT & RISK COMMITTEE – 2018-19

	Title	Action	Lead	Outcome
1	MOU with IJB	Update to September 2018 meeting	CP	Original action now superseded. A meeting with colleagues in the Partnership and Fife Council has recently taken place, to consider the conclusions of the recent Audit Scotland report on Integration and its recommendations for improved H&SCP governance and reporting, with an assessment of the current Fife position to be reported to the Scottish Government by 15 May.
2	Annual Internal Audit Plan 2018-19	Review planning process for future and report back to the Committee	TG	Better alignment between NHS Fife and Fife Council will be reflected in next Internal Audit annual plan, to be considered by Committee in March 2019.
3	Information Sharing	Prepare sharing protocols between NHS Fife and Fife Council	TG	As above.
4	Patients' Private Funds – Consolidated Abstract of Receipts and Payments for year ended 31.03.18	Archiving of forms for recording specific expenditure prior to audit – ask M Kellet to provide assurance that nothing of concern and ask Finance Dept to review internal control procedures and consider using LearnPro module	CP	Action to be completed as part of year-end accounting process.
5	Annual Accounts Process	Ensure consistency in the format of the Annual Assurance Statements	CP	More consistent approach undertaken this year across the Board's governance committees.

6	Committee Calendar	Sequencing of meetings to be considered between NHS Fife/Fife Council/IJB	GM	Checked future scheduled dates for Audit & Risk and confirmed that none clash with full meetings of Fife Council or any Fife Council committees on which Cllr Graham currently sits.
7	Internal Audit Progress & Summary reports	Standard format of paper	BH	Add in page numbers to the report in future.
8	Review of Committee's remit	To reflect the recent publication of the new NHS Audit and Assurance Committee Handbook, for review at the Committee in March 2019	CP / GM	Remit amended accordingly.
9	Audit Scotland report on Health & Social Care Integration	Director of Health & Social Care asked to prepare a paper for the NHS Fife and IJB Audit & Risk committees on how the report's recommendations will be addressed, for Committee's next meeting in March 2019	MK	As per Item 1 above.
10	Progress update on Annual Accounts Audit recommendations	Provide in future iterations of the report accurate information on the proposed approval by the IJB of its Financial Recovery Plan	CP / MK	This has now been rectified.

 Completed  Updated

Audit & Risk Committee

DATE OF MEETING:	16 May 2019
TITLE OF REPORT:	Committee Workplan 2019/20 - update
EXECUTIVE LEAD:	Carol Potter, Director of Finance
REPORTING OFFICER:	Carol Potter, Director of Finance

Purpose of the Report (delete as appropriate)		
		For Assurance

SBAR REPORT

Situation

The NHS Fife Code of Corporate Governance states that all Committees have in their Workplan that the Committee *"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 Audit & Risk Committee workplan for 2019/20 was agreed by the Committee on 13 March.

Assessment

The purpose of this report is to highlight a number of minor amendments to the Committee workplan for 2019/20. Changes are 'tracked' for ease of refernce.

Recommendation

The Committee is asked to:

- **approve** the updated workplan for 2019/20

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:	
Parties / Committees consulted prior to Committee Meeting:	
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 2019/20

	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**					√
Review of Code of Corporate Governance	**Board Secretary**	√				
Governance – General						
Committee Self Assessment	**Board Secretary**					√
Annual Assurance Statement (inc. best value report)	**Board Secretary**	√				
Annual Assurance Statements from Standing Committees	**Board Secretary**	~~√~~	√			
Draft Governance Statement	**Chief Executive**	√				
Property Transactions Report	**DoE&F**	√				
Review of Property Transactions	**Chief Internal Auditor**			√		
~~Best Value Report~~	~~**DoF**~~	~~√~~				
Review of Payment Verification Process (FHS/PMS)	**DDoF**	√				
Brexit	**Chair**	√	√	√	√	√
Governance – Internal Audit						
Internal Audit Progress Report	**Chief Internal Auditor**	√	√	√	√	√
Internal Audit Summary of Audit Reports	**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	**DoF**			√	√	√

Recommendations						
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						
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 Patient's Funds Auditor	**DoF**					
Progress on National Fraud Initiative (NFI)	**ADoF**					
Private Meeting with Internal / External Auditors	**Committee**					
Legal & regulatory updates (eg Audit Scotland reports; Technical Bulletin etc)	**DoF**					

Updated May 2019

Audit & Risk Committee

DATE OF MEETING:	16 May 2019
TITLE OF REPORT:	Annual Statement of Assurance for the Audit & Risk Committee 2018/19
EXECUTIVE LEAD:	Carol Potter, Director of Finance & Performance
REPORTING OFFICER:	Carol Potter, Director of Finance & Performance

Purpose of the Report (delete as appropriate)

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

SBAR REPORT

Situation

All formal Committees of the NHS Board are required to provide an Annual Statement of Assurance for the NHS Board. The requirement for these statements is set out in the Code of Corporate Governance.

Background

Each Committee must consider its proposed Annual Statement at the first Committee meeting of the new financial year or agreed with the Chair of the respective Committee by the end of May each year, for presentation to the Audit & Risk Committee and NHS Board in June. Summary.

Assessment

The Audit & Risk Committee has a duty to provide an Annual Statement of Assurance on its own area of remit. A draft Statement for the Audit & Risk Committee for the year 2018/19 is attached for consideration and review. The final Statement is to be considered to approve sign off by the Chair of the Committee.

The Audit & Risk Committee also reviews and considers the Annual Statements of Assurance of the other Committees, confirming whether they have fulfilled their remit and that there are adequate and effective internal controls operating within their particular area of operation. These will be considered in June as part of the overall governance and assurances linked to the annual accounts process.

Recommendation

Members of the Audit & Risk Committee are asked to:

- **approve** the Annual Statement of Assurance for the Audit & Risk Committee 2018/19.

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:	
Parties / Committees consulted prior to meeting:	
Impact: (must be completed)	
Financial / Value For Money	These factors are a key component of the assurance process
Risk / Legal:	
Quality / Patient Care:	
Workforce:	
Equality:	

ANNUAL STATEMENT OF ASSURANCE
FOR THE AUDIT & RISK COMMITTEE 2018/19

1. Purpose of Committee

1.1 The purpose of the Audit & Risk Committee is to provide the Board with 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 & Risk Committee shall be in accordance with the Audit & Assurance Committee Handbook, dated March 2018.

2. Membership of Committee

2.1 During the financial year to 31 March 2019, membership of the Audit & Risk Committee comprised:

Chair	Ms C Cooper (until 31.10.18) Mr M Black (since 01.11.18)
Members	Ms S Braiden (since 01.11.18) Ms J Owens Councillor D Graham Ms M Wells

2.2 The Committee may invite individuals to attend the Committee meetings, but the Board Chief Executive, Director of Finance, Chief Internal Auditor and statutory External Auditor will normally be in attendance.

3. Meetings

3.1 The Committee met on five occasions during the year to 31 March 2019, on the undernoted dates:

- 17 May 2018
- 21 June 2018
- 13 September 2018
- 13 December 2018
- 14 March 2019

3.2 The attendance schedule is attached at Appendix 1.

4. Business

4.1 Details of the substantive business items considered are attached at Appendix 2. Minutes of the meetings of the Committee have been timeously submitted to the Board for its information. The range of business covered at the meeting demonstrates that the

full range of matters identified in the Audit & Risk Committee remit is being addressed. In line with its Constitution and Terms of Reference, the Committee has considered issues concerned with the undernoted aspects:

- Internal Control and Corporate Governance;
- Internal Audit;
- External Audit;
- the Code of Corporate Governance and Standing Financial Instructions;
- Annual Accounts;
- Risk Management;
- Board Assurance Framework; and
- other matters arising during the year.

4.2 During the year, members of the Committee attended and participated in a local training session hosted by the external provider *On Board*. This provided tailored and specific training for members and attendees, covering best practice arrangements for Audit & Risk Committees.

5. Best Value

5.1 Since 2013/14 the Board has been required to provide overt assurance on Best Value. A revised Best Value Framework was considered and agreed by the NHS Board in January 2018. Appendix 3 provides evidence of where and when the Committee considered the relevant characteristics during 2018/19.

6. Risk Management

6.1 In line with the Board's agreed risk management arrangements, the Audit & Risk Committee, as a governance committee of the Board, has considered risk through a range of reports and scrutiny, including oversight on the detail of the Board Assurance Framework. Progress and appropriate actions were noted.

7. Self Assessment

7.1 The Committee has undertaken a self assessment of its own effectiveness, utilising a revised questionnaire considered and approved by the Committee in November 2018. Attendees were also invited to participate in this exercise, which was carried out via a more easily-accessible online portal. A report summarising the findings of the survey was considered and approved by the Committee at its March 2019 meeting, and action points are being taken forward at both Committee and Board level.

8. Conclusion

8.1 As Chair of the Audit & Risk Committee during financial year 2018/19, I am satisfied that the integrated approach, the frequency of meetings, the breadth of the business undertaken and the range of attendees at meetings of the Committee has allowed us to fulfil our remit as detailed in the Code of Corporate Governance. As a result of the work undertaken during the year, I can confirm that adequate and effective governance arrangements were in place throughout NHS Fife during the year.

8.2 I can confirm that that there were no significant control weaknesses or issues at the year end which the Committee considers should be disclosed in the Governance Statement, as they may have impacted financially or otherwise in the year or thereafter.

8.3 I would pay tribute to the dedication and commitment of fellow members of the Committee and to all attendees. I would thank all those members of staff who have prepared reports and attended meetings of the Committee.

_____ (signed)
Mr M Black
Chair

Appendix 1 – Attendance schedule of meetings
Appendix 2 – Business
Appendix 3 – Best Value

APPENDIX 1

AUDIT & RISK COMMITTEE
ATTENDANCE RECORD 2018/19

Name	*Position*	17.05.18	21.06.18	13.09.18	13.12.18	14.03.19
Members						
Mrs C Cooper	Chair (until 31.10.18)	✓	✓	✓		
Mr M Black	Chair (since 01.11.18)				✓	✓
Ms S Braiden	Non Executive Member (since 01.11.18)				x	✓
Mrs J Owens	Non Executive Member	✓	✓	✓	✓	✓
Cllr D Graham	Non Executive Member	✓	✓	x	x	✓
Ms M Wells	Non Executive Member	✓	✓	✓	✓	✓
In Routine Attendance:						
Mr P Hawkins	Chief Executive	✓	x	✓	✓	✓
Mrs C Potter	Director of Finance	✓	✓	✓	✓	✓
Mr T Gaskin	Chief Internal Auditor	x	✓	✓	✓	x
Mr B Hudson	Regional Audit Manager, Fife	✓	✓	✓	✓	✓
Mr A Brown	Principal Auditor	✓				
Mr B Howarth	Audit Scotland		✓			
Mrs P Tate	Audit Scotland	✓			✓	✓
Mrs S Davidson	Audit Scotland		✓			
Ms H Buchanan	Director of Nursing	✓		✓	✓	✓
Dr F Elliot	Medical Director		✓			
Ms J Gardner	Interim Chief Operating Officer		✓			
Mr A Mitchell	Thomson Cooper (Annual Accounts Endowments)		✓			
Mrs R Robertson	Deputy Director of Finance	✓	✓			
Mr M Doyle	Assistant Director of Finance		✓			
Dr G MacIntosh	Head of Corporate Planning & Performance			✓	✓	✓

APPENDIX 2

NHS FIFE AUDIT & RISK COMMITTEE
SCHEDULE OF BUSINESS CONSIDERED 2018/19

May 2018

Internal Audit:
a) Internal Audit Progress Report
b) Internal Audit Summary of Internal Audit Reports
c) Internal Audit Plan

External Audit – Audit Scotland:
a) Management Report

External Audit – Thomson Cooper:
a) Audit Planning Memorandum – Endowment Funds
b) Additional Proposal re Paul Gray Letter
c) Audit Planning Memorandum – Patients' Private Funds

Service Auditors Report
Board Assurance Framework
Governance Statement 2017/18
Significant Issues that are considered to be of wider interest
Post Transaction Monitoring
Audit Scotland Performance Report – annual update
Payments to Primary Care Practitioners
Annual Statement of Assurance
Committee Self-Assessment Checklist
Follow Up Monitoring Report
Items for Noting:
a) Third Party Service Audit – National IT Services 2016/17
b) Third Party Service Audit – Practitioner Services 2016/17
c) Technical Bulletin 2017/4

June 2018

Matters Arising:
a) Action Log
b) Annual Workplan 2018/19
c) Committee Self-Assessment Checklist 2017/18
d) Annual Internal Audit Plan 2018/19

Patients Private Funds – Consolidated Abstract of Receipts and Payments for Year Ended 31 March 2018
Endowment Fund – Annual Accounts for Year Ended 31 March 2018
NHS Fife Risk Management Annual Report
Annual Accounts Process:
a) Annual Assurance Statements for 2017/18
   (i) Clinical Governance Committee
   (ii) Staff Governance Committee
   (iii) Finance, Performance & Resources Committee
b) Service Auditors Reports
c) Audit & Risk Committee Annual Statement of Assurance
d) Internal Audit Annual Report

e) Notification from Sponsored Body Audit Committees

Draft Annual Accounts for the Year Ended 31 March 2018:

(a) Draft Report on Annual Accounts
(b) Annual Audit Report for the Board of NHS Fife and Auditor General for Scotland
(c) Annual Audit Report Cover Letter and draft Letter of Representation (ISA560)
(d) Annual Assurance Statement to the NHS Board
(e) Losses Schedules 2017/18

September 2018

Matters Arising:

a) Annual Workplan 2018/19
b) IJB Memorandum of Understanding
c) Committee Self-Assessment Checklist

Internal Audit:

a) Internal Audit Progress Report
b) Internal Audit Summary of Internal Audit Reports
c) Internal Audit – Post Transaction Monitoring
d) Internal Audit Framework

Board Governance Action Plan

Risk Management:

a) Board Assurance Framework
b) Risk Management Workplan 2018/19

Grant Thornton Review

Audit Recommendations:

a) Follow up Protocol
b) Internal Audit Monitoring Report
c) Annual Accounts – Progress Update on Audit Recommendations

Corporate Meeting Calendar / Dates 2019/20

December 2018

Matters Arising:

a) Public Sector Internal Audit Standards – Evaluation

Internal Audit:

a) Internal Audit Progress Report & Summary Report
b) Audit Committee Handbook
c) Internal Control Evaluation Report

External Audit:

a) Audit Scotland Annual Audit Plan
b) Audit Scotland Report: NHS in Scotland 2018
c) Audit Scotland Report: Health and Social Care Integration

Risk Management:

a) Board Assurance Framework

Committee Self Assessment Checklist

Audit Recommendations:

a) Internal Audit Monitoring Report
b) Annual Accounts – Progress Update on Audit Recommendations

c) Revised Annual Workplan 2018/19

Items for Noting:

a) Technical Bulletin 2018/3

March 2019

Internal Audit:

a) Internal Audit Progress Report & Summary Report
b) Internal Audit Plan 2019/20
c) Internal Audit Follow Up Report on Audit Recommendations
d) Internal Audit Information Sharing Protocol

Risk Management:

a) Risk Management Report
b) Board Assurance Framework

Annual Accounts Progress Update on Audit Recommendations
Annual Workplan 2019/2020
Annual Review of Code of Corporate Governance
Review of Terms of Reference
Committee Self Assessment Checklist
Update from Brexit Assurance Group

APPENDIX 3

BEST VALUE FRAMEWORK

Vision and Leadership

A Best Value organisation will have in place a clear vision and strategic direction for what it will do to contribute to the delivery of improved outcomes for Scotland's people, making Scotland a better place to live and a more prosperous and successful country. The strategy will display a clear sense of purpose and place and be effectively communicated to all staff and stakeholders. The strategy will show a clear direction of travel and will be led by Senior Staff in an open and inclusive leadership approach, underpinned by clear plans and strategies (aligned to resources) which reflect a commitment to continuous improvement.

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
The Board has identified the risks to the achievement of its strategic and operational plans are identified together with mitigating controls.	Each strategic risk has an Assurance Framework which maps the mitigating actions/risks to help achieve the strategic and operational plans. Assurance Framework contains the overarching strategic risks related to the strategic plan.	**COMMITTEES** **AUDIT & RISK COMMITTEE** **BOARD**	Bi-monthly 5 times per year 2 times per year	Board Assurance Framework (to FP&R/CG/SG Committees) Board Assurance Framework (to A&R Committee) Board

GOVERNANCE AND ACCOUNTABILITY

The “Governance and Accountability” theme focuses on how a Best Value organisation achieves effective governance arrangements, which help support Executive and Non-Executive leadership decision-making, provide suitable assurances to stakeholders on how all available resources are being used in delivering outcomes and give accessible explanation of the activities of the organisation and the outcomes delivered.

OVERVIEW

A Best Value organisation will be able to demonstrate structures, policies and leadership behaviours which support the application of good standards of governance and accountability in how the organisation is improving efficiency, focusing on priorities and achieving value for money in delivering its outcomes. These good standards will be reflected in clear roles, responsibilities and relationships within the organisation. Good governance arrangements will provide the supporting framework for the overall delivery of Best Value and will ensure open-ness and transparency. Public reporting should show the impact of the organisations activities, with clear links between the activities and what outcomes are being delivered to customers and stakeholders. Good governance provides an assurance that the organisation has a suitable focus on continuous improvement and quality. Outwith the organisation, good governance will show itself through an organisational commitment to public performance reporting about the quality of activities being delivered and commitments for future delivery.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
Board and Committee decision-making processes are open and transparent.	Board meetings are held in open session and minutes are publically available. Committee papers and minutes are publically available	**BOARD** **COMMITTEES**	On going	Internet Intranet
Board and Committee decision-making processes are based on evidence that can show clear links between activities and outcomes	Reports for decision to be considered by Board and Committees should clearly describe the evidence underpinning the proposed decision.	**BOARD** **COMMITTEES**	Ongoing	SBAR reports EQIA forms

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
NHS Fife has a robust framework of corporate governance to provide assurance to relevant stakeholders that there are effective internal control systems in operation which comply with the SPFM and other relevant guidance.	Explicitly detailed in the Governance Statement.	**AUDIT & RISK COMMITTEE**	Every three years Annual	Code of Corporate Governance Annual Assurance statements

USE OF RESOURCES

The “Use of Resources” theme focuses on how a Best Value organisation ensures that it makes effective, risk-aware and evidence-based decisions on the use of all of its resources.

OVERVIEW
A Best Value organisation will show that it is conscious of being publicly funded in everything it does. The organisation will be able to show how its effective management of all resources (including staff, assets, information and communications technology (ICT), procurement and knowledge) is contributing to delivery of specific outcomes.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
NHS Fife maintains an effective system for financial stewardship and reporting in line with the SPFM.	Statutory Annual Accounts process.	**AUDIT & RISK COMMITTEE**	Annual	Statutory Annual Accounts. Assurance Statements
NHS Fife understands and exploits the value of the data and information it holds.	Annual Operational Plan Integrated Performance Report	**BOARD** **COMMITTEES**	Annual Bi-monthly	Annual Operational Plan Integrated Performance Report

PERFORMANCE MANAGEMENT

The “Performance Management” theme focuses on how a Best Value organisation embeds a culture and supporting processes which ensures that it has a clear and accurate understanding of how all parts of the organisation are performing and that, based on this knowledge, it takes action that leads to demonstrable continuous improvement in performance and outcomes.

OVERVIEW

A Best Value organisation will ensure that robust arrangements are in place to monitor the achievement of outcomes (possibly delivered across multiple partnerships) as well as reporting on specific activities and projects. It will use intelligence to make open and transparent decisions within a culture which is action and improvement oriented and manages risk. The organisation will provide a clear line of sight from individual actions through to the National Outcomes and the National Performance Framework. The measures used to manage and report on performance will also enable the organisation to provide assurances on quality and link this to continuous improvement and the delivery of efficient and effective outcomes.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
Performance is systematically measured across all key areas of activity and associated reporting provides an understanding of whether the organisation is on track to achieve its short and long-term strategic, operational and quality objectives	Integrated Performance Report encompassing all aspects of operational performance, LDP targets / measures, and financial, clinical and staff governance metrics. The Board delegates to Committees the scrutiny of performance Board receives full Integrated Performance Report and notification of any issues for escalation from Committees.	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance Report Code of Corporate Governance Minutes of Committees
The Board and its Committees approve the format and content of the performance reports they receive	The Board / Committees review the Integrated Performance Report and agree the measures.	**COMMITTEES** **BOARD**	Annual	Integrated Performance Report

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
Reports are honest and balanced and subject to proportionate and appropriate scrutiny and challenge from the Board and its Committees.	Committee Minutes show scrutiny and challenge when performance is poor as well as good; with escalation of issues to the Board as required	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance Report Minutes of Committees
The Board has received assurance on the accuracy of data used for performance monitoring.	Performance reporting information uses validated data.	**COMMITTEES** **BOARD**	Every meeting Annual	Integrated Performance Report Annual Accounts including External Audit report
NHS Fife's performance management system is effective in addressing areas of underperformance, identifying the scope for improvement, agreeing remedial action, sharing good practice and monitoring implementation.	Encompassed within the Integrated Performance Report	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance Report Minutes of Committees
NHS Fife overtly links Performance Management with Risk Management to support prioritisation and decision-making at Executive level, support continuous improvement and provide assurance on internal control and risk.	Board Assurance Framework	**AUDIT & RISK COMMITTEE** **BOARD**	Ongoing	Board Assurance Framework Minutes of Committees

CROSS-CUTTING THEME – SUSTAINABILITY

The "Sustainability" theme is one of the two cross-cutting themes and focuses on how a Best Value organisation has embedded a sustainable development focus in its work.

OVERVIEW

The goal of Sustainable Development is to enable all people throughout the world to satisfy their basic needs and enjoy a better quality of life without compromising the quality of life of future generations. Sustainability is integral to an overall Best Value approach and an obligation to act in a way which it considers is most sustainable is one of the three public bodies' duties set out in section 44 of the Climate Change (Scotland) Act 2009. The duty to act sustainably placed upon Public Bodies by the Climate Change Act will require Public Bodies to routinely balance their decisions and consider the wide range of impacts of their actions, beyond reduction of greenhouse gas emissions and over both the short and the long term.

The concept of sustainability is one which is still evolving. However, five broad principles of sustainability have been identified as:

- promoting good governance;
- living within environmental limits;
- achieving a sustainable economy;
- ensuring a stronger healthier society; and
- using sound science responsibly.

Individual Public Bodies may wish to consider comparisons within the wider public sector, rather than within their usual public sector "family". This will assist them in getting an accurate gauge of their true scale and level of influence, as well as a more accurate assessment of the potential impact of any decisions they choose to make.

A Best Value organisation will demonstrate an effective use of resources in the short-term and an informed prioritisation of the use of resources in the longer-term in order to bring about sustainable development. Public bodies should also prepare for future changes as a result of emissions that have already taken place. Public Bodies will need to ensure that they are resilient enough to continue to deliver the public services on which we all rely.

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
NHS Fife can demonstrate that it is making a contribution to sustainable development by actively considering the social, economic and environmental impacts of activities and decisions both in the shorter and longer term.	Sustainability and Environmental report incorporated in the Annual Accounts process.	**AUDIT & RISK COMMITTEE** **BOARD**	Annual	Annual Accounts Climate Change Template

CROSS-CUTTING THEME – EQUALITY

The "Equality" theme is one of the two cross-cutting themes and focuses on how a Best Value organisation has embedded an equalities focus which will secure continuous improvement in delivering equality.

OVERVIEW
Equality is integral to all our work as demonstrated by its positioning as a cross-cutting theme. Public Bodies have a range of legal duties and responsibilities with regard to equality. A Best Value organisation will demonstrate that consideration of equality issues is embedded in its vision and strategic direction and throughout all of its work.

The equality impact of policies and practices delivered through partnerships should always be considered. A focus on setting equality outcomes at the individual Public Body level will also encourage equality to be considered at the partnership level.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE:**
NHS Fife meets the requirements of equality legislation.		**BOARD** **COMMITTEES**	Ongoing	EQIA form on all reports
The Board and senior managers understand the diversity of their customers and stakeholders.	Equality Impact Assessments are reported to the Board and Committees as required and identify the diverse range of stakeholders.	**BOARD** **COMMITTEES**	Ongoing	EQIA form on all reports
NHS Fife's policies, functions and service planning overtly consider the different current and future needs and access requirements of groups within the community.	In accordance with the Equality and Impact Assessment Policy, Impact Assessments consider the current and future needs and access requirements of the groups within the community.	**BOARD** **COMMITTEES**	Ongoing	Clinical Strategy EQIA forms on reports
Wherever relevant, NHS Fife collects information and data on the impact of policies, services and functions on different equality groups to help inform future decisions.	In accordance with the Equality and Impact Assessment Policy, Impact Assessments will collect this information to inform future decisions.	**BOARD** **COMMITTEES**	Ongoing	EQIA forms on reports

Audit & Risk Committee Meeting

DATE OF MEETING:	16 May 2019
TITLE OF REPORT:	Draft Governance Statement 2018/19
EXECUTIVE LEAD:	Carol Potter, Director of Finance & Performance
REPORTING OFFICER:	Carol Potter, Director of Finance & Performance

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

SBAR REPORT

Situation

As Accountable Officers, Chief Executives are responsible for maintaining sound systems of internal control. Chief Executives must prepare a Governance Statement that complies with guidance in the Scottish Public Finance Manual (SPFM) and that is accurate, complete and fairly reports the known facts.

Background

For 2018/19, there have been no substantial changes made to the Governance Statement format or guidance, as set out within the NHS Scotland Annual Accounts Manual. In addition, there are a number of areas not covered by national guidance, which merit consideration in the Governance Statement. These include:

- SPFM requirements for assurance from Directors have recently been widened in scope;
- March 2018 update of the SPFM Audit Committee Handbook and associated Treasury guidance on assurance mapping;
- NHS Scotland Blueprint for Good Governance;
- Ministerial Strategic Group review of progress with Integration of Health and Social Care

Assessment

A fundamental part the Accountable Officer's responsibility is to manage and control all the available resources used in his or her organisation. The Governance Statement is a key feature of the annual report and accounts, and provides commentary on how these duties have been carried out in the course of the year, including aspects of corporate governance and risk management.

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. In providing the Internal Audit Annual report, the Chief Internal Auditor reviews the Governance Statement for:

- consistency with information the internal audit team are aware of from their work;
- accurate and appropriate description of processes adopted in reviewing the effectiveness of the system of internal control and how these are reflected;
- format and content of the Governance Statement are compliant with relevant guidance;
- disclosure of all relevant issues.

The Draft Governance Statement is attached for consideration by members of the Committee.

Recommendation

The Audit & Risk Committee is asked to:

- **note** the Draft Governance Statement for 2018/19

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:	
Parties / Committees consulted prior to Audit & Risk Committee Meeting:	Executive Directors Group
Impact: (must be completed)	
Financial / Value For Money	These factors are a key component of the assurance process
Risk / Legal:	
Quality / Patient Care:	
Workforce:	
Equality:	

Governance Statement

Scope of Responsibility

As Accountable Officer, I am responsible for maintaining an adequate and effective system of internal control that supports compliance with the organisation's policies and promotes achievement of the organisation's aims and objectives, including those set by Scottish Ministers. Also I am responsible for safeguarding the public funds and assets assigned to the organisation.

Purpose of Internal Control

The system of internal control is based on an ongoing process designed to identify, prioritise and manage the principal risks facing the organisation. The system aims to evaluate the nature and extent of risks, and manage risks efficiently, effectively and economically.

The system of internal control is designed to manage rather than eliminate the risk of failure to achieve the organisation's aims and objectives. As such, it can only provide reasonable and not absolute assurance.

The process within the organisation accords with guidance from Scottish Ministers in the Scottish Public Finance Manual (SPFM) and supplementary NHS guidance, and has been in place for the year up to the date of approval of the annual report and accounts.

The SPFM is issued by Scottish Ministers to provide guidance to the Scottish Government and other relevant bodies on the proper handling and reporting of public funds. The SPFM sets out the relevant statutory, parliamentary and administrative requirements, emphasises the need for efficiency, effectiveness and economy, and promotes good practice and high standards of propriety.

Governance Framework

The Board has collective responsibility for health improvement, the promotion of integrated health and community planning through partnership working, involving the public in the design of healthcare services and staff governance.

Members of Health Boards, as detailed on **page ****, are selected on the basis of their position, or the particular expertise, which enables them to contribute to the decision making process at a strategic level.

The Board meets every two months to progress its business and holds a Development Session in intervening months to discuss topical and strategic issues for NHS Fife. The Code of Corporate Governance, revised in April 2018, identifies Committees and Sub-Committees that report to the Board to help it fulfil its duties.

These include the following governance Committees:

- Clinical Governance;
- Audit and Risk;
- Staff Governance; and
- Finance, Performance & Resources.

Clinical Governance Committee

Principal Function:
To provide the Board with the assurance that appropriate clinical governance mechanisms and structures are in place and effective throughout the whole of Fife Health Board's responsibilities, including health improvement activities.

Membership:
- Six Non-Executive or Stakeholder Members of the Board
- Chief Executive

- Medical Director
- Nurse Director
- Director of Public Health
- A Staff Side Representative of NHS Fife Area Partnership Forum;
- One Representative from Area Clinical Forum
- One Patient Representative

Chair:
Dr L Bisset, Non-Executive Board Member

Frequency of Meetings:
As necessary to fulfil its remit and not less than six times per year.

Audit and Risk Committee

Principal Function:
To provide the Board with the assurance that the activities of Fife Health 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 are in accordance with the Scottish Government Audit and Assurance Committee Handbook, dated March 2018.

Membership:
- Five Non-Executive or Stakeholder Members of the Board

Chair:
Mrs C Cooper, Non-Executive Board Member (until 31.10.18)
Mr M Black, Non-Executive Board Member (since 01.11.18)

Frequency of Meetings:
As necessary to fulfil its remit and not less than four times per year.

Staff Governance Committee

Principal Function:
To support the development of a culture within the health system where the delivery of the highest standard possible of staff management is understood to be the responsibility of everyone working within the system, and is built upon partnership and collaboration, and within the direction provided by the Staff Governance Standard.

Membership:
- Four Non-Executive or Stakeholder Members of the Board
- Employee Director
- Chief Executive
- Nurse Director
- Staff Side Chairpersons of the Local Partnership Forums

Chair:
Mr M Black, Non-Executive Board Member (until 31.10.18)
Ms M Wells, Non-Executive Board Member (since 01.11.18)

Frequency of Meetings:
As necessary to fulfil its remit but not less than four times a year.

Finance, Performance & Resources Committee

Principal Function:
To keep under review the financial position and performance against key non-financial targets of the Board and to ensure that suitable arrangements are in place to secure economy, efficiency and effectiveness in the use of all resources, and that the arrangements are working effectively.

Membership:
- Six Non-Executive or Stakeholder Members of the Board
- Chief Executive
- Director of Finance
- Medical Director
- Director of Public Health
- Nurse Director

Chair:
Ms R Laing, Non-Executive Board Member

Frequency of Meetings:
As necessary to fulfil its remit but not less than four times per year.

Other Governance Arrangements

The conduct and proceedings of the NHS Board are set out in its Standing Orders. These specify the matters which are solely reserved for the NHS Board to determine, the matters which are delegated under the scheme of delegation and the matters which are remitted to a Standing Committee of the NHS Board.

The Standing Orders also include the Code of Conduct that Board members must comply with, and, along with the Standing Financial Instructions, these documents are the focus of the NHS Board's Annual Review of Governance Arrangements. The annual review also covers the remits of the NHS Board's Standing Committees.

All committees of the Board are required to provide an Annual Statement of Assurance to the Audit & Risk Committee and Board, describing their membership, attendance, frequency of meetings, business addressed, outcomes, Best Value, risk management and to demonstrate they have fulfilled their roles and remit.

All NHS Board executive directors undertake a review of development needs as part of the annual performance management and development process. Access to external and national programmes in line with development plans and career objectives is also available.

During the year, Board and Board Committee members each completed a diagnostic self-assessment questionnaire, to identify common themes or issues and areas for improved effectiveness. The outcome of the self-assessment process was presented to Board members at the April 2019 Development Session and an action plan approved at the May 2019 Board meeting. This builds on the proposals originally approved by the Board in April 2017, as updated in May 2018, in relation to the Chair's ongoing review of governance arrangements in NHS Fife, and reflects the requirements of the new NHS Scotland Blueprint for Good Governance that is presently being rolled out across all Boards. In mapping the Board's arrangements for governance against the new national Blueprint, detailed consideration has been given as to whether the right systems are in place to provide appropriate levels of assurance and to identify areas where improvements can be made.

The Chief Executive is accountable to the NHS Board through the Chair of the Board. The Remuneration Sub-committee agrees the Chief Executive's annual objectives in line with the Board's strategic and corporate plans.

Non-executive directors have a supported orientation to the organisation as well as a series of development sessions. An enhanced induction programme has been put in place in the current year to support new members. This programme, developed by NHS Fife, has been recommended to all

Boards across Scotland, as best practice. Opportunities for ongoing development also exist at a national level.

To ensure that the NHS Board complies with relevant legislation, regulations, guidance and policies, a distribution process is in place to ensure that all Circulars and communications received from SGHSCD, internal policies and procedures, are directed to Senior Managers who are held responsible for implementation. A follow-up process to monitor compliance with regulations and procedures laid down by Scottish Ministers and the SGHSCD is in place.

In accordance with the principles of Best Value, the Board aims to foster a culture of continuous improvement. The Board Committees ensure Best Value is achieved through the Committees having Best Value written into their Terms of Reference and the annual work-plans. Directors and Managers are encouraged to review, identify and improve the efficient and effective use of resources.

NHS Fife has a Whistleblowing policy in place. The Board is committed to achieving the highest possible standards of service and the highest possible ethical standards in public life in all of its practices. To achieve these ends, it encourages staff to use internal mechanisms for reporting any malpractice or illegal acts or omissions by its staff. The Board wishes to create a working environment which encourages staff to contribute their views on all aspects of patient care and patient services. All staff have a duty to protect the reputation of the service they work within. The Board does not tolerate any harassment or victimisation of staff using this policy, and treats this as a serious disciplinary offence, which will be dealt with under the Board's Management of Employee Conduct policy.

There is in place a well-established complaints system whereby members of the public can make a formal complaint to the Board regarding care or treatment provided by or through the NHS, or how services in their local area are organised if this has affected care or treatment. Information on our complaints procedures is available on the NHS Fife website.

The Board is committed to working in partnership with staff, other public sector organisations and the third sector. NHS Fife strives to consult all of its key stakeholders. We do this in a variety of ways. How we inform, engage and consult with patients and the public in transforming hospitals and services is an important part of how we plan for the future. To fulfil our responsibilities for public involvement, we routinely communicate with, and involve, the people and communities we serve, to inform them about our plans and performance.

An Integrated Performance Report (IPR) was presented at every Staff Governance Committee, Clinical Governance Committee, Finance, Performance & Resources Committee and Board meeting. This provides detailed monitoring information on a range of measures covering financial and clinical delivery. The IPR is presented to all Committees and the NHS Board considers at each meeting the most up-to-date information available. In addition, an Executive Summary is prepared for the NHS Board and incorporates all matters escalated by each Committee.

During 2018/19 the Board, as the Corporate Trustee for the Fife Health Board Endowment Funds, reviewed the overall governance for charitable funds, including the approach to the management and oversight of endowment funds, as well as the supporting business model.

Integrated Joint Board (IJB)

Members of NHS Fife Board have a role on the Integration Joint Board and its Committees and therefore maintain an input and responsibility for their respective professional remits at all times. This is particularly relevant for the role of the Director of Health & Social Care as the Accountable Officer for the IJB and a direct report to the NHS Fife Chief Executive, who maintains responsibility for all aspects of governance relating to health services across Fife.

Minutes of the IJB are considered at the Clinical Governance Committee of the NHS Board and an annual assurance statement is also shared with the Board's Audit & Risk Committee to support the assurance process. The Integrated Performance Report encompasses all aspects of delegated services.

The approach adopted for health and social care within Fife is the 'fully delegated' model, with the IJB responsible for governance and assurance of all operational activities for its delegated functions. During 2018/19 the NHS Board and supporting governance committees have maintained an overarching assurance role in relation to both clinical and financial governance, and therefore oversight of the adequacy and effectiveness of controls for delegated functions. The operational and governance framework of the IJB will continue to be reviewed during 2019/20 to ensure clarity and consistency of approach, This will take account of the proposals set out in the Ministerial Strategic Group Review of Progress with Integration of Health & Social Care Integration, published in February 2019.

Review of Adequacy and Effectiveness

As Accountable Officer, I am responsible for reviewing the adequacy and effectiveness of the system of internal control. My review is informed by:

- Discussions with executive and senior managers who are responsible for developing, implementing and maintaining internal controls across their areas;
- Letters of Assurance from each Director;
- Reports from other inspection bodies;
- The work of the internal auditors, who submit to the Audit and Risk Committee regular reports which include their independent and objective opinion on the effectiveness of risk management, control and governance processes, together with recommendations for improvement;
- Comments by the external auditors in their management letters and other reports;
- The completion of self-assessment questionnaires considering the Board's own performance and that of its Committees;
- The range of topics covered at Board Development sessions, to develop the knowledge and awareness of both Executive and Non-Executives Board members;
- The Board's agreed approach to Risk Management is established within the Governance Committees;
- The work of the other assurance Committees and groups supporting the Board: Staff Governance Committee, Finance, Performance and Resources Committee, and the Clinical Governance Committee (which also embraces Information Governance);
- In line with National PIN Guidance, NHS Fife has a policy on Whistleblowing; and
- NHS Fife is committed to communicating and consulting with all Stakeholders and the general public.

Data Quality

The Board receives numerous reports which include detailed information covering financial, clinical and staffing information. In general these reports are considered by the Executive Directors Group and at a Governance Committee prior to being discussed at the Board. This allows for detailed consideration of the content, completeness and clarity of the information being provided to the Board.

Assurance on the information included in reports also comes from the overall approach to the management of information (through the Information Governance Group) and validation processes and assurances on the quality of information provided from internal audit and other scrutiny bodies.

Risk Management

The Chief Executive of the NHS Board as Accountable Officer whilst personally answerable to the Parliament is ultimately also accountable to the Board for the effective management of risk.

NHS Scotland bodies are subject to the requirements of the Scottish Public Finance Manual (SPFM) and must operate a risk management strategy in accordance with relevant guidance issued by Scottish Ministers. The general principles for a successful risk management strategy are set out in the SPFM.

All of the key areas within the organisation maintain a risk register. All risk registers are held on Datix (Risk Management Information System). Training and support for all Datix Modules are provided by

the Risk Management team either through formal training sessions or customised training e.g. for individuals, specialities and teams.

The high level risks that the Board needs to ensure are being managed are contained in the corporate risk register and since November 2017, where appropriate, included in the Board Assurance Framework (BAF).

Work to develop a Board Assurance Framework (BAF) continued in 2017, culminating in Board approval of the BAF in November 2017. The BAF currently contains six high level risks that could impact on the delivery of NHS Fife's strategic objectives. These are Financial Sustainability; Workforce Sustainability (including Training & Development); Environmental Sustainability; Quality & Safety (including Clinical Care and Patient Experience); Strategic Planning & Implementation (including Regional Working); and Integration Joint Board (IJB). Where they exist, related operational risks with a high risk rating of 15 or above are identified.

Executive Directors with responsibility for specific BAF risks, review, update and report on these bi monthly to the governance committee to which the risk is aligned. The risks are then subject to committee scrutiny and review.

The Audit and Risk Committee is responsible for ensuring that there is an overall Risk Management framework in place.

During 2018/19, risk management reports were provided to the Audit & Risk Committee by the Director of Nursing, as Lead Executive for Risk. These provided updates on the risk management workplan including the implementation of the Board Assurance Framework..

A statement of risk appetite is also to be agreed. This work commenced in 2018 and will conclude in 2019.

Disclosures

Disclosures are required where there are any significant control weaknesses or issues which may have impacted financially or otherwise in the year or thereafter.

The following are highlighted:

- For 2018/19 xxxxxx individuals have exceeded the Treatment Time Guarantee to have their treatment provided within 12 weeks. A letter of apology was sent to each patient and every effort was made to treat patients in as short a time as possible. This will continue to be monitored weekly and a recovery plan has been developed for 2018/19 to address recurring gaps.

- xx unannounced HAI inspections were conducted at xxxxx in xxxx. The inspection resulted in xx requirements and xx recommendations.

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- xx announced HAI inspection of xxx took place in xxxx. The inspection resulted in xx requirement and xx recommendations.

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- There were xxx personal data related incidents or data protection breaches reported to the Information Commissioner during the financial year ended 31 March 2019. This did not result in any patient harm.

During the 2018/19 financial year, no other significant control weaknesses or issues have arisen, in the expected standards for good governance, risk management and control.

Audit & Risk Committee

DATE OF MEETING:	16 May 2019
TITLE OF REPORT:	Property Transaction Report
EXECUTIVE LEAD:	Carol Potter, Director of Finance
REPORTING OFFICER:	Carol Potter, Director of Finance

Purpose of the Report (delete as appropriate)

For Decision		

SBAR REPORT

Situation

Under the terms of the NHS Property Transaction Handbook, it is essential that the Audit & Risk Committee receive appropriate assurance on property transactions. Monitoring is carried out on the basis of an annual cycle normally commencing no later than May each year with the Audit & Risk Committee being provided with details of property transactions (including addresses and monetary values) completed during the previous financial year.

Background

The Accountable Officer is responsible for ensuring that, among other matters, the Board has effective management systems to safeguard public funds. Included in this responsibility is the need to have effective processes in place for the purchase and lease of land and buildings from a third party and the sales and lease of property to a third party. Additionally, there should be a robust post transactional monitoring process in place to ensure compliance with statutory instruments and guidelines. As part of the annual planning process, time is set aside by Internal Audit to undertake a review of property transactions and report the findings to the Audit & Risk Committee and external auditors.

Assessment

The following transactions completed during 2018/19 meet the criteria set out in the NHS Property Transaction Handbook:

- 10 Acre Field, Stratheden Apr-18
- 34/36 Hazel Avenue, Kirkcaldy Jun-18
- Hayfield Clinic, Kirkcaldy Jan-19

Recommendation

The Audit & Risk Committee is asked to:

- **request** the Internal Audit service review the noted transaction(s), in accordance with the NHS Scotland Property Transaction Handbook, to allow reporting to the Audit & Risk Committee in September 2018, in advance of the 31 October 2019 deadline for Board reporting to the SGHSCD.

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:	
Parties / Committees consulted prior to Committee Meeting:	
Impact: (must be completed)	
Financial / Value For Money	Inaccurate completion of the annual return to the Scottish Government Health and Social Care Directorates (SGHSCD) may result in the Board being asked to complete further work which may incur additional cost. There is a risk of completing an inaccurate return to the SGHSCD, which may incur penalties. There are no direct implications for health from the inaccurate reporting of property transactions.
Risk / Legal:	
Quality / Patient Care:	
Workforce:	
Equality:	

Audit & Risk Committee

DATE OF MEETING:	16 May 2019
TITLE OF REPORT:	Payments to Primary Care Practitioners
EXECUTIVE LEAD:	Carol Potter, Director of Finance
REPORTING OFFICER:	Jacqueline Watson, Primary Care Accountant

Purpose of the Report (delete as appropriate)

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

SBAR REPORT

Situation

The expenditure budget for Primary Care Practitioners (PCPs) in Fife was £98m, excluding prescribing, for 2018/19. Ensuring that payments made to PCPs on behalf of (and charged to) NHS Fife are accurate and valid is a key element of financial control in the use of resources in NHS Fife. This report provides the Audit and Risk Committee with the annual update on these payments for 2018/19 and the monitoring arrangements in place

Background

NHS Fife continues to meet routinely with representatives from the Practitioner Services Division (PSD) of NHS National Services Scotland (NSS) to monitor the payment verification (PV) work undertaken by PSD on behalf of the Health Board. Finance representation at these meetings ensures any significant issues are communicated to the Deputy Director of Finance. Separate reports are produced and meetings held for the four different independent contractor payment streams – General Medical Practitioners, Ophthalmic, Dental and Pharmacy. Outcomes and issues arising from these discussions are documented in this report.

Scottish Government Health & Social Care Directorates (SGHSCD) issued circular DL (2018) 19 Payment Verification Procedures during 2018/19, notifying the revised payment verification protocol for Primary Medical Services, which was accepted by Audit Scotland. The NHS Fife Payment Verification (PV) Review Group, which includes representatives from both PSD and NHS Fife, ensures that procedures are in place to implement the protocol to give assurance to the Board of the validity and accuracy of payments.

Assessment

PAYMENT VERIFICATION REPORTS – GENERAL MEDICAL SERVICES

PV reports have been received quarterly as planned, with actions agreed in conjunction with NHS Fife staff. Assurances have been given on the verification exercises as in previous years. Key issues discussed at recent meetings include:

Global Sum Payments - The Registration and Data Quality teams within PSD carry out many day to day tasks where the primary objective is not payment verification. These tasks however enhance the quality of data held on the Community Health Index (CHI) and hence improve the accuracy of the Global Sum payment.

The revision for 2018-19 reflects the changes to the GP contract effective 1/4/2018 and the introduction of the Scottish Workload Formula. Consequently the following areas have been removed from the PV Protocol.

- Organisation Core Standard payment
- Core Standard Payment
- Temporary Patient Adjustment (TPA)
- Additional Services

In 2018/19 the number of practices selected at random were 3%, this equates to 2 practices in Fife.

Following publication of NHS circular PCA (M) (2016) (7), GP clusters were introduced in Scotland with the 2016/17 GMS agreement between the Scottish GP Committee and the Scottish Government. The agreement specifies that each GP practice will have a Practice Quality Lead, which will engage in a local GP cluster. Each GP cluster will have a GP designated as a Cluster Quality Lead who will have a coordinating role within the cluster

GP clusters have direct involvement and influence in improving the quality of all health and social care services provided to patients registered within their locality. This will include services that are not provided by GP practices in the community including those provided by secondary care.

DIRECTED ENHANCED SERVICES

NHS Circular PCA (M) (2012)11 confirmed the continuation of funding arrangements of Directed Enhanced Services (DES) for 2018/19 and was superseded by PCA (M) (2018)04.

The changes are:

- Updating rules relating to the Extended Hours DES including a requirement to display extended hours consultation times in the practice and a requirement for practices to regularly review the use of extended hour's appointments.

- Updating rules relating to the storage of vaccines for various schemes to provide that contractors ensure they have regard to Health Protection Scotland guidance on Vaccine Storage and Handling in accordance with equivalent provision on the storage of vaccines in the National Health Service (General Medical Services Contracts) (Scotland) Regulations 2018; and

- Minor drafting changes to update language and correct typographical issues.

These changes have been agreed with the Scottish General Practitioners Committee of the BMA Scotland.

There are currently 9 DES in place in NHS Fife for which the Scottish Government sets the payment rates.

- Palliative Care
- Minor Surgery
- Services to staff dealing with violent patients
- Childhood Immunisations (including seasonal flu, Rotavirus)
- Influenza & Pneumococcal
- Pertussis

- Extended Hours
- Shingles (zoster)
- Men B

During 2018/19 the number of Practices providing the Extended Hours service is 48 out of 55 which is the same as the previous year.

SCOTTISH ENHANCED SERVICES PROGRAMME

The programme of Enhanced Services commenced in 2008/09 and following review of each service has continued in 2018/19. The funding for the year was £840k and includes the following:

- Closer/Integrated Working with GP Practices - A Shared Care Service commenced in 2012 and is intended to support shared and integrated working between primary and secondary care. A total of all of 52 out of 55 Practices provide this service (95%).

- Care Homes - A wide ranging review of the delivery of care to patients in Care Homes was completed and the Enhanced Service has been redesigned in order to improve the quality of care provided. A total of 52 out of 55 Practices provide this service (95%).

- Patient Safety – Recording medication prescribed outside general practice The main purpose of the proposal is that all Fife Practices shall put in place a robust and understood system to record "Outside Medications" which are not prescribed by the Practice Clinical team for now and for the future, within the prescribing system. A total of 52 out of 55 Practices provide this service (95%).

OPHTHALMIC PAYMENTS

A meeting of the Review Group for Ophthalmic Services was held on 5th December 2018 for quarter ending September 2018.

The report was discussed and it was noted that claim levels remain broadly consistent with the previous year. The number of claims received for quarter ending 30th September 2018 (2 quarters) was 46,293 largely for eye examinations (82%).

The Ophthalmic Review Team has 3 visits to complete which took place between the January to March 2019 quarter. Practice visits and the report include analysis of the visits with a section on outlier analysis.

The follow up of any outliers is carried out by the Ophthalmic Advisers. To date, no significant issues have arisen.

DENTAL PAYMENTS

The report for the quarter ended December 2018 was presented and discussed in detail by the PV Review Group on the 21st March 2019. Ongoing cases were discussed and assurance given that the necessary checks were in place and any required investigations were being undertaken. Post Treatment Reports on referrals to the Scottish Dental Reference Service (SDRS) are a key element of the PV process within Dental.

The Review Group noted that the number of post treatment referrals from NHS Fife has

decreased on average over the quarters. For the quarter to December 2018 the total number referrals were 266, made to the SDRS from Fife. 12% of these were non random referrals. The figures below summarise the information returned from the SDRS on these appointments:

- 5 reports received 1.9%
- 0 failed appointments 0.0%
- 23 referral cancelled 8.6%
- 238 Outstanding 89.5%

For the six months to December 2018, 36 post-treatment reports have been completed (some of which relate to the prior financial year), and of these:

- 30 were grade 1
- 4 were grade 2
- 2 were grade 3
- 0 were grade 4

Gradings are based on the following:

- Grade 1 – Completely satisfactory – no further action
- Grade 2 – Satisfactory – no further action
- Grade 3 – Unsatisfactory – Dentist to receive further referrals
- Grade 4 – Completely unsatisfactory – increased level of referrals

The Review Group were content that all cases were being progressed in line with the protocols in place.

PHARMACY PAYMENTS

A meeting of the Pharmacy Review Group was held on 17th April 2019, and the reports for the quarter ending December 2018 were considered. The Tableau reports were discussed which highlight the ability to review the costs per NHS Board/service flag type/average per item & rank. NHS Fife is the 7th largest board in Scotland. After discussion at a national level, risk categories targeted by the Payment Verifcation team for particular scrutiny in are:

- Gluten Free foods
- MAS
- CMS
- AMS

PV check levels are as follows:

Level 1
The payments system will automatically carry out 100% checks on the payments.

Level 2
Consists of risk driven trend analysis of claims, including but not limited to:
a) Claim activity.
b) Random letters to patients to confirm provision of service.

Level 3
Checking will be undertaken as appropriate where the outcome of the above analysis proves

unsatisfactory or inconclusive. This may include:
a) Targeted letters to patients to confirm provision of service.
b) Sampling of patient's medication record and associated documentation.

Level 4
Checking will be undertaken using random sampling as described below:

One of the methods of verifying payments made under General Pharmaceutical Services (GPS) arrangements is to examine patient records as part of random sampling. During random sampling a selection of records will be examined looking at a range of claim/payment types

Practitioner Services will select the pharmacies to be included as part of the random sample. Pharmacies which have been selected within the previous five years random sampling will be excluded.

The level of this check will result in a minimum of 1% of all pharmacies across Scotland having records inspected annually and will involve the confirmation of a sample of claims across selected payment categories.

The size of the sample undertaken will be based on statistical strata using the number of claims submitted by the pharmacy.

The claims/payments included within the sample will be checked against the details

The Board and PV team discussed various service flag outliers: AMS – The NHS Board requested that PV analyse one contractor with an increased average GIC is related to a high cost item/patients; GFF – NHS Board requested that PV monitor for one contractor with a high average low items in November 2018; MAS – NHS Board requested that PV monitor for one contractor given the increase in registrations in December 2018; CMS - NHS Board requested PV monitor data for one contractor given the increased averages in cost per item and cost per patient.

COMMUNITY PHARMACY CONTRACT

The implementation of the new Community Pharmacy Contract began in July 2006 to introduce four new services to the pharmacy contract:

- Minor Ailments Service (MAS)
- Public Health Service (PHS)
- Acute Medication Service (AMS)
- Chronic Medication Service (CMS)

The first two elements MAS and PHS were introduced in July 2006. AMS was introduced in February 2010 allowing electronic transfer of prescriptions data between GP systems and Pharmacies by use of a bar code system. All 85 Community Pharmacies in NHS Fife were scanning and claiming their prescriptions electronically.

CMS was implemented on 11th May 2010. CMS provides personalised pharmaceutical care by a pharmacist to patients with long term conditions. Within Fife all 85 pharmacies have registered patients, undertaking review of medicines and completion of Pharmaceutical Care Plans through the on-line support tool; PCR. Serial prescribing is one element of CMS and all

GP practices are enabled to provide serial prescriptions (a prescription that can last for 24, 48 or 56 weeks) with 80% of practices generating serial prescriptions for their patients. All community pharmacies are able to receive and process serial prescriptions with 89.5% having dispensed a serial prescription.

In October 2015, the Gluten Free Foods Service (GFFS) was embedded as a permanent service following an 18 month trial and a positive evaluation. Information on the patient and an Annual Health Check for the service are recorded through PCR. Community Pharmacists also continue to record information for the Smoking Cessation service through PCR, which in turn updates the Smoking Cessation national database.

The total NHS Fife Community Pharmacy expenditure for 2018/19 including the above services was £13m.

COUNTER FRAUD SERVICES (CFS)

The role of NHS Counter Fraud Services (CFS) encompasses all services within the NHS in Scotland. NHS Fife receives monthly update reports from CFS which come directly to the Board's Fraud Liaison Officer (FLO) to be actioned and followed up as appropriate with the responsible individuals. In relation to primary payments, CFS also provides Boards with an annual analysis of the estimated level of fraud/error and potential fraud/error in respect of patient exemption checking for Primary Care Practitioners (based on calendar years).

	2018		**2017**	
	%	£'000	%	£'000
Dental	13.35	269	13.11	296
Ophthalmic	7.93	137	8.08	150

Recommendation

Members of the Committee are asked to **note** the contents of this report.

Objectives: (must be completed)	
Healthcare Standard(s):	All aspects of Healthcare Standards
HB Strategic Objectives:	All aspects of the Board's Strategic Framework
Further Information:	
Evidence Base:	NA
Glossary of Terms:	NA
Parties / Committees consulted prior to Committee Meeting:	
Impact: (must be completed)	
Financial / Value For Money	Financial governance is a key function of the payment verification process.
Risk / Legal:	Risk management is a key function of the payment verification process.
Quality / Patient Care:	The impact on quality / patient care is a key consideration for all aspects of governance
Workforce:	The impact on workforce is a key consideration for all aspects of governance
Equality:	N/A

Audit & Risk Committee

DATE OF MEETING:	16 May 2019
TITLE OF REPORT:	Annual Review of Code of Corporate Governance
EXECUTIVE LEAD:	Carol Potter, Director of Finance
REPORTING OFFICER:	Dr Gillian MacIntosh, Board Secretary

Purpose of the Report (delete as appropriate)		
For Decision	**For Discussion**	~~**For Information**~~

Route to the Board (must be completed)

The amended Code of Corporate Governance (attached) incorporates recent reviews by each Board Committee of their individual Terms of Reference. Also proposed are a number of clarifying changes to the Standing Financial Instructions, recommended by the Director of Finance. These amendments seeks to bring the current version of the Code up-to-date and reflective of current practice.

SBAR REPORT

Situation

The Fife NHS Code of Corporate Governance is an all-encompassing suite of documents setting out the Board's Standing Orders, Scheme of Delegation, Standing Financial Instructions and Code of Conduct for Board Members. It is therefore important that it remains current and correct.

Background

The most recent version of the Board's Code of Corporate Governance was formally approved in April 2018. At that date, the Board was invited to approve any future revisions on a three-year cycle of updates. However, various changes to job titles and structures might now be usefully reflected in the document, to keep this up-to-date. Going forward, an annual update of the Code is thus proposed and is reflected as such in the Committee's workplan.

Assessment

The attached version of the Code has been reviewed to ensure that the current text reflects present structures, terminology and job titles. Proposed textual changes have been tracked in the document for ease of identification.

The Committee should note that further changes to the Code will be required in the near future to reflect the work currently underway aligned to the implementation of the NHS Scotland Blueprint for Good Governance. It is expected that this will produce 'template' Standing Orders, Schemes of Delegation and Standing Financial Instructions on a 'Once for Scotland' approach, which individual Boards will be expected to implement and adapt locally as part of implementing the Blueprint. Additionally, standard Terms of Reference for 'mandatory' Board committees (i.e. Audit, Clinical Governance and Staff Governance) are presently being prepared, again to be adopted locally when finalised by the national group. A further update to the Committee on this will therefore follow in due course.

Recommendation

Members of the Committee are asked to:

- **review** the updated Code, noting the proposed changes that are tracked therein;
- **note** the intention to review the Code on an annual cycle in future years, as per the Committee's workplan; and
- **recommend** approval by the NHS Board.

Objectives: (must be completed)	
Healthcare Standard(s):	All aspects of Healthcare Standards
HB Strategic Objectives:	All aspects of the Board's Strategic Framework

Further Information:	
Evidence Base:	NA
Glossary of Terms:	NA
Parties / Committees consulted prior to Health Board Meeting:	Audit & Risk Committee

Impact: (must be completed)	
Financial / Value For Money	Financial governance is a key component of the Board's Code of Corporate Governance, containing therein the Scheme of Delegation and Standing Financial Instructions.
Risk / Legal:	Risk management is a key component of the Board's Code of Corporate Governance
Quality / Patient Care:	The impact on quality / patient care is a key consideration for governance
Workforce:	The impact on workforce is a key consideration for governance
Equality:	N/A

CODE OF CORPORATE GOVERNANCE

FIFE NHS BOARD

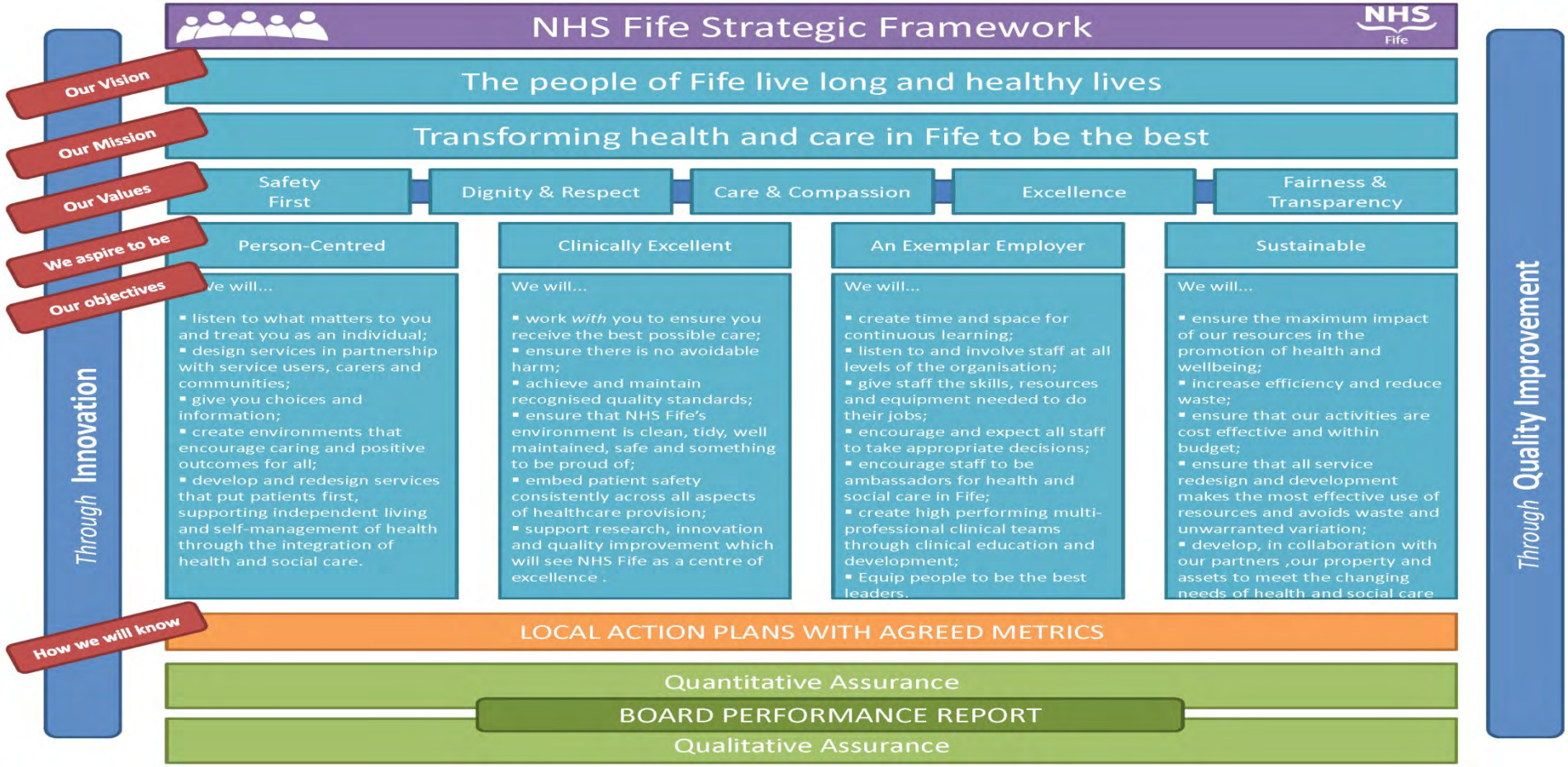
Reviewed by:	Board Secretary
Date of Board Approval:	29 May 2019
Review Date:	April 2020

Issue no. 14 – Master

CONTENTS

NHS FIFE
STRATEGIC FRAMEWORK

The Strategic Framework underpins all that NHS Fife as an organisation does. It highlights NHS Fife's key principles and provides a basis for all strategies and plans - each strategy needs to wrap around the principles set out in the framework. The organisation has worked closely with staff to develop the Framework, and it has been endorsed by the NHS Fife Board and staff groups



NHS FIFE
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) and The Health Boards (Membership and Procedure) (Scotland) Amendment Regulations 2005 (2005 No. 108).

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, removal 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 Board members are required to subscribe to and comply with the NHS Fife Code of Conduct (see Appendix 6), which is made under the Ethical Standards in Public Life etc (Scotland) Act 2000.

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

1.5 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.

1.6 The ~~Head of Corporate Services~~Board 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 and intranet.

2 Chair

2.1 The Scottish Ministers shall appoint the Chair of the Board and all other members of the Board.

3 Vice-Chair

3.1 The Board shall appoint a non-executive Board member to be 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, and the Board may appoint another member as Vice-Chair.

3.3 Where the Chair has died, ceased to hold office, or is unable to perform his or her duties due to illness, absence from Scotland or for any other reason, the Vice-Chair shall assume the role of the Chair in the conduct of the business of the Board and references to the Chair shall, so long as there is no Chair able to perform the duties, be taken to include references to the Vice-Chair.

4 Calling and Notice of Board Meetings

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

4.2 A Board meeting may be called if one third of the whole number of members sign a requisition for that purpose. The requisition must specify the business proposed to be transacted. The Chair is required to call a meeting within seven 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. However no business shall be transacted at the meeting other than that specified in the requisition.

4.3 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 delivered to every member (e.g. sent by email) or sent by post to the usual place of residence of such members so as to be available to them at least five clear days before the meeting. The notice shall be distributed along with any papers for the meeting that are available at that point. The Board may exceptionally convene a meeting at shorter notice only if all members agree.

4.4 With regard to calculating clear days for the purpose of notice under 4.3 and 4.6, the period of notice excludes the day the notice is sent out and the day of the meeting itself. Working days and weekend days are counted. e.g. If a notice is sent out on Wednesday for a meeting to be held on the following Tuesday, five clear days notice will have been given.

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

4.6 Board meetings shall be held in public. The ~~Head of Corporate Services~~Board Secretary shall place a public notice of the time and place of the meeting at the Board's offices at least five clear days before the meeting is held. If the meeting is held at shorter notice (see 4.3) then the public notice shall be placed at the same time that the shorter notice is served. The notice and the meeting papers shall also be placed on the Board's website.

4.7 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. However the Chair has the right to adjourn a meeting in the event of disorderly conduct or other misbehaviour at the meeting.

4.8 The Board and its Committees may meet in private in order to consider certain items of business. Only Board members and other Directors/senior managers as agreed by the Chair and Chief Executive will be present, together with the ~~Head of Corporate Services~~Board Secretary and minute taker. The Board may decide to do so 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 any commercial concerns.
- 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 Conduct of Meetings

Authority of the Chair

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 non-executive Board member 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.

5.4 Any member who disregards the authority of the Chair, obstructs the meeting, or conducts himself/herself offensively shall be suspended for the remainder of the meeting, if a motion (which shall be determined without discussion) for his/her suspension is carried. Any person so suspended shall leave the meeting immediately and shall not return without the consent of the meeting.

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 five non-executive Board members. The quorum for committees will be set out in their terms of reference; however it can never be less than three Non-Executive or Stakeholder members.

5.6 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. The Chair shall provide a report to the next meeting of the Board in the event of quorum not being reached.

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

5.8 If a member, or an associate of the member, has any pecuniary or other interest 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.

5.9 Paragraph 5.8 will not apply where a member's 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.

5.10 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 a decision of the members at that meeting. For this latter purpose, the Chair is not to be counted for quorum or voting purposes.

5.11 Paragraphs 5.7-5.10 equally apply to members of any Board committees, whether or not they are also members of the Board.

Adjournment

5.12 If it is necessary or expedient to do so for any reason, 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 a motion, which shall be moved and seconded and be put to the meeting without discussion. If such a motion is carried, the meeting shall be adjourned to such day, time and place as may be specified in the motion.

Business of the Meeting

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 at the start of the meeting. 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.

Any request for the consideration of an additional item of business must be raised at the start of the meeting and the majority of members present must agree to the item being included on the agenda.

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.

5.15 The Board may reach consensus on an item of business without taking a formal vote. Where a vote is taken, every question at a meeting 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 person presiding at the meeting shall have a second or casting vote. A vote may be taken by members by a show of hands, or by ballot, or any other method determined by the Chair. Under no circumstances may an absent board member vote by proxy, except where the member is participating via video-conferencing, teleconferencing etc.

5.16 Any member may move a motion or an amendment to a motion (a "motion"), and it is expected that members will notify the Chair in advance of the meeting. The Chair may require the motion to be produced in writing. The member who moved the motion may speak to it. However, another member must second the motion before there is any further debate on it.

5.17 A motion which is contradictory to a resolution of the Board shall not be competent within six months of the date of adoption of such resolution.

5.18 Any member may second the motion and may reserve his/her speech for a later period of the debate.

5.19 Once a motion has been seconded it shall not be withdrawn without the leave of the Board.

5.20 After debate, the mover of any original motion shall have the right to reply. In replying he/she shall not introduce any new matter, but shall confine himself/herself strictly to answering previous observations, and, immediately after his/her reply, the question shall be put by the Chair without further debate.

5.21 When more than one amendment is proposed, the Chair of the meeting shall decide the order in which amendments are put to the vote. All amendments carried shall be incorporated in the original motion which shall be put to the meeting as a substantive motion.

5.22 A motion to adjourn any debate on any question or for the closure of a debate shall be moved and seconded and put to the meeting without discussion. Unless otherwise specified in the motion, an adjournment of any debate shall be to the next meeting.

Minutes

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

5.24 The ~~Head of Corporate Services~~Board Secretary (or his/her authorised nominee) shall prepare the minutes of meetings of the Board and its committees. The Board or the committee shall receive and review the minutes at the following meeting.

5.25 Minutes of governance committees shall be submitted as soon as is practicable to the Board.

6 Receipt of Deputations and Petitions

6.1 Every application for the reception of a deputation or petition must be in writing, duly signed and delivered to the ~~Head of Corporate Services~~Board Secretary at least five clear days prior to the date of the meeting at which it wishes to be received. If granted, two representatives may address the Board for ten minutes. Board members may raise questions but reserve opinions until the representatives have withdrawn.

7 Matters Reserved for the Board

Introduction

7.1 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 a NHS Board meeting, due to either Scottish Government directions or a Board decision in the interests of good governance practice.

7.2 This section summarises the matters reserved to the Board.

Standing Orders

7.3 The Board shall approve its Standing Orders.

Committees

7.4 The Board shall approve the establishment of, and terms of reference of, all of its committees.

7.5 The Chair shall appoint all committee members.

Values

7.6 The Board shall approve organisational values agreed in the Strategic Framework.

Strategic Planning

7.7 The Board shall approve all strategies for all the functions that it has planning responsibility for. This is subject to any provisions for major service change which require Ministerial approval.

7.8 The Board shall review and approve the NHS Fife contribution to the Integration Joint Board through the Strategic Plan.

7.9 The Board shall approve the ~~Local Delivery~~Annual Operational Plan for submission to the Scottish Government for its approval.

7.10 The Board shall approve its Corporate Objectives as detailed in the Strategic Framework.

Risk Management

7.11 The Board shall define the risk appetite and associated risk tolerance levels.

7.12 The Board shall approve its Risk Management Policy and Board Assurance Framework.

Health & Safety

7.13 The Board shall approve its Health & Safety Policy.

Finance

7.14 The Board shall approve its financial plan for the forthcoming year, and the opening revenue and capital budgets.

7.15 The Board shall approve Standing Financial Instructions and a Scheme of Delegation.

7.16 The Board shall approve its annual accounts and report.

Capital – Acquisitions and Disposals

7.17 The Board shall comply with the Scottish Capital Investment Manual. The Board shall review and approve any business case item that is beyond the scope of its delegated financial authority before it is presented to the Scottish Government for approval.

Other Organisational Policy

7.18 The approval of all policies is delegated to groups throughout NHS Fife, and this is set out in GP/P1-1 Policies, Procedures and Guidelines: Writing and Approval.

Performance Management

7.19 The Board shall approve the content, format, and frequency of performance reporting to the Board. The Board shall consider performance through the Integrated Performance Report (IPR) and the IPR Executive Summary. This will be submitted two monthly via the Clinical Governance, Finance, Performance and Resources and the Staff Governance Committees, and will contain issues / comments from the Committee Chairs.

Other Items of Business

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

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

8 Delegation of Authority by the Board

8.1 Except for the Matters Reserved to 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.

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

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

8.4 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.

9 Board Members – Ethical Conduct

9.1 Members have a personal responsibility to comply with the Fife NHS Board Code of Conduct for Board Members (see Appendix 6). The Commissioner for Public Standards can investigate complaints about members who are alleged to have breached their Code of Conduct. The ~~Head of Corporate Services~~Board Secretary shall maintain the NHS Fife Board Register of

Interests. When a member needs to update or amend his or her entry in the Register, he or she must notify the ~~Head of Corporate Services~~Board Secretary of the need to change the entry within one month after the date the matter required to be registered.

9.2 The ~~Head of Corporate Services~~Board Secretary 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.

9.3 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 5.8 and 5.9 of these Standing Orders, and have regard to Section 5 of the Code of Conduct (Declaration of Interests).

9.4 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.

9.5 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 ~~Head of Corporate Services~~Board Secretary 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.

10 Common Seal and Execution of Documents

10.1 The ~~Head of Corporate Services~~Board Secretary is responsible for the safe custody of the common seal of the Board, and for maintaining a register of the use of the seal.

10.2 Any document or proceeding requiring authentication by the Board by affixation of its Common Seal shall be subscribed by three Board members. Normally the Chair and the Director of Finance will be subscribers.

10.3 Where a document requires for the purpose of any enactment or rule of law relating to the authentication of documents under the Law of Scotland, or otherwise requires 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 provisions of 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.

10.4 Scottish Ministers have directed that the Chief Executive or Director of Finance can sign on their behalf in relation to the acquisition, management and disposal of land.

10.5 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.

11 Committees

11.1 Subject to any direction issued by Scottish Ministers, the Board shall appoint such committees (and sub-committees) as it thinks fit. The Chair shall appoint the chairs of these committees. The Board shall approve the terms of reference and membership of the committees and shall review these as and when required.

11.2 The Chair 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

11.3 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.

11.4 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.

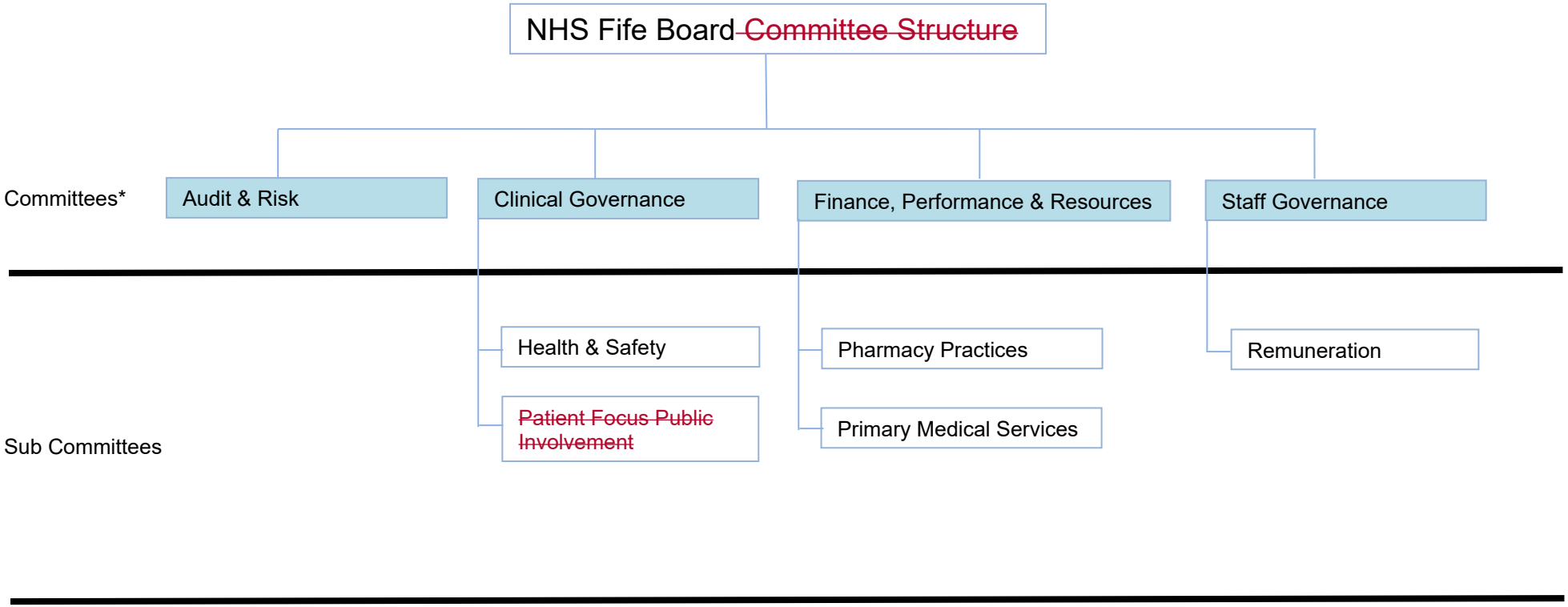
11.5 The Board shall approve a calendar of meeting dates for its committees. A committee Chair may call an extraordinary meeting at any time, and also when requested by the Board.

List of Appendices

Appendix 1 – Board Committee Structure
Appendix 2 – Terms of Reference for Board Committees
Appendix 3 – Standing Financial Instructions
Appendix 4 – Scheme of Delegation
Appendix 5 – SEAT Framework of Governance
Appendix 6 – Code of Conduct for Board Members

NHS Fife

NHS FIFE BOARD COMMITTEE STRUCTURE



*Denotes Governance Committees

TERMS OF REFERENCE FOR BOARD COMMITTEES

AUDIT AND RISK COMMITTEE
CONSTITUTION AND TERMS OF REFERENCE

Date of Board Approval: ~~14 March 2018~~29 May 2019

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 201~~July 200~~8.

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
- ~~Director of Strategic Planning and Performance~~
- 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.

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

5.154 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.

5.165 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. ~~On behalf of the Trustees of the NHS Fife Endowment Funds to consider all statutory audit material, in particular:~~

~~Audit Reports;~~
~~Annual Reports;~~
~~Management Letters~~

~~relating to the Annual Endowment 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 report summarising any significant changes to the Boards 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;

- 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.

Standing Orders and Standing Financial Instructions

5.25 To review every ~~three years~~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 Work Plan 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.

CLINICAL GOVERNANCE COMMITTEE
CONSTITUTION AND TERMS OF REFERENCE

Date of Board Approval: ~~14 March 2018~~29 May 2019

1. PURPOSE

1.1 To oversee clinical governance mechanisms in NHS Fife.

1.2 To observe and check the clinical governance activity being delivered within NHS Fife and provide assurance to the Board that the mechanisms, activity and planning are acceptable.

1.3 To oversee the clinical governance and risk management activities in relation to the development and delivery of the Clinical Strategy.

1.4 To assure the Board that appropriate clinical governance mechanisms and structures are in place for clinical governance to be supported effectively throughout the whole of Fife NHS Board's responsibilities, including health improvement activities.

1.5 To assure the Board that the Clinical and Care Governance Arrangements in the Integration Joint Board are working effectively.

1.6 To escalate any issues to the NHS Fife Board if serious concerns are identified about the quality and safety of care in the services across NHS Fife, including the services devolved to the Integration Joint Board.

2. COMPOSITION

2.1 The membership of the Clinical Governance Committee will be:

- Six Non-Executive or Stakeholder members of the 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)
- Chief Executive
- Medical Director
- Nurse Director
- Director of Public Health
- One Staff Side representative of NHS Fife Area Partnership Forum
- One Representative from Area Clinical Forum
- One Patient Representative

2.2 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 other Senior Staff should attend meetings, routinely or otherwise. The following will normally be routinely invited to attend Committee meetings:

- Chief Operating Officer (Acute Services)
- Director of Health & Social Care
- Director of Pharmacy
- Associate Medical Director Acute Services Division
- Associate Medical Director Fife Health & Social Care Partnership
- Board Secretary

2.3 The Medical Director shall serve as the lead officer to the Committee.

3. QUORUM

3.1 No business shall be transacted at a meeting of the Committee unless at least three Non-Executive members 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 six 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.

5. REMIT

5.1 The remit of the Clinical Governance Committee is to:

- monitor progress on the health status targets set by the Board.
- provide oversight of the implementation of the Clinical Strategy in line with the NHS Fife Strategic Framework and the Care and Clinical Governance Strategy.
- receive the minutes of meetings of:
  - Acute Services Division Clinical Governance Group
  - Area Clinical Forum
  - Area Drug & Therapeutics Group
  - Area Radiation Protection Committee
  - H&SCP Clinical & Care Governance Committee~~Group~~
  - eHealth Board
  - Fife Research Governance Group
  - Health and Safety Sub Committee
  - NHS Fife Resilience Group

- H&SCP Integration Joint Board
- Infection Control Committee
- Information & Security Governance Group
- Joint Strategic Transformation Group
- ~~Organ & Tissue Donation Committee~~
- ~~Patient Focus Public Involvement Sub Committee (PFPI)~~
- Public Health ~~Risk Management & Governance Group~~Assurance Committee
- ~~Quality & Safety Governance~~NHS Fife Clinical Governance Steering Group

- The Committee will produce an Annual Report incorporating a Statement of Assurance for submission to the Board, via the Audit and Risk Committee. The proposed Annual ~~Statement~~ Report will be presented to the first Committee meeting in the new financial year or agreed with the Chairperson of the respective Committee by the end of May each year for presentation to the Audit and Risk Committee in June.

- Receive updates on and oversee the progress on the recommendations from relevant external reports of reviews of all healthcare organisations including clinical governance reports and recommendations from relevant regulatory bodies which may include Healthcare Improvement Scotland (HIS) reviews and visits.

- Issues arising from these Committees will be brought to the attention of the Chair of the Clinical Governance Committee for further consideration as required.

- To provide assurance to Fife NHS Board about the quality of services within NHS Fife.

- To undertake an annual self assessment of the Committee's work and effectiveness.

- The Committee shall review regularly the sections of the NHS Fife Integrated Performance Report relevant to the Committee's responsibility.

5.2 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".

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

6. AUTHORITY

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

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

7. REPORTING ARRANGEMENTS

7.1 The Clinical Governance Committee reports directly to Fife NHS Board. Minutes of the Committee are presented to the Board by the Committee Chair, 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 Corporate Risk Register will be scrutinised by the relevant Committees of the Board with a bi-annual update on all changes being submitted to the Audit and Risk Committee.

7.3 The Board Assurance Framework will be scrutinised by the relevant Committees of the Board with an ~~quarterly~~ update on all changes being submitted to the Audit & Risk Committee.

FINANCE, PERFORMANCE AND RESOURCES COMMITTEE CONSTITUTION AND TERMS OF REFERENCE

Date of Board Approval: ~~14 March 2018~~29 May 2019

1. PURPOSE

1.1 The purpose of the Committee is to keep under review the financial position and performance against key non-financial targets of the Board, and to ensure that suitable arrangements are in place to secure economy, efficiency and effectiveness in the use of all resources, and that the arrangements are working effectively.

2. COMPOSITION

2.1 The membership of the Finance, Performance and Resources Committee will be:

- Six Non-Executive or Stakeholder members (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)
- Chief Executive
- Director of Finance
- Medical Director
- Director of Public Health
- Director of Nursing

2.2 The Chair of the Audit and Risk Committee will not be a member of the Finance, Performance and Resources Committee.

2.3 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 other Senior Staff should attend meetings, routinely or otherwise. The following will normally be routinely invited to attend Committee meetings:

- Chief Operating Officer (Acute Services)
- Director of Health & Social Care Partnerships
- ~~Director of Planning and Performance~~Board Secretary

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

3. QUORUM

3.1 No business shall be transacted at a meeting of the Committee unless at least three Non-Executive members 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 per 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.

5. REMIT

5.1 The Committee shall have accountability to the Board for ensuring that the financial position of the Board is soundly based, having regard to:

- compliance with statutory financial requirements and achievement of financial targets;
- such financial monitoring and reporting arrangements as may be specified from time-to-time by Scottish Government Health & Social Care Directorates and/or the Board;
- levels of balances and reserves;
- the impact of planned future policies and known or foreseeable future developments on the financial position;
- undertake an annual self assessment of the Committee's work and effectiveness; and
- review regularly the sections of the NHS Fife Integrated Performance Report relevant to the Committee's responsibility.

Arrangements for Securing Value for Money

5.2 The Committee shall keep under review arrangements for securing economy, efficiency and effectiveness in the use of resources. These arrangements will include procedures for (a) planning, appraisal, control, accountability and evaluation of the use of resources, and for (b) reporting and reviewing performance and managing performance issues as they arise in a timely and effective manner. In particular, the Committee will review action (proposed or underway) to ensure that the Board achieves financial balance in line with statutory requirements.

Allocation and Use of Resources

5.3 The Committee has key responsibilities for:

- reviewing the development of the Board's Financial Strategy in support of the ~~Local Delivery~~Annual Operational Plan, and recommending approval to the Board;
- reviewing all resource allocation proposals outwith authority delegated by the Board and make recommendations to the Board thereon;
- monitoring the use of all resources available to the Board; and
- reviewing all matters relating to Best Value.

5.4 Specifically, the Committee is charged with recommending to the Board annual revenue and capital budgets and financial plans consistent with its statutory financial responsibilities. It shall also have responsibility for the oversight of the Board's Capital Programme (including individual Business Cases for Capital Investment) and the review of the Property Strategy (including the acquisition and disposal of property), and for making recommendations to the Board as appropriate on any issue within its terms of reference.

5.5 The Committee will receive minutes from the Pharmacy Practices Committee and the Primary Medical Services Committee.

Issues arising from these Committees will be brought to the attention of the Chair of the Finance, Performance and Resources Committee for further consideration as required.

5.6 The Committee will produce an Annual Report incorporating a Statement of Assurance for submission to the Board, via the Audit and Risk Committee. The proposed Annual ~~Statement~~ Report will be presented to the first Committee meeting in the new financial year or agreed with the Chairperson of the respective Committee by the end of May each year for presentation to the Audit and Risk Committee in June.

5.7 The Annual ~~Statement~~ Report will include the Committee's assessment and conclusions on ~~the achievement of Best Value by NHS Fife~~its effectiveness over the financial year in question.

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

5.9 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".

6. AUTHORITY

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

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

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

7. REPORTING ARRANGEMENTS

7.1 The Finance, Performance and Resources Committee reports directly to Fife NHS Board on its work. Minutes of the Committee are presented to the Board by the Committee Chair, 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 Corporate Risk Register will be scrutinised by the relevant Committees of the Board with a bi-annual update on all changes to the Corporate Risk Register being submitted to the Audit and Risk Committee.

7.3 The Board Assurance Framework will be scrutinised by the relevant Committees of the Board with an ~~quarterly~~ update on all changes being submitted to the Audit & Risk Committee.

STAFF GOVERNANCE COMMITTEE
CONSTITUTION AND TERMS OF REFERENCE

Date of Board Approval: 29 May 2019~~14 March 2018~~

1. PURPOSE

1.1 The purpose of the Staff Governance Committee is to support the development of a culture within the health system where the delivery of the highest standard possible of staff management is understood to be the responsibility of everyone working within the system, and is built upon partnership and collaboration, and within the direction provided by the Staff Governance Standard.

1.2 To assure the Board that the staff governance arrangements in the Integration Joint Board are working effectively.

1.3 To escalate any issues to the NHS Fife Board if serious concerns are identified regarding staff governance issues within the services devolved to the Integration Joint Board.

2. COMPOSITION

2.1 The membership of the Staff Governance Committee will be:

- Four Non-Executive or Stakeholder members one of whom will be the Chair of the Committee. (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)
- Employee Director
- Chief Executive
- Director of Nursing
- Staff Side Chairs of the Local Partnership Forums

2.2 Each of the Staff Side Chairs of the Local Partnership Forums shall, annually, notify the Lead Officer to the Committee of a specific nominated deputy who will attend meetings in their absence. This will be reported to the Chair.

2.3 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 other Senior Staff should attend meetings, routinely or otherwise. The following will normally be routinely invited to attend Committee meetings:

- Director of Workforce
- Chief Operating Officer (Acute Services)
- Director of Health & Social Care
- Board Secretary

2.4 The Director of Workforce will act as Lead Officer to the Committee.

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 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. In addition each meeting will require one of the staff side Chairs of the Local Partnership Forums or their nominated deputy to be present.

4. MEETINGS

4.1 The Staff Governance Committee shall meet as necessary to fulfil its purpose 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.

5. REMIT

5.1 The remit of the Staff Governance Committee is to:

- Consider NHS Fife's performance in relation to its achievements of effective Staff Governance and its compliance with the Staff Governance Standard;
- Review action taken on recommendations made by the Committee, NHS Boards, or the Scottish Ministers on Staff Governance matters;
- Give assurance to the Board on the operation of Staff Governance systems within NHS Fife, identifying progress, issues and actions being taken, where appropriate;
- Support the operation of the Area Partnership Forum and the Local Partnership Forums in their Staff Governance monitoring role and the appropriate flow of information to facilitate this;
- Encourage the further development of mechanisms for engaging effectively with all members of staff within the NHS in Fife;
- Contribute to the development of the ~~Local Delivery~~Annual Operational Plan, in particular but not exclusively, around issues affecting staff;
- Support the continued development of personal appraisal professional learning and performance and, in particular, establish a Remuneration Sub-

Committee empowered to consider and determine objectives and performance appraisals for the Executive cohort and oversee performance arrangements for designated Senior Managers;

- Review regularly the sections of the NHS Fife Integrated Performance Report relevant to the Committee's responsibility;

- Undertake an annual self assessment of the Committee's work and effectiveness; and

- Receive minutes from the Remuneration Sub Committee. Issues arising from this Committee will be brought to the attention of the Chair of the Staff Governance Committee for further consideration as required.

5.2 The Committee is also required to carry out a review of its function and activities and to provide an Annual Report incorporating a Statement of Assurance. This will be submitted to the Board via the Audit and Risk Committee. The proposed Annual ~~Statement~~ Report will be presented to the first Committee meeting in the new financial year or agreed with the Chairperson of the respective Committee by the end of May each year for presentation to the Audit and Risk Committee in June.

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

5.4 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".

6. AUTHORITY

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

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

6.3 Delegated authority is detailed in the Board's Standing Orders, as set out in the Purpose and Remit of the Committee.

7. REPORTING ARRANGEMENTS

7.1 The Staff Governance Committee reports directly to Fife NHS Board on its work. Minutes of the Committee are presented to the Board by the Committee Chair, 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 Corporate Risk Register will be scrutinised by the relevant Committees of the Board with a bi-annual update on all changes to the Corporate Risk Register being submitted to the Audit & Risk Committee.

7.3 The Board Assurance Framework will be scrutinised by the relevant Committees of the Board with an ~~quarterly~~ update on all changes being submitted to the Audit & Risk Committee.

[TEMPLATE FOR COMMITTEE STATEMENT OF ASSURANCE TO THE AUDIT AND RISK COMMITTEE]

ANNUAL STATEMENT OF ASSURANCE OF NHS FIFE [*COMMITTEE TITLE*] FOR [*YEAR*]

PURPOSE

[Reproduce from Terms of Reference].

MEMBERSHIP

[For the year in question list Committee Members (identifying separately the Committee Chairperson) and status or job description. Include those who served only part of the year, indicating the relevant period.]

MEETINGS

[List the dates on which the Committee met during the year. This should cross-refer to an attendance schedule ~~in Appendix A~~ showing the attendance record of Committee Members].

BUSINESS

[~~Either w~~Within this section ~~or in an Appendix B or as a balance between both,~~ the report should describe the business transacted during the year at each of its meetings. It should demonstrate how the Committee is fulfilling its Remit and implementing its Work Plan and should *specifically report on the timely presentation of its minutes to the Board].*

[The Statement of Assurance should specifically record and provide assurance that the Committee has carried out the annual self-assessment of its effectiveness. ~~As an Appendix D, a summary report on the Committee's Self Assessment Checklist should be provided.~~]

BEST VALUE

[Reference should be made to ~~an *Appendix C* which should be an extract of~~ the relevant characteristics from the Best Value Framework for the Committee with the evidence source completed.]

RISK MANAGEMENT

The Committee should describe how it has addressed risk management within the context of the Board Assurance Framework.

CONCLUSION

[The following standard form of words should be used (with the necessary changes) before the Report is signed by the Committee Chairperson.]

"As Chair of the [Committee] during financial year *[20XX/XX]*, I am satisfied that the integrated approach, the frequency of meetings, the breadth of the business undertaken and the range of attendees at meetings of the Committee has allowed us to fulfil our remit as detailed in the Standing Orders. As a result of the work undertaken this year, I can confirm that adequate and effective governance was in place throughout NHS Fife during the year.

I pay tribute to the dedication and commitment of fellow members of the Committee and to all attendees, and I would thank all those members of staff who have prepared reports and attended meetings of the Committee.

_____ (signed)"

~~*Appendix A – Attendance Schedule*~~
~~*Appendix B – Business Transacted*~~
~~*Appendix C – Best Value*~~
~~*Appendix D – Summary Report on Committee Self Assessment Checklist*~~

STANDING FINANCIAL INSTRUCTIONS

INDEX

1. INTRODUCTION

1.1 Standing Financial Instructions (SFIs) are issued in accordance with the financial directions made under the provisions of the NHS (Financial Provisions) (Scotland) Regulations 1974, and all other enabling powers, for the regulation of the conduct of the Board, its members, officers and agents in relation to all financial matters. These SFIs form part of the Standing Orders and should be used along with the Standing Orders and Scheme of Delegation.

1.2 **Terminology**

Any expression to which a meaning is given in the Health Service Acts, Scottish Statutory Instrument number 302 (2001) which brought NHS Boards into being, or in the financial regulations made under the Acts shall have the same meaning in these Instructions; and:

(a) "NHS Fife" means all elements of the NHS under the auspices of Fife Health Board.
(b) "Board" and "Health Board" mean Fife NHS Board, the common name of Fife Health Board.
(c) "Budget" means a resource expressed in financial terms and set by the Board for the purposes of carrying out for a specified period any or all functions of the Health Board.
(d) "Chief Executive" means the Chief Officer of the Health Board.
(e) "Director of Finance" means the Chief Financial Officer of the Health Board.
(f) "Budget Holder" means any individual with delegated authority to manage finances (Income and/or expenditure) for a specific area of the Board.

1.3 All staff individually and collectively are responsible for the security of the property of the Board, for avoiding loss, for economy and efficiency in the use of the resources and for conforming with the requirements of the Code of Corporate Governance, including Standing Orders, Standing Financial Instructions and Financial Operating Procedures.

1.4 The Director of Finance, on behalf of the Chief Executive, shall be responsible for supervising the implementation of the Board's Standing Financial Instructions and Financial Operating Procedures and for co-ordinating any action necessary to further these as agreed by the Chief Executive. The Director of Finance shall review these at least every three years and be accountable to the Board for these duties.

1.5 Wherever the title, Chief Executive, Director of Finance, or other nominated officer is used in these Instructions, it shall be deemed to include such other staff who have been duly authorised to represent them.

1.6 All relevant employees and agents shall be provided with a copy of these SFIs and are required to complete a form stating that these Instructions have been read and understood and that the individual will comply with the Instructions. They must also sign for any amendments.

1.7 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Director of Finance must be sought before acting.

1.8 Failure to comply with Standing Financial Instructions is a disciplinary matter, which could result in dismissal.

1.9 The Standing Financial Instructions along with the Scheme of Delegation and Financial Operating Procedures provide details of delegated financial responsibility and authority.

2. KEY RESPONSIBILITIES FOR FINANCIAL GOVERNANCE

The Board and Audit and Risk Committee

2.1 The Board shall approve these SFIs and Scheme of Delegation

2.2 The Board shall ensure and be assured that the SFIs and Scheme of Delegation are complied with at all times.

2.3 The Board shall agree the terms of reference of the Audit and Risk Committee which must conform with extant Scottish Government Instruction and other guidance on good practice.

2.4 The Board shall perform its functions within the total funds allocated by the Scottish Government.

The Chief Executive (Accountable officer)

2.5 The Chief Executive as Accountable Officer for the organisation is ultimately responsible for ensuring that the Board meets its obligations to perform its functions within the allocated financial resources. The Director of Finance is responsible for providing a sound financial framework that assists the Chief Executive when fulfilling these commitments.

2.6 The Board shall delegate executive responsibility for the performance of its functions to the Chief Executive. Board Members shall exercise financial supervision and control by requiring the submission and approval of budgets within approved allocations, by defining and approving essential features of the arrangements in respect of important procedures and financial systems, including the need to obtain value for money, and by defining specific responsibilities placed on individuals.

2.7 It shall be the duty of the Chief Executive to ensure that existing staff and all new employees and agents are notified of their responsibilities within these Instructions.

The Director of Finance

2.8 Without prejudice to any other functions of employees of the Board, the duties of the Director of Finance shall include the provision of financial advice to the Board and its employees, the design, implementation and supervision of systems of financial control and preparation and maintenance of such accounts, certificates, estimates, records and reports as the Board may require for the purpose of carrying out its statutory duties.

2.9 The Director of Finance shall keep records of the Board's transactions sufficient to disclose with reasonable accuracy at any time the financial position of the Board.

2.10 The Director of Finance shall require any individual who carries out a financial function to discharge his duties in a manner, and keep any records in a form, that shall be to the satisfaction of the Director of Finance.

2.11 The Director of Finance shall prepare, document and maintain detailed financial procedures and systems incorporating the principles of separation of duties and internal checks to supplement these Standing Financial Instructions.

2.12 The Director of Finance shall be responsible for setting the Board's accounting policies, consistent with the Scottish Government and Treasury guidance and generally accepted accounting practice.

2.13 The Director of Finance will either undertake the role of Fraud Liaison Officer or nominate another senior manager to the role, to work with Counter Fraud Services and co-ordinate the reporting of Fraud and Thefts.

2.14 The Director of Finance is entitled without necessarily giving prior notice to require and receive:-

- access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
- access at all reasonable times to any land, premises or employee of the health board;
- the production of any cash, stores or other property of the health board under an employee's control; and
- explanations concerning any matter under investigation.

All Directors and Employees

2.15 All directors and employees, individually and working together, are responsible for:

- Keeping the property of the Board secure, and to apply appropriate routine security practices as may be determined by the Board. This includes:-

  a. ensuring that the assets within their area of responsibility are included within the appropriate asset register (see Section 7);

  b. ensuring that asset records/registers are kept up-to-date;

  c. performing verification exercises to confirm the existence and condition of the assets, and the completeness of the appropriate asset register; and

  d. following any prescribed procedures to notify the organisation of any theft, loss or damage to assets.

- Avoiding loss;

- Securing Best Value in the use of resources; and

- Following these SFIs and any other policy or procedure that the Board may approve.

2.16 All budget holders shall ensure that:-

- Information is provided to the Director of Finance to enable budgets to be compiled;

- Budgets are only used for their stated purpose; and

- Budgets are never exceeded.

2.17 When a budget holder expects his expenditure will exceed his delegated budget, he must secure an increased budget, or seek explicit approval to overspend before doing so.

2.18 All NHS staff who commit NHS resources directly or indirectly must be impartial and honest in their conduct of business and all employees must remain beyond suspicion.

2.19 All employees shall observe the requirements of MEL (1994) 48, which sets out the Code of Conduct for all NHS staff. There are 3 crucial public service values which underpin the work of the health service:-

Conduct
There should be an absolute standard of honesty and integrity which should be the hallmark of all personal conduct in decisions affecting patients, staff and suppliers; in the use of information acquired in the course of NHS duties; in dealing with the assets of the NHS.

Accountability
Everything done by those who work in the NHS must be able to stand the test of parliamentary and public scrutiny, judgements on propriety and professional codes of conduct.

Openness
The Board should be open about its activities and plans so as to promote confidence between the component parts of NHS Fife, other health organisations and its staff, patients and the public.

2.20 All employees shall:-

- Ensure that the interest of patients remain paramount at all times;
- Be impartial and honest in the conduct of their official business;
- Use the public funds entrusted to them to the best advantage of the service, always ensuring value for money; and
- Demonstrate appropriate ethical standards of personal conduct.

2.21 Furthermore all employees shall not:-

- Abuse their official position for the personal gain or to the benefit of their family or friends;
- Undertake outside employment that could compromise their NHS duties; and
- Seek to advantage or further their private business or interest in the course of their official duties.

2.22 The Director of Finance shall publish supplementary guidance and procedures in the form of Financial Operating Procedures to ensure that the above principles are understood and applied in practice.

2.23 The Chief Executive shall establish procedures for voicing complaints or concerns about misadministration, breaches of the standards of conduct, suspicions of criminal behaviour (e.g. theft, fraud, bribery) and other concerns of an ethical nature.

2.24 All employees must protect themselves and the Board from any allegations of impropriety by seeking advice from their line manager, or from the appropriate contact point, whenever there is any doubt as to the interpretation of these standards.

3. AUDIT

Audit and Risk Committee

3.1 In accordance with Standing Orders the Board shall formally establish an Audit and Risk Committee, with clearly defined terms of reference.

3.2 Where the Audit and Risk Committee feels there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the committee wish to raise, the Chairperson of the Audit and Risk Committee should raise the matter at a full meeting of the Board. In considering whether to do so, the Committee must be mindful of the arrangements with NHS Counter Fraud Services (CFS) and the role of the Fraud Liaison Officer (FLO). Exceptionally, the matter may need to be referred to the Scottish Government Health & Social Care Directorates (SGHSCD).

3.3 It is the responsibility of the Audit and Risk Committee to ensure an effective internal audit service is provided and this will be largely influenced by the professional judgement of the Director of Finance.

Director of Finance

3.4 The Director of Finance is responsible for:

a. Ensuring there are arrangements to measure, evaluate and report on the effectiveness of internal control and efficient use of resources, including the establishment of a professional internal audit function headed by a Chief Internal Auditor;

b. Ensuring that Internal Audit is adequate and meets the mandatory NHS internal audit standards;

c. Taking appropriate steps, in line with SGHSCD guidance, to involve CFS and/or the Police in cases of actual or suspected fraud, misappropriation, and other irregularities;

d. Ensuring that the Chief Internal Auditor prepares the following risk based plans for approval by the Audit and Risk Committee:

- Strategic audit plan covering the coming four years,
- A detailed annual plan for the coming year.

e. Ensuring that an annual internal audit report is prepared by the Chief Internal Auditor, in accordance with the timetable laid down by the Audit and Risk Committee, for the consideration of the Audit and Risk Committee and the Board.

The report should include:

- A clear statement on the adequacy and effectiveness of internal control;
- Main internal control issues and audit findings during the year;
- Extent of audit cover achieved against the plan for the year.

f. Progress on the implementation of internal audit recommendations including submission to the Audit and Risk Committee.

3.5 The Director of Finance shall refer audit reports to the appropriate officers designated by the Chief Executive and failure to take any necessary remedial action within a reasonable period shall be reported to the Chief Executive.

Internal Audit

3.6 Internal Audit shall adopt the Public Sector Internal Audit Standards (PSIAS), which are mandatory and which define internal audit as "an independent, objective assurance and consulting activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes."

Minor deviations from the PSIAS should be reported to the Audit and Risk Committee. More significant deviations should be considered for inclusion in the Annual Governance Statement.

3.7 Internal Audit activity must evaluate and contribute to the improvement of governance, risk management and control processes using a systematic and disciplined approach. Internal Audit activity and scope is fully defined within the Audit plan, approved by the Audit & Risk Committee.

3.8 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance, as the FLO, must be notified immediately, and before any detailed investigation is undertaken.

3.9 The Chief Internal Auditor is entitled without necessarily giving prior notice to require and receive:

(a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature (in which case he shall have a duty to safeguard that confidentiality), within the confines of the data protection act.

(b) Access at all reasonable times to any land, premises or employees of the Board;

(c) The production or identification by any employee of any cash, stores or other property of the Board under an employee's control; and

(d) Explanations concerning any matter under investigation.

3.10 The Chief Internal Auditor, or appointed representative, will normally attend Audit and Risk Committee meetings; and has a right of access to all Audit Committee members, the Chairperson and Chief Executive of the Board.

3.11 The Chief Internal Auditor shall be accountable to the Director of Finance. The reporting and follow-up systems for internal audit shall be agreed between the Director of Finance, the Audit and Risk Committee and Chief Internal Auditor. The agreement shall comply with the guidance on reporting contained in Government Internal Audit Standards.

External Audit

3.12 The External Auditor is concerned with providing an independent assurance of the Board's financial stewardship including value for money, probity, material accuracy, compliance with guidelines and accepted accounting practice for NHS accounts. Responsibility for securing the audit of the Board rests with Audit Scotland. The appointed External Auditor's statutory duties are contained in the Public Finance and Accountability (Scotland) Act 2000 which supersedes the Local Government (Scotland) Act 1973 (Part VII) as amended by the National Health Services and Community Care Act 1990.

3.13 The appointed auditor has a general duty to satisfy himself that:

(a) The Board's accounts have been properly prepared in accordance with the Direction of the Scottish Ministers to comply with the accounting principles and disclosure requirements of the edition of the Government Financial Reporting Manual (FReM) which is in force for the year for which the statement of accounts are prepared;

(b) Proper accounting practices have been observed in the preparation of the accounts;

(c) The Board has made proper arrangements for securing economy, efficiency and effectiveness in the use of its resources.

3.14 In addition to these responsibilities, Audit Scotland's Code of Audit Practice requires the appointed auditor to consider:

(a) Whether the statement of accounts presents fairly the financial position of the Board;

(b) The Board's main financial systems;

(c) The arrangements in place at the Board for the prevention and detection of fraud and corruption;

(d) Aspects of the performance of particular services and activities;

(e) The Board's management arrangements to secure economy, efficiency and effectiveness in the use of resources.

3.15 The Board's Audit and Risk Committee provides a forum through which Non-Executive Members can secure an independent view of any major activity within the appointed auditor's remit. The Audit and Risk Committee has a responsibility to ensure that the Board receives a cost-effective audit service and that co-operation with Board senior managers and Internal Audit is appropriate.

3.16 The External Auditor, or appointed representative, will normally attend Audit and Risk Committee meetings; and has a right of access to all Audit and Risk Committee members, the Chairperson and Chief Executive of the Board.

4. FINANCIAL MANAGEMENT

This section applies to both revenue and capital budgets.

Planning

4.1 The Scottish Government has set the following financial targets for all boards:-

- To operate within the revenue resource limit.
- To operate within the capital resource limit.
- To operate within the cash requirement.

4.2 The Chief Executive shall produce an ~~Local Delivery~~Annual Operational Plan. The Chief Executive shall submit a Plan for approval by the Board that takes into account financial targets and forecast limits of available resources. The ~~Local Delivery~~Annual Operational Plan shall contain:-

- a statement of the significant assumptions within the Plan; and
- details of major changes in workload, delivery of services or resources required to achieve the plan.

4.3 Before the financial year begins, the Director of Finance shall prepare and present a financial plan to the Board. The report shall:-

- show the total allocations received from the Scottish Government and their proposed uses, including any sums to be held in reserve;
- be consistent with the ~~Local Delivery~~Annual Operational Plan;
- be consistent with the Board's financial targets;
- identify potential risks;

- identify funding and expenditure that is of a recurring nature; and

- identify funding and expenditure that is of a non-recurring nature.

4.4 The Health Board shall approve the financial plan for the forthcoming financial year.

4.5 The Director of Finance shall continuously review the financial plan, to ensure that it meets the Board's requirements and the delivery of financial targets.

4.6 The Director of Finance shall regularly update the Board on significant changes to the allocations and their uses.

4.7 The Director of Finance shall keep the Chief Executive and the Board informed of the financial consequences of changes in policy, pay awards and other events and trends affecting budgets and shall advise on the financial and economic aspects of future plans and projects.

4.8 The Director of Finance shall establish the systems for identifying and approving how the Board's capital allocation will be used, consisting of proposals for individual schemes, major equipment, IT developments, backlog maintenance, statutory compliance works and minor scheme provision. The approval of business cases shall be as described in the Scheme of Delegation.

4.9 The Director of Finance shall release capital funds allowing for project start dates and phasing.

Budgetary Control

4.10 The Board shall approve the opening budgets for each financial year on an annual basis.

4.11 The Chief Executive shall delegate the responsibility for budgetary control to designated budget holders. The Scheme of Delegation sets out the delegated authorities to take decisions and approve expenditure for certain posts.

4.12 Employees shall only act on their delegated authority when there is an approved budget in place to fund the decisions they make.

4.13 Delegation of budgetary responsibility shall be in writing and be accompanied by a clear definition of:-

- the amount of the budget;

- the purpose(s) of each budget heading;

- what is expected to be delivered with the budget in terms of organisational performance; and

- how the budget holder will report and account for his or her budgetary performance.

4.14 The Chief Executive may agree a virement procedure that would allow budget holders to transfer resources from one budget heading to another. The Board shall set the virement limits for the Chief Executive and the Chief Executive shall ensure these are not exceeded

4.15 If the budget holder does not require the full amount of the budget delegated to him for the stated purpose (s), and virement is not exercised, then the amount not required shall revert back to the Chief Executive.

4.16 The Director of Finance shall devise and maintain systems of budgetary control. These will include:-

- monthly financial reports to the Board in a form approved by the Board containing:-

  a. net expenditure of the Board for the financial year to date; and

  b. a forecast of the Board's expected net expenditure for the remainder of the year on a monthly basis from (at the latest) the month 6 position onwards.

  c. capital project spend and projected outturn against plan;

  d. explanations of any material variances from plan and/or emerging trends;

  e. details of any corrective action where necessary and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation;

- the issue of timely, accurate and comprehensible advice and financial reports to each holder of a budget, including those responsible for capital schemes, covering the areas for which they are responsible;

- investigation and reporting of variances from agreed budgets;

- monitoring of management action to correct variances and/or emerging adverse trends; and

- ensuring that adequate training is delivered on an on-going basis to budget holders.

Monitoring

4.17 The Director of Finance shall provide monthly reports in the form requested by the Cabinet Secretary showing the charge against the Board's resource limits on the last day of each month.

5. ANNUAL ACCOUNTS AND REPORTS

5.1 The Director of Finance, on behalf of the Board, shall prepare, certify and submit audited Annual Accounts to the SGHSCD in respect of each financial year in such a form as the SGHSCD may direct.

5.2 The Director of Finance will ensure that the Annual Accounts and financial returns are prepared in accordance with the guidance issued in the Government Financial Reporting Manual (FReM), detailing the accounts and returns to be prepared, the accounting standards to be adopted and the timetable for submission to the SGHSCD.

5.3 The Audit and Risk Committee will ensure that the Annual Accounts are reviewed and submitted to the Board for formal approval and the Chief Executive will ensure that they are recorded as having been so presented. The Annual Accounts will be subject to statutory audit by the external auditor appointed by Audit Scotland.

5.4 The Director of Finance shall prepare a Financial Statement for inclusion in the Board's Annual Report, in accordance with relevant guidelines, for submission to Board members and others who need to be aware of the Board's financial performance.

5.5 The Board shall publish an Annual Report, in accordance with the Scottish Government's guidelines on local accountability requirements.

6. BANKING AND CASH HANDLING

6.1 The Director of Finance shall manage the Board's banking arrangements and advise the Board on the provision of banking services and operation of accounts. This advice shall take into account guidance/Directions issued from time to time by the Scottish Government.

6.2 The Director of Finance shall ensure that the banking arrangements operate in accordance with the Scottish Government banking contract (GBS) and the Scottish Public Finance Manual.

6.3 The Board shall approve the banking arrangements. No employee may open a bank account for the Board's activities or in the Board's name, unless the Board has given explicit approval.

6.4 The Director of Finance shall:-

- Establish separate bank accounts for non-exchequer funds;
- Ensure payments made from bank or GBS accounts do not exceed the amount credited to the account, except where arrangements have been made;

- Ensure money drawn from the Scottish Government against the Cash Requirement is required for approved expenditure only, and is drawn down only at the time of need;

- Promptly bank all monies received intact. Expenditure shall not be made from cash received that has not been banked, except under exceptional arrangements approved by the Director of Finance; and

- Report to the Board all arrangements made with the Board's bankers for accounts to be overdrawn.

6.5 The Director of Finance shall prepare detailed instructions on the operation of bank and GBS accounts, which must include:-

- The conditions under which each bank and GBS account is to be operated;

- Ensuring that the GBS account is used as the principal banker and that the amount of cleared funds held at any time within exchequer commercial bank accounts is limited to a maximum of £50,000 (of cleared funds).

- The limit to be applied to any overdraft;

- Those authorised to sign cheques or other orders drawn on the Board's accounts; and

- The required controls for any system of electronic payment.

6.6 The Director of Finance shall:-

- Approve the stationery for officially acknowledging or recording monies received or receivable, and keep this secure;

- Provide adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

- Approve procedures for handling cash and negotiable securities on behalf of the Board.

6.7 Money in the custody of the Board shall not under any circumstances be used for the encashment of private cheques.

6.8 The holders of safe keys shall not accept unofficial funds for depositing in their safes other than in exceptional circumstances. Such deposits must be in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Board is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Board from responsibility for any loss.

7. SECURITY OF ASSETS

7.1 Overall responsibility for the security of the Board's assets rests with the Board's Chief Executive. All members and employees have a responsibility for the security of property of the Board and it shall be an added responsibility of senior staff in all disciplines to apply appropriate routine security practices in relation to NHS property. Any significant breach of agreed security practice should be reported to the Chief Executive.

7.2 Wherever practicable, items of equipment shall be marked as property of Fife NHS Board.

7.3 The Chief Executive shall define the items of equipment to be controlled, and officers designated by the Chief Executive shall maintain an up-to-date register of those items. This shall include separate records for equipment on loan from suppliers, and lease agreements in respect of assets held under a finance lease and capitalised.

7.4 The Director of Finance shall approve the form of register and the method of updating which shall incorporate all requirements extant for capital assets.

7.5 Additions to the fixed asset register must be added to the records based on the documented cost of the asset at the time of acquisition.

7.6 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorised documentation.

7.7 The value of each asset where applicable shall be indexed to current values and depreciated using methods and rates as suggested in the Capital Accounting Manual and notified by the SGHSCD.

7.8 Revaluation of land and buildings will be provided by the Board's recommended Valuation Agent on a rolling annual programme designed to ensure that all such assets are revalued once every five years.

7.9 Annual indexation for land and buildings not included in the revaluation exercise in any given year will be provided by the Board's recommended Valuation Agent.

7.10 Any damage to the Board's premises, vehicles and equipment, or any loss of equipment or supplies shall be reported by staff in accordance with the procedure for reporting losses.

8. PAY

Remuneration Committee

8.1 The Board shall approve the terms of reference for the Remuneration Committee, in line with any extant guidance or requirements.

8.2 The Board shall remunerate the Chair and other non-executive directors in accordance with instructions issued by Scottish Government

Processes

8.3 The Chief Executive shall establish a system of delegated budgetary authority within which budget holders shall be responsible for the engagement of staff within the limits of their approved budget.

8.4 All time records, payroll timesheets and other pay records and notifications shall be in a form approved by the Director of Finance and shall be authorised and submitted in accordance with his instructions. This also includes e-expenses and SSTS.

8.5 The Director of Finance shall be responsible for ensuring that rates of pay and relevant conditions are applied in accordance with current agreements. The Chief Executive, or the Board in appropriate circumstances, shall be responsible for the final determination of pay. There will be no variation to agreed terms and conditions without the prior approval of the Director of Human Resources and Director of Finance. The Director of Finance shall determine the dates on which the payment of salary and wages are to be made. These may vary due to special circumstances (e.g. Christmas and other Public Holidays). Payments to an individual shall not be made in advance of normal pay, except:

a. To cover a period of authorised leave, involving absence on the normal pay day; or

b. As authorised by the Chief Executive and Director of Finance to meet special circumstances, and limited to the net pay due at the time of payment.

8.6 All employees shall be paid by bank credit transfer unless otherwise agreed by the Director of Finance.

8.7 The Board shall delegate responsibility to the Director of Workforce for ensuring that all employees are issued with a contract of employment in a form approved by the Board and which complies with employment legislation and any extant NHS policies.

9. NON PAY

Tendering, Contracting and Purchasing Procedures

9.1 The Director of Finance shall prepare detailed procedural instructions on the obtaining of goods, services and works, incorporating thresholds set by the Board. The current Authorisation Limits are set out in Scheme of Delegation and the Financial Operating Procedures.

9.2 The Chief Executive shall designate a senior officer as the lead senior officer for procurement, and this person shall oversee the procurement of goods

and services, to ensure there is an adequate approval of suppliers and their supplies based on cost and quality.

9.3 NSS National Procurement shall undertake procurement activity on a national basis on behalf of boards (including NHS Fife), and the Board shall implement these nationally negotiated contracts.

9.4 The Board shall operate within the processes established for the procurement of publicly funded construction work.

9.5 The Board shall comply with Public Contracts (Scotland) Regulations 2012 (and any subsequent relevant legislation) for any procurement it undertakes directly.

9.6 The Director of Finance shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

9.7 All other aspects of procurement activity must follow the requirements of the Standing Orders and SFIs. Any decision to depart from the requirements of this section must have the approval of NHS Fife Board.

9.8 The Director of Finance shall:-

- Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained in accordance with the Public Contracts (Scotland) Regulations, as issued annually through Scottish Statutory Instrument.

- Ensure the preparation of comprehensive procedures for all aspects of procurement activity.

9.9 The following basic principles shall be generally applied:-

- Procurement activity satisfies all legal requirements;

- Adequate contracts are in place with approved suppliers for the supply of approved products and services;

- Segregation of duties is applied throughout the process;

- Adequate approval mechanisms are in place before orders are raised;

- All deliveries are checked for completeness and accuracy, and confirmed before approval to pay is made; and

- All payments made are in accordance with previously agreed terms, and what the Board has actually received.

9.10 Limits of Authorisation of Orders

(a) Up to £100,000

- All Corporate Directors, Chief Operating Officer (Acute Services) and the Director of Health & Social Care can on their own authority commit expenditure up to £100,000 provided this is within the budgets for which they have responsibility.

- All other orders with a value up to £100,000 are subject to a scheme of delegation to Designated Ordering Officers with assigned limits. This scheme is detailed in the Financial Operating Procedures

(b) £100,000 to £1,000,000

All orders between £100,000 and £1,000,000 submitted by any authorised officer must be countersigned by the Board Chief Executive, Chief Operating Officer (Acute Services), Director of Health & Social Care (or a designated deputy for them), or Director of Finance.

(c) Above £1,000,000 and less than £2,000,000

All orders above £1,000,000 and less than £2,000,000 must be authorised by the Board Chief Executive~~, Chief Operating Officer (Acute Services), or the Director of Health & Social Care~~ and the Director of Finance, subject to the expenditure having been approved by the Board as part of a capital or revenue plan.

(d) The placing of annual orders and the acceptance of all annual contracts over £2,000,000, whether capital or revenue, is reserved to the Board and must be authorised by the Board Chief Executive and Director of Finance.

9.11 For all orders raised between £2,500 and £10,000 there is a requirement for the ordering officer to obtain two written quotations. Orders over £10,000 and up to £25,000 should ensure 3 tendered quotes are received subject to the Board's tendering procedures.

In the following exceptional circumstances, except in cases where EU Directives must be adhered to, the Director of Finance and Chief Executive, as specified in the Scheme of Delegation, can approve the waiving of the above requirements. Where goods and services are supplied on this basis and the value exceeds £2,500, a "Waiver of Competitive Tender/Quotation" may be granted by completing a Single Source Justification form for approval by the appropriate director and the Head of Procurement. Where the purchase of equipment is valued in excess of £5,000 and where the purchase of other goods and services on this basis exceeds £10,000, the completed Single Source Justification Form shall be endorsed by the Director of Finance and Chief Executive.

At least one of the following conditions must be outlined in the Single Source Justification Form:

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

In the case of 1, 2, 3, and 4 above, the Waiver of Competitive Tender/Quotation Form must be completed in advance of the order being placed, but may be completed retrospectively in the case of 5.

The Head of Procurement will maintain a record of all such exceptions.

Where additional works, services or supplies have become necessary and a change of supplier/contractor would not be practicable (for economic, technical or interoperability reasons) or would involve substantial inconvenience and/or duplication of cost, an existing contractor may be asked to undertake additional works providing the additional works do not exceed 50% of the original contract value and are provided at a value for money cost which should normally be at an equivalent or improved rate to the original contract.

When goods or services are being procured for which quotations or tenders are not required and for which no contract exists, it will be necessary to demonstrate that value for money is being obtained. Written notes/documentation to support the case, signed by the responsible Budget Holder, must be retained for audit inspection.

Further detail on the ordering of goods and services and relevant documentation are set out in the Financial Operating Procedures.

The use of supplies within the Office of Government (OGC) framework agreements may negate the need for three competitive tenders. The use of this route must always be recorded. In all instances, the regulations in respect of Official Journal of the European Union (OJEU) must be followed.

9.12 No order shall be issued for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive.

9.13 Orders shall not be placed in a manner devised to avoid the financial thresholds specified by the Board within the Scheme of Delegation.

9.14 All procurement on behalf of the Board must be made on an official order on the e-Procurement system (PECOS).

9.15 The Board shall not make payments in advance of need. However payment in advance of the receipt of goods or services is permitted in circumstances approved by the lead senior officer for procurement. Examples of such instances are:-

- Items such as conferences, courses and travel, foreign currency transactions, where payment is to be made at the time of booking.
- Where payment in advance of complete delivery is a legal or contractual requirement, e.g. maintenance contracts, utilities, rates.
- Where payment in advance is necessary to support the provision of services/delivery of a project by external providers (e.g. grants to local authorities or voluntary bodies.)

9.16 Purchases from petty cash shall be undertaken in accordance with procedures stipulated by the Director of Finance.

Commissioning of Patient Services

9.17 The Director of Finance, jointly with the Chief Operating Officer or Director of Health & Social Care will ensure service agreements are in place with other healthcare providers for the delivery of patient services, ensuring the appropriate ~~The Director of Finance shall be responsible for the~~ financial details are contained ~~in all service agreements entered into by the Board, for the delivery of patient services by other healthcare providers~~and clarity on reporting of performance, quality and safety issues.

9.18 The Director of Finance shall be responsible for maintaining a system for the payment of invoices in respect of patient services in accordance with agreed terms and national guidance and shall ensure that adequate ~~statistical and~~ financial systems are in place to monitor and control these.

Payment of Accounts and Expense Claims

9.19 The Director of Finance shall be responsible for the prompt payment of ~~-~~all accounts and expense claims. The Director of Finance shall publish the Board's performance in achieving the prompt payment targets in accordance with specified terms and national guidance.

9.20 The Director of Finance shall be responsible for designing and maintaining a system for the verification, recording and payment of all amounts payable by the Board. The system shall provide for authorisation by agreed delegated officers, a timetable and system for the payment of accounts and instruction to staff regarding handling, checking and payment of accounts and claims.

9.21 The Director of Finance shall ensure that payments for goods and services are made only after goods and services are received. Prepayments will be

permitted in exceptional circumstances and with the prior approval of the Director of Finance

Additional Matters for Capital Expenditure

Overall Arrangements for the Approval of the Capital Plan

9.22 The Board shall follow any extant national instructions on the approval of capital expenditure, such as the Scottish Capital Investment Manual. The authorisation process shall be described in the Scheme of Delegation.

9.23 The Chief Executive shall ensure that:-

- there is an adequate appraisal and approval process in place for determining capital expenditure priorities within the Property Strategy and the effect of each proposal upon business plans;

- all stages of capital schemes are managed, and are delivered on time and to cost;

- capital investment is not undertaken without confirmation that the necessary capital funding and approvals are in place; and

- all revenue consequences from the scheme, including capital charges, are recognised, and the source of funding is identified in financial plans.

Implementing the Capital Programme

9.24 For every major capital expenditure proposal the Chief Executive shall ensure:-

- that a business case as required by the Scottish Capital Investment Manual (SCIM) is produced setting out:-

    a. an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs; and

    b. appropriate project management and control arrangements; and

- that the Director of Finance has assessed the costs and revenue consequences detailed in the business case.

9.25 The approval of a business case and inclusion in the Board's capital plan shall not constitute approval of the individual elements of expenditure on any scheme. The Chief Executive shall issue to the manager responsible for any scheme:-

- specific authority to commit expenditure; and
- following the required approval of the business case, authority to proceed to tender.

9.26 The Scheme of Delegation shall stipulate where delegated authority lies for:-

- approval to accept a successful tender; and
- where Frameworks Scotland applies, authority to agree risks and timelines associated with a project in order to arrive at a target price.

9.27 The Director of Finance shall issue procedures governing the financial management of capital investment projects (e.g. including variations to contract, application of Frameworks Scotland) and valuation for accounting purposes.

Public Private Partnerships and other Non-Exchequer Funding

9.28 When the Board proposes to use finance which is to be provided other than through its capital allocations, the following procedures shall apply:-

- The Director of Finance shall demonstrate that the use of public private partnerships represents value for money and genuinely transfers significant risk to the private sector.
- Where the sum involved exceeds the Board's delegated limits, the business case must be referred to the Scottish Government for approval or treated as per current guidelines.
- Board must specifically agree the proposal.
- The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

Disposals of Assets

9.29 The Director of Finance shall issue procedures for the disposal of assets including condemnations. All disposals shall be in accordance with MEL(1996)7: Sale of surplus and obsolete goods and equipment.

9.30 There is a requirement to achieve Best Value for money when disposing of assets belonging to the Health Board. A competitive process should normally be undertaken.

9.31 When it is decided to dispose of a Health Board asset, the head of department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

9.32 All unserviceable articles shall be:-

- Condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance.

- Recorded by the Condemning Officer in a form approved by the Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance.

Capital Accounting

9.33 The Director of Finance shall be notified when capital assets are sold, scrapped, lost or otherwise disposed of, and what the disposal proceeds were. The value of the assets shall be removed from the accounting records. Each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

9.34 The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

9.35 The value of each asset shall be indexed and depreciated in accordance with methods specified by the Capital Accounting Manual.

9.36 The Director of Finance shall calculate capital charges, which will be charged against the Board's revenue resource limit.

10. PRIMARY CARE CONTRACTORS

10.1 In these SFIs and all other Board documentation, Primary Care contractor means:-

- an independent provider of healthcare who is registered to provide general dental, medical, ophthalmic or pharmaceutical services under the National Health Service in the United Kingdom (UK); or

- an employee of an National Health Service organisation in the UK who is registered to provide general dental, medical, ophthalmic or pharmaceutical services under the National Health Service in the UK.

10.2 The Primary Care Manager shall devise and implement systems to control the registers of those who are entitled to provide general dental, medical, ophthalmic or pharmaceutical services under the National Health Service in Fife. Systems shall include criteria for entry to and deletions from the registers.

10.3 The Director of Finance shall agree the Service Level Agreement (s) with NHS National Services Scotland for:-

- the development, documentation and maintenance of systems for the verification, recording and receipt of NHS income collected by or on behalf of primary care contractors; and

- the development, documentation and maintenance of systems for the verification, recording and payment of NHS expenditure incurred by or on behalf of primary care contractors.

10.4 The agreements at paragraph F10.3 shall comply with guidance issued from time to time by the Scottish Government. In particular they shall take account of any national systems for the processing of income and expenditure associated with primary care contractors.

10.5 The Director of Finance shall ensure that all transactions conducted for or on behalf of primary care contractors by the Board shall be subject to these SFIs.

11. INCOME

11.1 The Director of Finance shall be responsible for designing and maintaining systems for the proper recording and collection of all monies due.

11.2 The Director of Finance shall take appropriate recovery action on all outstanding debts and shall establish procedures for the write-off of debts after all reasonable steps have been taken to secure payment.

11.3 The Director of Finance is responsible for ensuring the prompt banking of all monies received.

11.4 In relation to business development/income generation schemes, the Director of Finance shall ensure that there are systems in place to identify and control all costs and revenues attributed to each scheme.

11.5 The Director of Finance shall approve all fees and charges other than those determined by the Scottish Government or by Statute.

12. FINANCIAL MANAGEMENT SYSTEM

12.1 The Director of Finance shall carry prime responsibility for the accuracy and security of the computerised financial data of the Board and shall devise and implement any necessary procedures to protect the Board and individuals from inappropriate use or misuse of any financial and other information held on computer files for which he is responsible, after taking account of all relevant legislation and guidance

12.2 The Director of Finance shall ensure that contracts for computer services for financial applications with another Board or any other agency shall clearly define the responsibility of all the parties for the security, privacy, accuracy,

completeness and timeliness of data during processing, transmission and storage.

12.3 The Director of Finance shall ensure that adequate data controls exist to provide for security of financial applications during data processing, including the use of any external agency arrangements.

12.4 The Director of Finance shall satisfy her/himself that such computer audit checks as s/he may consider necessary are being carried out.

12.5 The Director of Finance shall ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and are thoroughly tested prior to implementation.

12.6 Where another health organisation or any other agency provides a financial system service to the Board, the Director of Finance shall periodically seek assurances, through Audit where appropriate, that adequate controls are in operation and that disaster recovery arrangements are robust.

13. CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

13.1 Any employee or agent discovering or suspecting a loss of any kind shall forthwith inform his head of department, who shall immediately inform the Chief Executive and the Director of Finance. Where a criminal offence is suspected, the Director of Finance shall follow the Anti-Theft, Fraud, and Corruption Policy, as set out in the Financial Operating Procedures.

13.2 The Director of Finance shall notify the Audit and Risk Committee and Counter Fraud Services of all actual or suspected frauds. See 13.10 below.

13.3 In all instances where there is any suspicion of fraud then the guidance contained within NHS Circular, HDL (2005) 5: “Tackling Fraud in Scotland – Joint Action Programme. Financial Control : Procedures where criminal offences are suspected” must be followed. The Board’s Fraud Liaison Officer (FLO) must be notified immediately of all cases of fraud or suspected fraud.

13.4 The Director of Finance shall issue procedures on the recording of and accounting for Losses and special payments to meet the requirements of the Scottish Public Finance Manual. These procedures shall include the steps to be taken where the loss may have been caused by a criminal act.

13.5 The Scheme of Delegation shall describe the process for the approval of the write-off of losses and making of special payments

13.6 The Director of Finance shall maintain a Losses and Special Payments Register in which details of all Category 1 and Category 2 losses shall be recorded as they are known. Category 3 losses may be recorded in summary form. Write-off action shall be recorded against each entry in the Register.

13.7 No special payments exceeding the delegated limits shall be made without prior approval by the SGHSCD.

13.8 The Director of Finance shall be authorised to take any necessary steps to safeguard the Board's interest in bankruptcies and company liquidations.

13.9 The Director of Finance is required to produce a report on Condemnations, Losses and Special Payments, where the delegated limits have been exceeded and SGHSCD approval has been requested, to the Audit and Risk Committee.

13.10 The Bribery Act came into force in 2010; it aims to tackle bribery and corruption in both the private and public sectors. The Act is fully endorsed by Fife NHS Board. NHS Fife conducts its contracting and procurement practices with integrity, transparency and fairness and has a zero tolerance policy on bribery or any kind of fraud. There are robust controls in place to help deter, detect and deal with it. These controls are regularly reviewed in line with the Standing Financial Instructions and feedback is provided to the Audit & Risk Committee. Procurement actively engage with NHS Scotland Counter Fraud Services to ensure that our team is fully trained on spotting potential signs of fraud and knowing how to report suspected fraud. As an existing or potential contractor to NHS Fife, you are required to understand that it may be a criminal offence under the Bribery Act 2010, punishable by imprisonment, to promise, give or offer any gift, consideration, financial or other advantage whatsoever as an inducement or reward to any officer of a public body and that such action may result in the Board excluding the organisation from the selected list of Potential Bidders, and potentially from all future public procurements. It is therefore vital that staff, contractors and agents understand what is expected of them and their duties to disclose and deal with any instances they find.

14. RISK MANAGEMENT

14.1 The Chief Executive shall ensure that the Board has a programme of risk management, which will be approved and monitored by the Board and which complies with the Standards issued by NHS Health Improvement Scotland.

14.2 The programme of risk management shall include:

a. A process for identifying and quantifying risks and potential liabilities, including the establishment and maintenance of a Risk Register;

b. Engendering among all levels of staff a positive attitude towards the control of risk;

c. Management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover and decisions on the acceptable level of retained risk;

d. Contingency plans to offset the impact of adverse events;

4. Audit arrangements including internal audit, clinical audit and health and safety review;

5. Arrangements to review the risk management programme.

g.. A review by each Governance Committee of relevant risks pertaining to their business.

The existence, integration and evaluation of the above elements will provide a basis for the Audit and Risk Committee to make a statement on the overall effectiveness of Internal Control and Corporate Governance to the Board.

14.3 The programme of risk management will be underpinned by a Board Assurance Framework, approved, and reviewed annually by the NHS Board.

15. RETENTION OF DOCUMENTS

15.1 The Chief Executive shall be responsible for maintaining archives for all documents in accordance with the NHS Code of Practice on Records Management.

15.2 The documents held in archives shall be capable of retrieval by authorised persons.

15.3 Documents held under the Code shall only be destroyed at the express instigation of the Chief Executive, and records shall be maintained of documents so destroyed.

16. PATIENTS' PROPERTY AND FUNDS

16.1 The Board has a responsibility to provide safe custody, for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

16.2 The Chief Executive shall be responsible for ensuring that patients or their guardians, as appropriate, are informed before, or at their admission, by: -

- Notices and information booklets
- Hospitals' admission documentation and property records, and
- The oral advice of administrative and nursing staff responsible for admissions, that the Board will not accept responsibility or liability for patients' monies and personal property brought into Board premises unless it is handed in for safe custody and a copy of an official patient property record is obtained as a receipt.

16.3 The Director of Finance shall provide detailed written instructions on the collection, custody, investment, recording, safekeeping and disposal of patients' property (including instructions on the disposal of the property of deceased patients and patients transferred to other premises), for all staff whose duty it is to administer, in any way, the property of the patients.

16.4 Bank accounts for patients' monies shall be operated under arrangements agreed by the Director of Finance.

16.5 A patients' property record, in a form determined by the Director of Finance, shall be completed.

16.6 The Director of Finance is responsible for providing detailed instructions on the Board's responsibility as per the Adults with Incapacity (Scotland) Act 2000 and the updated Part 5 in CEL11(2008) Code of Practice. These instructions are contained within the Financial Operating Procedures.

16.7 The Director of Finance shall prepare an abstract of receipts and payments of patients private funds in the form laid down by Scottish Government.

17. STORES

17.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use), should be:-

- Kept to a minimum;
- Subject to annual stocktake; and
- Valued at the lower of cost and net realisable value.

17.2 Subject to the responsibility of the Director of Finance for the systems of control, the control of stores throughout the organisation shall be the responsibility of the relevant managers. The day-to-day management may be delegated to departmental officers and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance.

17.3 The responsibility for security arrangements, and the custody of keys for all stores locations, shall be clearly defined in writing by the manager responsible for the stores and agreed with the Director of Finance. Wherever practicable, stock items, which do not belong to the Board, shall be clearly identified.

17.4 All stores records shall be in such form and shall comply with such system of control and procedures as the Director of Finance shall approve.

17.5 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year. The physical check shall involve at least one officer other than the Storekeeper, and the Director of Finance and Internal & External Audit shall be notified and may attend, or be represented, at their discretion. The stocktaking records shall be numerically controlled and signed by the officers undertaking the check. Any surplus or deficiency revealed on stocktaking shall be reported immediately to the Director of Finance, and he may investigate as necessary. Known losses of stock items not on stores control shall be reported to the Director of Finance.

17.6 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

17.7 Instructions for stock take and the basis for valuation will be issued at least once a year by the Director of Finance.

18. AUTHORISATION LIMITS

18.1 The purpose of Standing Financial Instructions is to ensure adequate controls exist for the committing and payment of funds on behalf of NHS Fife. The main principles applied in determining authorisation limits are those of devolved accountability and responsibility. The rules for financial delegation to all levels of management within the Board's established policies and priorities are set out in the Scheme of Delegation and Financial Operating Procedures

18.2 Areas covered by the Scheme of Delegation include:

- Limitation and Authority to vire budgets between one budget heading and another.
- Limitation of level of Authority for the placing of orders or committing resources
- Limitation as to the level of authority to approve receipt of orders, expenses, travel claims, payment of invoices, write off of losses.

19. ENDOWMENT FUNDS

19.1 The Standing Financial Instructions deal with matters related to exchequer income and expenditure for NHS Fife. Whilst Endowment Funds fall outwith the scope of core exchequer funds, it is important that all relevant employees and agents are aware of the arrangements for the financial responsibility and authority for such funds.

19.2 Endowment Funds and are those held in trust for purposes relating to the National Health Service, either by the Board or Special Trustees appointed by the Scottish Ministers or by other persons.

19.3 Members of the Fife Health Board become Trustees of the Board's Endowment Funds. The responsibilities as Trustees are discharged separately from the responsibilities as members of the Board.

19.4 The Director of Finance shall prepare detailed procedural instructions covering the receiving, recording, investment and accounting for Endowment Funds.

19.5 Through the Board's Scheme of Delegation, authority will be given by the Trustees to allow for the day to day management of the funds within specified limits.

19.6 The Authorisation Limits are set out in the Scheme of Delegation and the Financial Operating Procedures.

19.7 The Director of Finance shall prepare annual accounts for the funds held in trust, to be audited independently and presented annually to the trustees.

FIFE NHS BOARD SCHEME OF DELEGATION

1. Introduction

Board's Responsibility

The Standing Orders for the proceedings and Business of the Fife NHS Board include a section on Matters Reserved for the Board (7). This section of the Standing Orders summarises all matters where decision making is reserved to the Board.

The subsequent section (8) within the Standing Orders, identifies that other "matters" may be delegated to Committees or individuals to act on behalf of the Board.

The following appendix sets out:

- Committee's delegated responsibility on behalf of the Board
- Matters delegated to individuals

2. Committee's Delegated Responsibility on behalf of the Board

2.1 Audit & Risk Committee	
Responsible Director for this Section	Director of Finance

Role and Remit	• Supporting the Accountable Officer and Fife NHS Board formulate their assurance needs with regard to risk management, governance and internal control;
	
	• Drawing attention to weaknesses in systems of risk management, governance and internal control;
	
	Internal Control and Corporate Governance
	
	• 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.
	
	• 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.
	
	• To ensure that the activities of Fife NHS Board are within the law and regulations governing the NHS.
	
	• To review the disclosures included in the Governance Statement on behalf of the Board.
	
	• 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
	
	• To review and approve the Internal Audit Strategic and Annual Plans.
	
	• To monitor audit progress and review audit reports.
	
	• To monitor the management action taken in response to the audit recommendations through an appropriate follow-up mechanism.
	
	• To consider the Chief Internal Auditor's annual report and assurance statement.
	
	• To review the operational effectiveness of Internal Audit by considering the audit standards, resources, staffing, technical competency and performance measures.
	
	External Audit
	
	• 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.
	
	• To review the Audit Strategy and Plan, including the Best Value and Performance Audits programme.
	
	• To consider all statutory audit material, in particular:-
	
	  • Audit Reports;
	  • Annual Reports;
	  • Management Letters
	
	relating to the certification of Fife NHS Boards Annual Accounts, Annual Patients' Funds Accounts. ~~On behalf of the Trustees of NHS Endowment Funds to consider all statutory audit material, in particular:~~
	
	~~Audit Reports;~~
	~~Annual Reports;~~
	~~Management Letters~~
	
	~~Relating to the Annual Endowment Funds Accounts.~~
	
	Risk Management
	
	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. • The Committee will also receive and review a report summarising any significant changes to the Boards 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. • 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. **Standing Orders and Standing Financial Instructions** • To review every three years the Standing Orders and associated appendices of Fife NHS Board and advise the Board of any amendments required. • To examine the circumstances associated with any occasion when Standing Orders of Fife NHS Board have been waived or suspended. **Annual Accounts** • To review and recommend approval of draft Fife NHS Board Annual Accounts to the Board. • To review the draft Annual Report and Financial Review of Fife NHS Board as found within the Directors Report incorporated within the Annual Accounts. • To review annually (and approve any changes in) the accounting policies of Fife NHS Board. • 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 • 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. • The Committee shall review regular reports on Fraud and potential Frauds. • 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". • 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. • 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).

2.2 Clinical Governance Committee	
Responsible Director for this Section	Medical Director
Sub-Committees	• Health & Safety • Patient Focus Public Involvement
Role and Remit	• To monitor progress on the health status targets set by the Board. • The Committee will produce an Annual Statement of Assurance for submission to the Board, via the Audit & Risk Committee and PFPI Committee. The proposed Annual Statement will be presented to the first Committee meeting in the new financial year or agreed with the Chairperson of the respective Committee by the end of May each year for presentation to the Audit and Risk Committee in June. • To capture and record all issues and risks on an operational risk register to be monitored through the Committee, and where appropriate these should be escalated to the Board for consideration in addition to the corporate risk register until mitigated to a tolerable level. • To receive updates on and oversee the progress on the recommendations from relevant external reports of reviews of all healthcare organisations including clinical governance reports and recommendations from relevant regulatory bodies which may include Healthcare Improvement Scotland (HIS) reviews and visits. • To provide assurance to Fife NHS Board about the quality of services within NHS Fife. • The Committee shall review regularly the sections of the NHS Fife Integrated Performance Report relevant to the Committee's responsibility. • To undertake an annual self assessment of the Committee's work and effectiveness. • 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".

	2.3 Finance, Performance and Resources Committee
Responsible Director for this Section	Director of Finance
Sub-Committees	• Pharmacy Practices • Primary Medical Services
Role and Remit	• The Committee shall have accountability to the Board for ensuring that the financial position of the Board is soundly based, having regard to: • compliance with statutory financial requirements and achievement of financial targets; • such financial monitoring and reporting arrangements as may be specified from time-to-time by SGHSCD and/or the Board; • levels of balances and reserves; • the impact of planned future policies and known or foreseeable future developments on the financial position; • undertake an annual self assessment of the Committee's work and effectiveness; and • review regularly the sections of the NHS Fife Integrated Performance Report relevant to the Committee's responsibility. **Arrangements for Securing Value for Money** • The Committee shall keep under review arrangements for securing economy, efficiency and effectiveness in the use of resources. These arrangements will include procedures for (a) planning, appraisal, and control, accountability and evaluation of the use of resources, and for (b) reporting and reviewing performance and managing performance issues as they arise in a timely and effective manner. In particular, the Committee will review action (proposed or underway) to ensure that the Board achieves financial balance in line with statutory requirements. **Allocation and Use of Resources** The Committee has key responsibilities for: • reviewing the development of the Board's Financial Strategy in support of the ~~Local Delivery~~Annual Operational Plan, and recommending approval to the Board; • reviewing all resource allocation proposals outwith authority delegated by the Board and make recommendations to the

	Board thereon; and • monitoring the use of all resources available to the Board. • Specifically, the Committee is charged with recommending to the Board annual revenue and capital budgets and financial plans consistent with its statutory financial responsibilities. It shall also have responsibility for the oversight of the Board's Capital Programme (including individual Business Cases for Capital Investment) and the review of the Property Strategy (including the acquisition and disposal of property), and for making recommendations to the Board as appropriate on any issue within its terms of reference; • The Committee will produce an Annual Statement of Assurance for submission to the Board, via the Audit and Risk Committee. The proposed Annual Statement will be presented to the first Committee meeting in the new financial year or agreed with the Chairperson of the respective Committee by the end of May each year for presentation to the Audit and Risk Committee in June; and • 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".

2.4 Staff Governance Committee	
Responsible Director for this Section	Director of Workforce
Sub-Committees	• Remuneration
Role and Remit	• The remit of the Staff Governance Committee is to: • consider NHS Fife's performance in relation to its achievements of effective Staff Governance and its compliance with the Staff Governance Standard; • review action taken on recommendations made by the Committee, NHS Boards, or the Scottish Ministers on Staff Governance matters; • give assurance to the Board on the operation of Staff Governance systems within NHS Fife, identifying progress, issues and actions being taken, where appropriate; • support the operation of the Area Partnership Forum and the Local Partnership Forums in their Staff Governance monitoring role and the appropriate flow of information to facilitate this; • encourage the further development of mechanisms for engaging effectively with all members of staff within the NHS in Fife; • contribute to the development of the ~~Local Delivery~~Annual Operational Plan, in particular but not exclusively, around issues affecting staff; • support the continued development of personal appraisal professional learning and performance and, in particular, establish a Remuneration Sub-Committee empowered to consider and determine objectives and performance appraisals for the Executive cohort and oversee performance arrangements for designated Senior Managers; • review regularly the sections of the NHS Fife Integrated Performance Report relevant to the Committee's responsibility; and • undertake an annual self assessment of the Committee's work and effectiveness.

3. Matters Delegated to Individuals

	• The Committee is also required to carry out a review of its function and activities and to provide an Annual Statement of Assurance. This will be submitted to the Board via the Audit and Risk Committee. The proposed Annual Statement will be presented to the first Committee meeting in the new financial year or agreed with the Chairperson of the respective Committee by the end of May each year for presentation to the Audit and Risk Committee in June. • 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".

	3.1 Matters Delegated to the Chief Executive
	General Provisions In the context of the Board's principal role to protect and improve the health of Fife residents, the Chief Executive as Accountable Officer shall have delegated authority and responsibility to secure the economical, efficient and effective operation and management of Fife NHS Board and to safeguard its assets: • in accordance with the statutory requirements and responsibilities laid upon the Chief Executive as Accountable Officer for Fife NHS Board; • in accordance with direction from the Scottish Government Health and Social Care Directorates; • in accordance with the current policies of and decisions made by the Board; • within the limits of the resources available, subject to the approval of the Board; • and in accordance with the Code of Corporate Governance as detailed in Standing Orders and Standing Financial Instructions. The Chief Executive is authorised to take such measures as may be required in emergency situations, subject to advising, where possible, the Chairperson and the Vice-Chairperson of the Board, and the relevant Standing Committee Chairperson. Such measures, that might normally be outwith the scope of the authority delegated by the Board or its Standing Committees to the Chief Executive, shall be reported to the Board or appropriate Standing Committee as soon as possible thereafter. The Chief Executive is authorised to give a direction in special circumstances that any officer shall not exercise a delegated function subject to reporting on the terms of the direction to the next meeting of the appropriate Committee. **Finance** Resources shall be used only for the purpose for which they are allocated, unless otherwise approved by the Chief Executive, after taking account of the advice of the Director of Finance. The Chief Executive acting together with the Director of Finance has delegated authority to approve the transfer of funds between budget heads, including transfers from reserves and balances, up to a maximum of £2,000,000 in any one instance. The Chief Executive shall report to the Finance, Performance and Resources Committee those instances where this authority is exercised and/or the change in use of the funds relates to matters

	of public interest. The Chief Executive may, acting together with the Director of Finance, and having taken all reasonable action to pursue recovery, approve the writing-off of losses, subject to the financial limits and categorisation of losses laid down from time to time by the Scottish Government Health and Social Care Directorates. **Legal Matters** The Chief Executive is authorised to institute, defend or appear in any legal proceedings or any inquiry, including proceedings before any statutory tribunal, board or authority, and following consideration of the advice of the Central Legal Office of the National Services Scotland (NSS), to appoint or consult with Counsel where it is considered expedient to do so, for the promotion or protection of the Board's interests. In circumstances where a claim against the Board is settled by a decision of a Court, and the decision is not subject to appeal, the Chief Executive shall implement the decision of the relevant Court on behalf of the Board. In circumstances where the advice of the Central Legal Office is to reach an out-of-court settlement, the Chief Executive may, acting together with the Director of Finance, settle claims against the Board, subject to a report thereafter being submitted to the Finance, Performance and Resources Committee. The Chief Executive, acting together with the Director of Finance, may make ex gratia payments subject to the limits laid down from time to time by the Scottish Government Health & Social Care Directorates. The arrangements for signing of documents in respect of matters covered by the Property Transactions Manual shall be in accordance with the direction of Scottish Ministers. The Chief Executive and the Director of Finance are currently authorised to sign such documentation on behalf of the Board and Scottish Ministers. The Chief Executive shall have responsibility for the safe keeping of the Board's Seal, and together with the Chairperson or other nominated Non-Executive Member of the Board, shall have responsibility for the application of the Seal on behalf of the Board. **Procurement of Supplies and Services**

	The Chief Executive shall have responsibility for nominating officers or agents to act on behalf of the Board, for specifying, and issuing documentation associated with invitations to tender, and for receiving and opening of tenders. Where post tender negotiations are required, the Chief Executive shall nominate in writing, officers and/or agents to act on behalf of the Board. The Chief Executive, acting together with the Director of Finance, has authority to approve on behalf of the Board the acceptance of tenders, submitted in accordance with the Board's Standing Orders, up to an annual value of £2,000,000, within the limits of previously approved Revenue and Capital Budgets, where the most economically advantageous tender is to be accepted. The Chief Executive through the Director of Finance shall produce a listing, including specimen signatures, of those officers or agents to whom they have given delegated authority to sign official orders on behalf of the Board. **Human Resources** The Chief Executive may, after consultation and agreement with the Director of Workforce, and the relevant Director~~/Chief Officer~~, amend staffing establishments in respect of the number and grading of posts. In so doing, the Director of Finance must have been consulted, and have confirmed that the cost of the amended establishment can be contained within the relevant limit approved by the Board for the current and subsequent financial years. Any amendment must also be in accordance with the policies and arrangements relating to workforce planning, approved by the Board or Staff Governance Committee. The Chief Executive has delegated authority from Fife NHS Board to approve the establishment of salaried dentist posts within NHS Fife, within the systematic approach as laid down by the Scottish Government Health & Social Care Directorates Circular No PCA(D)(2005)3. The Chief Executive may attend and may authorise any member of staff to attend within and outwith the United Kingdom conferences, courses or meetings of relevant professional bodies and associations, provided that: • attendance is relevant to the duties or professional development of such member of staff; and • appropriate allowance has been made within approved budgets; or

	• external reimbursement of costs is to be made to the Board. • Under the terms of the public sector reform act the Chief Executive is required to keep a register of all such approvals. The Chief Executive may, in accordance with the Board's agreed Employee Conduct Policy, take disciplinary action, in respect of members of staff, including dismissal where appropriate. The Chief Executive shall have overall responsibility for ensuring that the Board complies with Health and Safety legislation, and for ensuring the effective implementation of the Board's policies in this regard. The Chief Executive may, following consultation and agreement with the Director of Workforce and the Director of Finance approve payment of honoraria to any employee. The Chief Executive may, in consultation with the Director of Workforce and Director of Finance, approve applications to leave the employment of the Board on grounds of early retirement by any employee provided the terms and conditions relating to the early retirement are in accordance with the relevant Board policy. All such applications and outcomes will be reported to the Remuneration sub-Committee. **Patients' Property** The Chief Executive shall have overall responsibility for ensuring that the Board complies with legislation in respect of patients' property. The term 'property' shall mean all assets other than land and building. (e.g. furniture, pictures, jewellery, bank accounts, shares, cash.)

3.2 Matters Delegated to the Director of Finance	
	Authority is delegated to the Director of Finance to take the necessary measures as undernoted, in order to assist the Board and the Chief Executive in fulfilling their corporate responsibilities: **Accountable Officer** The Director of Finance has a general duty to assist the Chief Executive in fulfilling their responsibilities as the Accountable Officer of the Board. **Financial Statements** The Director of Finance is empowered to take all steps necessary to assist the Board to: • Act within the law and ensure the regularity of transactions by putting in place systems of internal control to ensure that financial transactions are in accordance with the appropriate authority; • Maintain proper accounting records; and • Prepare and submit for External Audit timeous financial statements which give a true and fair view of the financial position of the Board and its income and expenditure for the period in question. **Corporate Governance and Management** The Director of Finance is authorised to put in place proper arrangements to ensure that the financial position of the Board is soundly based by ensuring that the Board, its Committees, and supporting management groupings receive appropriate, accurate and timely information and advice with regard to: • The development of financial plans, budgets and projections; • Compliance with statutory financial requirements and achievement of financial targets; • The impact of planned future policies and known or foreseeable developments on the Board's financial position. The Director of Finance is empowered to take steps to ensure that proper arrangements are in place for: • Developing, promoting and monitoring compliance with Standing Orders and Standing Financial Instructions, and appropriate guidance on standards of business conduct; • Developing and implementing systems of internal control, including systems of financial, operational and compliance controls and risk management;

	• Developing and implementing strategies for the prevention and detection of fraud and irregularity; • Internal Audit. **Performance Management** The Director of Finance is authorised to assist the Chief Executive to ensure that suitable arrangements are in place to secure economy, efficiency, and effectiveness in the use of resources and that they are working effectively. These arrangements include procedures: • for planning, appraisal, authorisation and control, accountability and evaluation of the use of resources; • to ensure that performance targets and required outcomes are met and achieved. **Banking** The Director of Finance is authorised to oversee the Board's arrangements in respect of accounts held in the name of the Board with the Paymaster General Office and the commercial bankers duly appointed by the Board. The Director of Finance will be responsible for ensuring that the Paymaster General's Office and the commercial bankers are advised in writing of amendments to the panel of nominated authorised signatories. **Patients' Property** The Director of Finance shall have delegated authority to ensure that detailed operating procedures in relation to the management of the property of patients (including the opening of bank accounts where appropriate) are compiled for use by staff involved in the management of patients' property and financial affairs, in line with the terms of the Adults with Incapacity (Scotland) Act 2000.

3.3 Matters Delegated to Other Senior Officers of the Board	
	Chief Operating Officer (Acute Services) and Director of Health and Social Care
	General Provisions The Chief Operating Officer/Director of Health and Social Care shall have delegated authority and responsibility from the Board Chief Executive to secure the economical, efficient and effective operation and management of their services: • in accordance with the current policies and decisions made by the Board; • within the limits of the resources made available to the Division/IJB; • in accordance with the Code of Corporate Governance as detailed in the Board's Standing Orders and Standing Financial Instructions. The Chief Operating Officer and Director of Health and Social Care have a general duty to assist the Chief Executive in fulfilling his responsibilities as the Accountable Officer of the Board. The Chief Operating Officer and Director of Health and Social Care are authorised to take such measures as may be required in emergency situations, subject to advising, where possible, the Chairperson or the Vice-Chairperson of the Board, the Chief Executive and where appropriate the relevant Standing Committee Chairperson. Such measures, that might normally be outwith the scope of the authority delegated by the Board or its Standing Committees to the Chief Executive, shall be reported to the Board or appropriate Standing Committee as soon as possible thereafter. The Chief Operating Officer and Director of Health and Social Care are authorised to give a direction in special circumstances that any officer within their area shall not exercise a delegated function subject to reporting on the terms of the direction to the next meeting of the Board. **Finance** Resources shall be used only for the purpose for which they are allocated, unless otherwise approved by the Chief Operating Officer and Director of Health and Social Care, after taking account of the advice of the ~~designated Assistant~~Deputy Director of Finance. The Chief Operating Officer and Director of Health and Social Care acting together with the ~~designated Assistant~~Deputy

	Director of Finance have delegated authority to approve the transfer of funds between budget heads, up to a maximum of £500,000 in any one instance. Those instances where this authority is exercised and/or the change in use of the funds relates to matters of public interest shall be notified to the Finance, Performance and Resources Committee. **Legal Matters** The Chief Operating Officer and Director of Health and Social Care are authorised to institute, defend or appear in any legal proceedings or any inquiry, (including proceedings before any statutory tribunal, board or authority) in respect of their service areas, and following consideration of the advice of the Central Legal Office of the National Services Scotland and in consultation with the Chief Executive, to appoint or consult with Counsel where it is considered expedient to do so, for the promotion or protection of the Board's interests. **Procurement of Supplies and Services** The Chief Operating Officer and Director of Health and Social Care shall have responsibility for nominating officers or agents to act on behalf of the Board, for specifying, and issuing documentation associated with invitations to tender, and for receiving and opening of tenders. The Chief Operating Officer and Director of Health and Social Care shall work with the ~~designated Assistant~~Deputy Director of Finance and the Director of Finance to produce a listing, including specimen signatures, of those officers or agents to whom he has given delegated authority to sign official orders on behalf of the Board within their areas of responsibility. **Human Resources** The Chief Operating Officer and Director of Health and Social Care may, after consultation and agreement with Human Resources, amend staffing establishments in respect of the number and grading of posts. In so doing, the ~~Assistant~~ Deputy Director of Finance ~~– Management Accounting~~, must have been consulted, and have confirmed that the cost of the amended establishment can be contained within the relevant limit approved for the current and subsequent financial years. Any amendment must also be in accordance with the policies and arrangements relating to workforce planning, approved by the Board or the Staff Governance Committee. The Chief Operating Officer and Director of Health and Social Care may, in accordance with the Board's agreed Employee Conduct Policy, take disciplinary action in respect of members of staff,

	including dismissal where appropriate. **Patients' Property** The Chief Operating Officer and Director of Health and Social Care shall have overall responsibility for ensuring compliance with legislation in respect of patient's property and that effective and efficient management arrangements are in place.
	3.4 Champion Roles The following roles are filled by Non-Executive Board members. • Public Health Champion • Whistle Blowing Champion • Counter Fraud Services Champion

FRAMEWORK OF GOVERNANCE: SOUTH EAST AND TAYSIDE (SEAT) REGIONAL PLANNING GROUP

1. STATUTORY DUTY

1.1 The National Health Service Reform (Scotland) Act 2004 placed a statutory duty on NHS Boards to co-operate for the benefit of the people of Scotland.

1.2 The Scottish Executive Health Department (SEHD) letter of 13 December 2004 (HDL (2004) 46) entitled "Regional Planning", set out a framework for NHS Boards engagement in the regional planning of health services, in support of the legislation, covering both service and workforce planning.

1.3 There are three Regional Planning Groups within NHS Scotland, which provide structures and mechanisms for taking forward the statutory duty. NHS Fife participates in the South East and Tayside (SEAT) Regional Planning Group, which comprises the following NHS Board areas:-

- NHS Borders;
- NHS Fife;
- NHS Forth Valley;
- NHS Lothian; and
- NHS Tayside.

For the purposes of planning some specific services, NHS Dumfries and Galloway and NHS Highland also participate in SEAT.

1.4 The Framework of Governance: SEAT Regional Planning Group (Appendix A) describes how decisions in SEAT are made and how the Regional Planning Group carries out its functions and is accountable for its performance. The Framework covers the following four areas:-

- Scheme of Delegation;
- Terms of Reference;
- Statement of the Expected Standards of Corporate Governance and Internal Control; and
- Repository of control documents and operating procedures.

1.5 The Framework of Governance does not take precedence over the Board's internal Code of Corporate Governance.

Appendix 5

APPENDIX A

SOUTH EAST AND TAYSIDE (SEAT) REGIONAL PLANNING GROUP

FRAMEWORK OF GOVERNANCE

Introduction

SEAT Regional Planning Group requires to have a framework of governance to describe how decisions will be made when it convenes, and how it will carry out its functions and be accountable for its performance.

This Framework has four key sections:

1. A **Scheme of Delegation**, describing the relationship between SEAT and the member boards, and how boards will delegate authority to SEAT and the individual members, namely the Chief Executives.

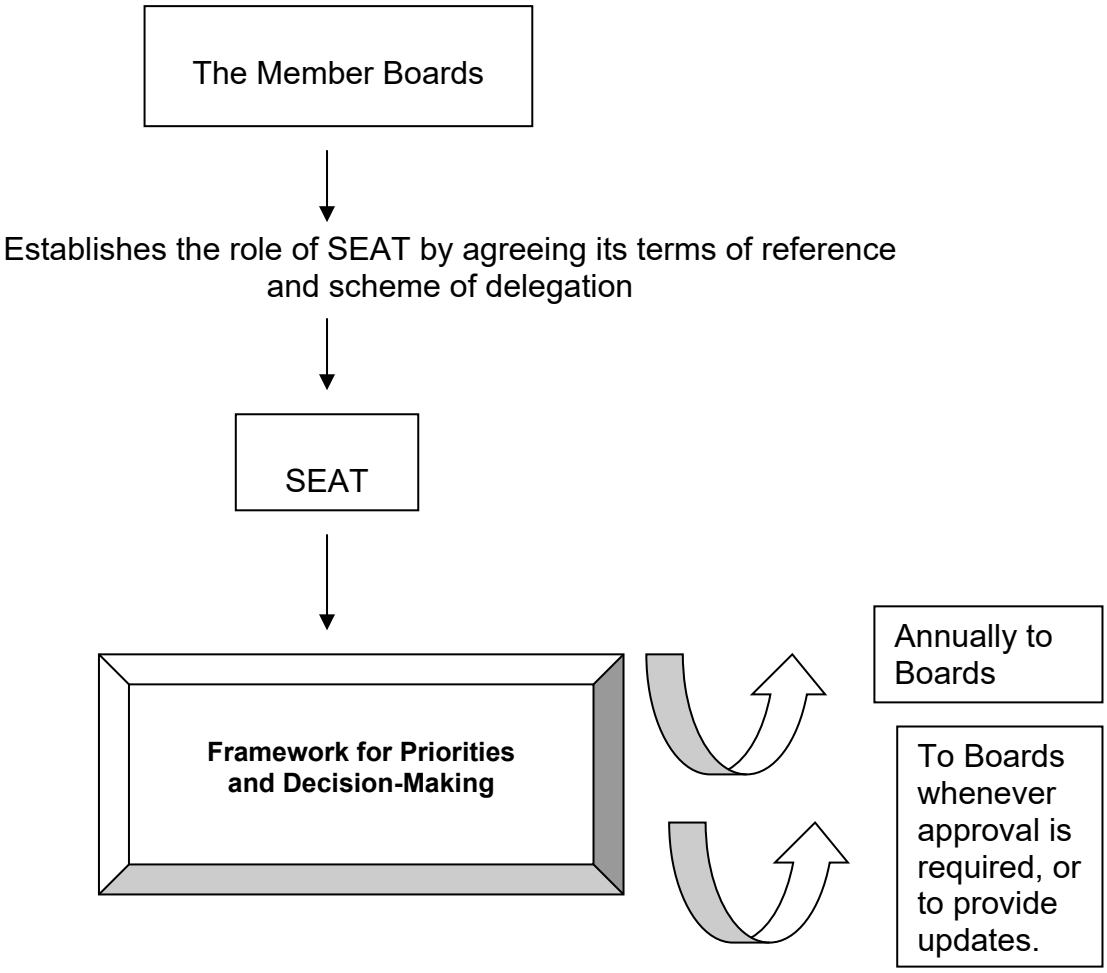
2. A **Terms of Reference**, describing the remit of the group, how it will make decisions, and how the different control elements of regional planning comes together to form the system of governance for SEAT.

3. A **Statement of the Expected Standards of Corporate Governance and Internal Control** that the member boards expect of each other when implementing the work of SEAT.

4. A **repository of control documents and operating procedures** that will be used to implement, monitor and account for the activities of SEAT. These together will form the system of control for SEAT operations. These will be live control documents and will not normally be presented as part of the framework of governance, but should be available upon request.

1. THE SCHEME OF DELEGATION

1.1 – The Overall Process



1.2 – Schedule of Delegated Authority from Member Boards to SEAT

DELEGATE	Description of Agreed Authority/ Responsibilities
SEAT (through the designated Chair of SEAT)	• To take forward the member boards' objectives and responsibilities with regard to regional planning in accordance with HDL (2004) 46; • To operate within its terms of reference; • To develop a work plan for member boards' approval, and implement the Framework for Priorities and Investments (as approved by the member boards).
Chief Executives of Member Boards	• To represent his or her Board at SEAT and act on its behalf; • To operate within the terms of reference of SEAT and to ensure that the board's statutory responsibilities for regional planning are met; • To ensure that this Framework of Governance has been presented and agreed by his or her Board; • To present SEAT documents to his or her Board for approval, as required by this Framework of Governance; • If designated as the lead member of a project within the Framework of Priorities and Decision Making, to lead the delivery of that project with the autonomy normally granted to a Chief Executive if acting entirely within his or her own host board; • To be accountable for the performance of projects assigned to him or her within the Framework of Priorities and Decision Making; • Generally to act in such a way as to deliver the goals of regional planning.
SEAT Project Officers (these are individuals who are identified by SEAT to lead work commissioned by them)	• To operate within the scope of his or her job description and any further delegated authority that may be given by the lead member for the project.

2. TERMS OF REFERENCE OF THE SEAT REGIONAL PLANNING GROUP

2.1 REMIT

2.1.1 The remit of the Group is to assist in the delivery of the following NHS Scotland objectives:

- To plan, fund and implement services across NHS Board boundaries;
- To harness and support the potential of Managed Clinical Networks;
- To develop integrated workforce planning for cross-board services;
- To facilitate the commissioning and monitoring of services which extend beyond NHS Board boundaries, services between members and out with the region on an inter-regional or national basis;
- To harmonise the NHS Board service plans at the regional level;
- To plan emergency response across NHS Board boundaries; and
- To support the delivery of NHS Boards' duty to co-operate for the benefit of the people of Scotland.

2.1.2 The above remit is to be delivered by the Group. However, the member boards remain accountable and responsible for the continued delivery of their statutory duties and general corporate governance requirements.

2.2 OUTCOMES FROM THE SEAT REGIONAL PLANNING GROUP ("THE GROUP")

2.2.1 The Group maintains and works to a Framework for Priorities and Decision-Making. The members must present this to their Boards for approval on an annual basis. This is the SEAT equivalent of the "Annual Regional Planning Agenda" referred to in HDL (2004) 46.

2.2.2 The Framework will include service, workforce, financial and other appropriate planning issues.

2.2.3 It is the responsibility of the member organisations to ensure congruence between their local plans and the Framework.

2.2.4 The Framework will contain all projects that have progressed beyond initial review stage, and require approval from member boards to progress to implementation. This document will also provide an analysis of the progress of projects that have previously been approved by the Boards for implementation, and is therefore key to effective performance management of the Group's agenda.

2.2.5 The Group will prepare an Annual Report of its activities, which will be sent to all members and partner organisations, and will be used as the focus for any public accountability processes. The Annual Report, prepared in accordance with this Framework of Governance, is submitted direct to Member Boards and, therefore, does not need to comply with the Audit Committee schedule and process for the production of Annual Reports.

2.2.6 The Group will support the retained accountability duties of member organisations, by making available any information to those organisations, which will support public reporting and the development of Local Delivery Plans.

2.2.7 The principal form of reporting by the Regional Group to the Board will be through the regular presentation of its minutes to the Board by the Board Chief Executive.

2.3 MEMBERSHIP OF THE SEAT REGIONAL PLANNING GROUP

2.3.1 The executive members of the SEAT Regional Planning Group are the Chief Executives of NHS Borders, NHS Fife, NHS Forth Valley, NHS Lothian and NHS Tayside.

2.3.2 Each member remains personally and legally accountable for their decisions both to their local Board and the Chief Executive of the NHS in Scotland. (This accountability incorporates the duty of regional planning as set out in SE guidance). All of the member Boards must formally recognise and approve the Scheme of Delegation in Section 1 of this Framework of Governance.

2.3.3 Once a decision is reached, each Board is bound by collective responsibility. The minutes of the meeting will reflect the decision of the Group.

2.3.4 The position of Chair of SEAT will rotate every three years as agreed by the executive members.

2.3.5 The Group will invite any other organisation or officers to attend meetings as it sees fit. Those who will be routinely invited to SEAT meetings will be:

- Directors of Planning for the member boards;
- Regional Planning Director;
- Regional Workforce Planning Director;
- Director (National Services Division);
- Representatives of:
  - the Chief Executive (NHS Scotland);
  - the Scottish Ambulance Service;
  - NHS Education Scotland;
  - Dumfries and Galloway NHS Board;
- The Postgraduate Dean for SE Scotland;
- Director of Pay Modernisation (SGHSCD);
- SEAT Workforce Champion; and
- the Lead Representative from each functional group, recognised by SEAT.

2.4 IMPLEMENTING THE WORK PLAN AND THE FRAMEWORK OF PRIORITIES AND DECISION MAKING

2.4.1 SEAT cannot progress any item on the Work Plan or implement any project on the Framework of Priorities and Decision Making without the prior approval of member boards. This would normally be via approval of the Annual Workplan.

2.4.2 Once all member board approvals are in place, SEAT is free to decide how to progress its workload. Each project will have a lead member assigned to it.

2.4.3 Once a member has been given lead responsibility for an item in the Work Plan or Framework of Priorities and Decision Making, he or she has complete authority from SEAT to progress the matter, as if the matter was an issue contained within his or her Board. The lead member will account to the SEAT Regional Planning Group by updating the Framework of Priorities and Decision Making.

2.4.4 All members are required to conduct SEAT business under the same standards of internal control and corporate governance as is generally expected of Chief Executives in NHS Scotland (Section 3). The lead member for a particular SEAT project will be primarily responsible for standards of internal control for activities within the scope of the project, on the understanding that all members have established adequate systems of internal control in their organisations.

2.4.5 For all items in the Framework of Priorities and Decision Making, a Project Agreement will be developed. This will describe the precise scope and objectives of the project, including timescales and accountability arrangements, as well as the associated resources required to deliver the project. This Project Agreement will define the parameters within which the member with lead responsibility for the project can operate.

2.4.6 In the event of the SEAT Regional Planning Group being in disagreement with the aspects of the delivery of the implementation of a project agreement, or if the Group wishes to amend or discontinue an agreed project, then a resolution to overrule the lead member responsible for the project (as stated in the project agreement) or alter the project terms of reference must be approved by the Group. An event of this nature should be reported back to the member boards.

2.5 SCOPE OF ACTIVITY TO BE ADDRESSED BY THE SEAT REGIONAL PLANNING GROUP

2.5.1 The national regional planning framework grants SEAT the authority to act on behalf of its members in the delivery of the following tasks:

- Develop and progress a co-ordinated approach to service delivery for and on behalf of constituent NHS Boards;

- Facilitate commissioning and monitoring of services which extend beyond NHS Board boundaries, services between members and out with the region on an inter-regional or national basis;
- Develop strategic workforce solutions which support service delivery models;
- Commit and monitor resources, within the agreed financial framework, for the purposes for which it was approved;
- Determine commissioning policy for those services within its workplan;
- Agree a prioritisation framework for the regional planning group, reflective of those within individual NHS Boards;
- Commission reviews or other research in order to inform decisions;
- Agree. Monitor and update action plans;
- Develop delivery plans (often in collaboration with other Regional Planning Groups) for highly specialised services;
- Performance manage regional Managed Clinical Networks.
- Establish sub-groups as appropriate.

2.6 EXCEPTIONAL MATTERS

2.6.1 There may exceptionally be decisions that require significant expenditure commitments (or controversial service changes), which would be beyond the scope of delegated authority conventionally awarded to Board Chief Executives. In these exceptional circumstances, the member NHS Boards can delegate the authority to act on their behalf to executive sub-committees of each Board as opposed to their Chief Executive. It would be for the member NHS Boards to determine the membership of this executive subcommittee. The five executive sub-committees would then meet together (as opposed to the five Chief Executives acting on their own delegated authority) to form the Regional Planning Group.

2.6.2 The undertaking of work not previously foreseen in the agreed Work Plan or Framework of Priorities and Decision Making can be classed as an exceptional matter. This may be because the issue relates to a matter that requires an emergency response.

2.6.3 In these exceptional circumstances, the Chair of each executive sub-committee will act on behalf of his or her Board.

2.6.4 The Chair of SEAT has the authority to make decisions in emergency situations on behalf of this group, following consultation with the other members. If the issue falls within the agreed Work Plan or Framework of Priorities and Decision Making, then it can be formally endorsed at the next meeting of the Group. If the issue is not within these documents, then it should be formally endorsed at the next meetings of the member boards.

2.6.5 It is intended that the members of the Regional Planning Groups will work together in order to reach consensus. In the event of a material dispute arising, a meeting will be convened between the Chief Executives and Chairs of the member boards in order to resolve the issue, recognising the back-up arrangements set out in Section 4 of Annex 3 of HDL (2004) 46.

3. THE EXPECTED STANDARDS OF CORPORATE GOVERNANCE AND INTERNAL CONTROL

Introduction

Paragraph 2.4.4 of the SEAT Regional Planning Group's Framework of Governance makes reference to the "standards of internal control and corporate governance as is generally expected of chief executives in NHS Scotland".

The standards of corporate governance and internal control which apply to NHS Boards will apply to the work of SEAT. In the event of a query arising about this, e.g. if wording differs between Boards' governance documents, the Chair for the time being of SEAT shall decide the issue.

Scope of Corporate Governance

Six key subjects make up Corporate Governance for the member boards:-

- **Clinical Governance** – How we deliver our clinical services;
- **Patient Focus and Public Accountability** – How we inform individual patients and involve them and other stakeholders in the manner by which we deliver our clinical services;
- **Staff Governance** – How we engage our employees and their representatives;
- **Financial Governance** – How we manage our financial resources;
- **Research Governance** – How we conduct research and development;
- **Educational Governance** – How we teach and train healthcare professionals.

The principles of corporate governance are covered at slightly greater length in Annex A.

4. REPOSITORY OF CONTROL DOCUMENTS

SEAT has developed standardised templates to implement the above terms of reference. The templates are maintained centrally and made widely available for use. These are then elements of the overall Framework of Governance.

Items included:

- Template for the Work Plan;

- Template for the Framework of Priorities and Decision Making.

These are designed in a way that allows new projects and existing commitments to be presented efficiently, providing high level information to the member boards. They can be used to seek approval of new items, and present updates on progress. The detail will be in the individual Project Agreements.

- Template for the Project Agreement

This is the key control document to be presented to SEAT for approval. This should contain everything you need to know about the project, e.g. SMART objectives, funding requirements, service implications, lead Chief Executive, project staff, monitoring arrangements, etc.

ANNEX A

THE EXPECTED STANDARDS OF CORPORATE GOVERNANCE AND INTERNAL CONTROL

The Principles of Corporate Governance

In the following, the "organisation" is taken to be both the member boards individually and when they come together as the Regional Planning Group. All of the organisation's activities, policies and procedures should be consistent with these principles. In the absence of a specific procedure, employees should comply with the requirements of these principles.

General

1. The organisation will discharge its responsibilities in accordance with the relevant legislative requirements of European Parliament, and the United Kingdom and Scottish Parliaments. The organisation will also comply with any directions or guidance issued by the Scottish Ministers.

2. No person will receive less favourable treatment regardless or individual differences or be disadvantaged by conditions or requirements which cannot be shown to be justifiable.

Clinical Governance

3. The organisation will plan for, and monitor the provision of a range of services consistent with the overall strategy of NHS Scotland, as established by Scottish Ministers.

4. The organisation will provide care in accordance with relevant and nationally recognised standards and with all due care and attention.

5. The organisation will work in partnership with others in the development of healthcare and the general well being of the public.

6. The organisation will provide undergraduate and postgraduate education to the standards required by the relevant funding authorities.

Patient Focus and Public Accountability

7. The organisation will conduct its activities in an open and accountable manner. Its activities and organisational performance will be auditable.

8. The organisation will give patients the knowledge to make it possible for them to become active partners, with professionals, in making informed decisions and choices about their own treatment and care.

9. The organisation will establish mechanisms to inform, engage and consult patients and members of the public to inform its decision making appropriately.

Staff Governance

10. The organisation recognises the important of working in partnership with its staff.

11. The organisation will ensure that its employees are well informed, appropriately trained, involved in decisions that affect them, treated fairly and consistently and provided with a safe working environment.

Financial Governance

12. The organisation will perform its activities within the available financial resources at its disposal.

13. The organisation will conduct its activities in a manner that is cost-effective and demonstrably secures value for money.

Research Governance

14. The organisation will conduct research and development activity in accordance with the Research Governance Framework.

Educational Governance

15. This is taken forward through the applications of principles 1, 2, 6, 9 and 10.

CODE of CONDUCT

for

MEMBERS

of

The NHS Fife Public Board

CODE OF CONDUCT for MEMBERS of the NHS Fife Public Board

CONTENTS

Section 5: Declaration of Interests

General

Interests which Require Declaration

Your Financial Interests

Your Non-Financial Interests

The Financial Interests of Other Persons

The Non-Financial Interests of Other Persons

Making a Declaration

Frequent Declaration of Interests

Dispensations

Section 6: Lobbying and Access to Members of Public Bodies

Introduction

Rules and Guidance

Annexes

Annex 6.1: Sanctions Available to the Standards Commission for Breach of Code

Annex 6.2: Definitions

SECTION 1: INTRODUCTION TO THE CODE OF CONDUCT

1.1 The Scottish public has a high expectation of those who serve on the boards of public bodies and the way in which they should conduct themselves in undertaking their duties. You must meet those expectations by ensuring that your conduct is above reproach.

1.2 The Ethical Standards in Public Life etc. (Scotland) Act 2000, "the Act", provides for Codes of Conduct for local authority councillors and members of relevant public bodies; imposes on councils and relevant public bodies a duty to help their members to comply with the relevant code; and establishes a Standards Commission for Scotland, "The Standards Commission" to oversee the new framework and deal with alleged breaches of the codes.

1.3 The Act requires the Scottish Ministers to lay before Parliament a Code of Conduct for Councillors and a Model Code for Members of Devolved Public Bodies. The Model Code for members was first introduced in 2002 and has now been revised in December 2013 following consultation and the approval of the Scottish Parliament. These revisions will make it consistent with the relevant parts of the Code of Conduct for Councillors, which was revised in 2010 following the approval of the Scottish Parliament.

1.4 As a member of The NHS Fife PUBLIC BOARD, "the Board", it is your responsibility to make sure that you are familiar with, and that your actions comply with, the provisions of this Code of Conduct which has now been made by the Board.

Appointments to the Boards of Public Bodies

1.5 Public bodies in Scotland are required to deliver effective services to meet the needs of an increasingly diverse population. In addition, the Scottish Government's equality outcome on public appointments is to ensure that Ministerial appointments are more diverse than at present**.** In order to meet both of these aims, a board should ideally be drawn from varied backgrounds with a wide spectrum of characteristics, knowledge and experience. It is crucial to the success of public bodies that they attract the best people for the job and therefore it is essential that a board's appointments process should encourage as many suitable people to apply for positions and be free from unnecessary barriers. You should therefore be aware of the varied roles and functions of the public body on which you serve and of wider diversity and equality issues. You should also take steps to familiarise yourself with the appointment process that your board will have agreed with the Scottish Government's Public Appointment Centre of Expertise.

1.6 You should also familiarise yourself with how the public body's policy operates in relation to succession planning, which should ensure public bodies have a strategy to make sure they have the staff in place with the skills, knowledge and experience necessary to fulfil their role economically, efficiently and effectively.

Guidance on the Code of Conduct

1.7 You must observe the rules of conduct contained in this Code. It is your personal responsibility to comply with these and review regularly, and at least annually, your personal circumstances with this in mind, particularly when your circumstances change. You must not at any time advocate or encourage any action contrary to the Code of Conduct.

1.8 The Code has been developed in line with the key principles listed in Section 2 and provides additional information on how the principles should be interpreted and applied in practice. The Standards Commission may also issue guidance. No Code can provide for all circumstances and if you are uncertain about how the rules apply, you should seek advice from the public body. You may also choose to consult your own legal advisers and, on detailed financial and commercial matters, seek advice from other relevant professionals.

1.9 You should familiarise yourself with the Scottish Government publication "On Board – a guide for board members of public bodies in Scotland". This publication will provide you with information to help you in your role as a member of a public body in Scotland and can be viewed on the Scottish Government website.

Enforcement

1.10 Part 2 of the Ethical Standards in Public Life etc. (Scotland) Act 2000 sets out the provisions for dealing with alleged breaches of this Code of Conduct and where appropriate the sanctions that will be applied if the Standards Commission finds that there has been a breach of the Code. Those sanctions are outlined in **Annex 6.1**.

SECTION 2: KEY PRINCIPLES OF THE CODE OF CONDUCT

2.1 The general principles upon which this Code is based should be used for guidance and interpretation only. These general principles are:

Duty
You have a duty to uphold the law and act in accordance with the law and the public trust placed in you. You have a duty to act in the interests of the public body of which you are a member and in accordance with the core functions and duties of that body.

Selflessness
You have a duty to take decisions solely in terms of public interest. You must not act in order to gain financial or other material benefit for yourself, family or friends.

Integrity
You must not place yourself under any financial, or other, obligation to any individual or organisation that might reasonably be thought to influence you in the performance of your duties.

Objectivity
You must make decisions solely on merit and in a way that is consistent with the functions of the public body when carrying out public business including making appointments, awarding contracts or recommending individuals for rewards and benefits.

Accountability and Stewardship
You are accountable for your decisions and actions to the public. You have a duty to consider issues on their merits, taking account of the views of others and must ensure that the public body uses its resources prudently and in accordance with the law.

Openness
You have a duty to be as open as possible about your decisions and actions, giving reasons for your decisions and restricting information only when the wider public interest clearly demands.

Honesty
You have a duty to act honestly. You must declare any private interests relating to your public duties and take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership
You have a duty to promote and support these principles by leadership and example, and to maintain and strengthen the public's trust and confidence in the integrity of the public body and its members in conducting public business.

Respect
You must respect fellow members of your public body and employees of the body and the role they play, treating them with courtesy at all times. Similarly you must respect members of the public when performing duties as a member of your public body.

2.2 You should apply the principles of this Code to your dealings with fellow members of the public body, its employees and other stakeholders. Similarly you should also observe the principles of this Code in dealings with the public when performing duties as a member of the public body.

SECTION 3: GENERAL CONDUCT

3.1 The rules of good conduct in this section must be observed in all situations where you act as a member of the public body.

Conduct at Meetings

3.2 You must respect the chair, your colleagues and employees of the public body in meetings. You must comply with rulings from the chair in the conduct of the business of these meetings.

Relationship with Board Members and Employees of the Public Body (including those employed by contractors providing services)

3.3 You will treat your fellow board members and any staff employed by the body with courtesy and respect. It is expected that fellow board members and employees will show you the same consideration in return. It is good practice for employers to provide examples of what is unacceptable behaviour in their organisation. Public bodies should promote a safe, healthy and fair working environment for all. As a board member you should be familiar with the policies of the public body in relation to bullying and harassment in the workplace and also lead by exemplar behaviour.

Remuneration, Allowances and Expenses

3.4 You must comply with any rules of the public body regarding remuneration, allowances and expenses.

Gifts and Hospitality

3.5 You must not accept any offer by way of gift or hospitality which could give rise to real or substantive personal gain or a reasonable suspicion of influence on your part to show favour, or disadvantage, to any individual or organisation. You should also consider whether there may be any reasonable perception that any gift received by your spouse or cohabitee or by any company in which you have a controlling interest, or by a partnership of which you are a partner, can or would influence your judgement. The term “gift” includes benefits such as relief from indebtedness, loan concessions or provision of services at a cost below that generally charged to members of the public.

3.6 You must never ask for gifts or hospitality.

3.7 You are personally responsible for all decisions connected with the offer or acceptance of gifts or hospitality offered to you and for avoiding the risk of damage to public confidence in your public body. As a general guide, it is usually appropriate to refuse offers except:

(a) isolated gifts of a trivial character, the value of which must not exceed £50;
(b) normal hospitality associated with your duties and which would reasonably be regarded as appropriate; or
(c) gifts received on behalf of the public body.

3.8 You must not accept any offer of a gift or hospitality from any individual or organisation which stands to gain or benefit from a decision your body may be involved in determining, or who is seeking to do business with your organisation, and which a person might reasonably consider could have a bearing on your judgement. If you are making a visit in your capacity as a member of your public body then, as a general rule, you should ensure that your body pays for the cost of the visit.

3.9 You must not accept repeated hospitality or repeated gifts from the same source.

3.10 Members of devolved public bodies should familiarise themselves with the terms of the Bribery Act 2010 which provides for offences of bribing another person and offences relating to being bribed.

Confidentiality Requirements

3.11 There may be times when you will be required to treat discussions, documents or other information relating to the work of the body in a confidential manner. You will often receive information of a private nature which is not yet public, or which perhaps would not be intended to be public. You must always respect the confidential nature of such information and comply with the requirement to keep such information private.

3.12 It is unacceptable to disclose any information to which you have privileged access, for example derived from a confidential document, either orally or in writing. In the case of other documents and information, you are requested to exercise your judgement as to what should or should not be made available to outside bodies or individuals. In any event, such information should never be used for the purposes of personal or financial gain or for political purposes or used in such a way as to bring the public body into disrepute.

Use of Public Body Facilities

3.13 Members of public bodies must not misuse facilities, equipment, stationery, telephony, computer, information technology equipment and services, or use them for party political or campaigning activities. Use of such equipment and services etc. must be in accordance with the public body's policy and rules on their usage. Care must also be exercised when using social media networks not to compromise your position as a member of the public body.

Appointment to Partner Organisations

3.14 You may be appointed, or nominated by your public body, as a member of another body or organisation. If so, you are bound by the rules of conduct of these organisations and should observe the rules of this Code in carrying out the duties of that body.

3.15 Members who become directors of companies as nominees of their public body will assume personal responsibilities under the Companies Acts. It is possible that conflicts of interest can arise for such members between the company and the public body. It is your responsibility to take advice on your responsibilities to the public body and to the company. This will include questions of declarations of interest.

SECTION 4: REGISTRATION OF INTERESTS

4.1 The following paragraphs set out the kinds of interests, financial and otherwise which you have to register. These are called "Registerable

Interests". You must, at all times, ensure that these interests are registered, when you are appointed and whenever your circumstances change in such a way as to require change or an addition to your entry in the body's Register. It is your duty to ensure any changes in circumstances are reported within one month of them changing.

4.2 The Regulations[1] as amended describe the detail and timescale for registering interests. It is your personal responsibility to comply with these regulations and you should review regularly and at least once a year your personal circumstances. **Annex 6.2** contains key definitions and explanatory notes to help you decide what is required when registering your interests under any particular category. The interests which require to be registered are those set out in the following paragraphs and relate to you. It is not necessary to register the interests of your spouse or cohabitee.

Category One: Remuneration

4.3 You have a Registerable Interest where you receive remuneration by virtue of being:

- employed;
- self-employed;
- the holder of an office;
- a director of an undertaking;
- a partner in a firm; or
- undertaking a trade, profession or vocation or any other work.

4.4 In relation to 4.3 above, the amount of remuneration does not require to be registered and remuneration received as a member does not have to be registered.

4.5 If a position is not remunerated it does not need to be registered under this category. However, unremunerated directorships may need to be registered under category two, "Related Undertakings".

4.6 If you receive any allowances in relation to membership of any organisation, the fact that you receive such an allowance must be registered.

4.7 When registering employment, you must give the name of the employer, the nature of its business, and the nature of the post held in the organisation.

4.8 When registering self-employment, you must provide the name and give details of the nature of the business. When registering an interest in a partnership, you must give the name of the partnership and the nature of its business.

4.9 Where you undertake a trade, profession or vocation, or any other work, the detail to be given is the nature of the work and its regularity. For example, if

[1] SSI - The Ethical Standards in Public Life etc. (Scotland) Act 2000 (Register of Interests) Regulations 2003 Number 135, as amended.

you write for a newspaper, you must give the name of the publication, and the frequency of articles for which you are paid.

4.10 When registering a directorship, it is necessary to provide the registered name of the undertaking in which the directorship is held and the nature of its business.

4.11 Registration of a pension is not required as this falls outside the scope of the category.

Category Two: Related Undertakings

4.12 You must register any directorships held which are themselves not remunerated but where the company (or other undertaking) in question is a subsidiary of, or a parent of, a company (or other undertaking) in which you hold a remunerated directorship.

4.13 You must register the name of the subsidiary or parent company or other undertaking and the nature of its business, and its relationship to the company or other undertaking in which you are a director and from which you receive remuneration.

4.14 The situations to which the above paragraphs apply are as follows:

- you are a director of a board of an undertaking and receive remuneration declared under category one – and
- you are a director of a parent or subsidiary undertaking but do not receive remuneration in that capacity.

Category Three: Contracts

4.15 You have a registerable interest where you (or a firm in which you are a partner, or an undertaking in which you are a director or in which you have shares of a value as described in paragraph 4.19 below) have made a contract with the public body of which you are a member:

(i) under which goods or services are to be provided, or works are to be executed; and
(ii) which has not been fully discharged.

4.16 You must register a description of the contract, including its duration, but excluding the consideration.

Category Four: Houses, Land and Buildings

4.17 You have a registerable interest where you own or have any other right or interest in houses, land and buildings, which may be significant to, of relevance to, or bear upon, the work and operation of the body to which you are appointed.

4.18 The test to be applied when considering appropriateness of registration is to ask whether a member of the public acting reasonably might consider any interests in houses, land and buildings could potentially affect your responsibilities to the organisation to which you are appointed and to the public, or could influence your actions, speeches or decision making.

Category Five: Interest in Shares and Securities

4.19 You have a registerable interest where you have an interest in shares comprised in the share capital of a company or other body which may be significant to, of relevance to, or bear upon, the work and operation of (a) the body to which you are appointed and (b) the **nominal value** of the shares is:

(i) greater than 1% of the issued share capital of the company or other body; or
(ii) greater than £25,000.

Where you are required to register the interest, you should provide the registered name of the company in which you hold shares; the amount or value of the shares does not have to be registered.

Category Six: Gifts and Hospitality

4.20 You must register the details of any gifts or hospitality received within your current term of office. This record will be available for public inspection. It is not however necessary to record any gifts or hospitality as described in paragraph 3.7 (a) to (c) of this Model Code.

Category Seven: Non–Financial Interests

4.21 You may also have a registerable interest if you have non-financial interests which may be significant to, of relevance to, or bear upon, the work and operation of the body to which you are appointed. It is important that relevant interests such as membership or holding office in other public bodies, clubs, societies and organisations such as trades unions and voluntary organisations, are registered and described.

4.22 In the context of non-financial interests, the test to be applied when considering appropriateness of registration is to ask whether a member of the public might reasonably think that any non-financial interest could potentially affect your responsibilities to the organisation to which you are appointed and to the public, or could influence your actions, speeches or decision-making.

SECTION 5: DECLARATION OF INTERESTS

General

5.1 The key principles of the Code, especially those in relation to integrity, honesty and openness, are given further practical effect by the requirement for you to declare certain interests in proceedings of the public body. Together

with the rules on registration of interests, this ensures transparency of your interests which might influence, or be thought to influence, your actions.

5.2 Public bodies inevitably have dealings with a wide variety of organisations and individuals and this Code indicates the circumstances in which a business or personal interest must be declared. Public confidence in the public body and its members depends on it being clearly understood that decisions are taken in the public interest and not for any other reason.

5.3 In considering whether to make a declaration in any proceedings, you must consider not only whether you will be influenced but whether anybody else would think that you might be influenced by the interest. You must, however, always comply with the **objective test** ("the objective test") which is whether a member of the public, with knowledge of the relevant facts, would reasonably regard the interest as so significant that it is likely to prejudice your discussion or decision making in your role as a member of a public body.

5.4 If you feel that, in the context of the matter being considered, your involvement is neither capable of being viewed as more significant than that of an ordinary member of the public, nor likely to be perceived by the public as wrong, you may continue to attend the meeting and participate in both discussion and voting. The relevant interest must however be declared. It is your responsibility to judge whether an interest is sufficiently relevant to particular proceedings to require a declaration and you are advised to err on the side of caution. If a board member is unsure as to whether a conflict of interest exits, they should seek advice from the board chair.

5.5 As a member of a public body you might serve on other bodies. In relation to service on the boards and management committees of limited liability companies, public bodies, societies and other organisations, you must decide, in the particular circumstances surrounding any matter, whether to declare an interest. Only if you believe that, in the particular circumstances, the nature of the interest is so remote or without significance, should it not be declared. You must always remember the public interest points towards transparency and, in particular, a possible divergence of interest between your public body and another body. Keep particularly in mind the advice in paragraph 3.15 of this Model Code about your legal responsibilities to any limited company of which you are a director.

Interests which Require Declaration

5.6 Interests which require to be declared if known to you may be financial or non-financial. They may or may not cover interests which are registerable under the terms of this Code. Most of the interests to be declared will be your personal interests but, on occasion, you will have to consider whether the interests of other persons require you to make a declaration. The paragraphs which follow deal with (a) your financial interests (b) your non-financial interests and (c) the interests, financial and non-financial, of other persons.

5.7 You will also have other private and personal interests and may serve, or be associated with, bodies, societies and organisations as a result of your private

and personal interests and not because of your role as a member of a public body. In the context of any particular matter you will need to decide whether to declare an interest. You should declare an interest unless you believe that, in the particular circumstances, the interest is too remote or without significance. In reaching a view on whether the objective test applies to the interest, you should consider whether your interest (whether taking the form of association or the holding of office) would be seen by a member of the public acting reasonably in a different light because it is the interest of a person who is a member of a public body as opposed to the interest of an ordinary member of the public.

Your Financial Interests

5.8 You must declare, if it is known to you, any financial interest (including any financial interest which is registerable under any of the categories prescribed in Section 4 of this Code). If, under category one (or category seven in respect of non-financial interests) of section 4 of this Code, you have registered an interest

(a) as an employee of the Board; or
(b) as a Councillor or a Member of another Devolved Public Body where the Council or other Devolved Public Body, as the case may be, has nominated or appointed you as a Member of the Board;

you do not, for that reason alone, have to declare that interest.

There is no need to declare an interest which is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

You must withdraw from the meeting room until discussion of the relevant item where you have a declarable interest is concluded. There is no need to withdraw in the case of an interest which is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

Your Non-Financial Interests

5.9 You must declare, if it is known to you, any non-financial interest if:

(i) that interest has been registered under category seven (Non- Financial Interests) of Section 4 of the Code; or
(ii) that interest would fall within the terms of the objective test.

There is no need to declare an interest which is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

You must withdraw from the meeting room until discussion of the relevant item where you have a declarable interest is concluded. There is no need to withdraw in the case of an interest which is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

The Financial Interests of Other Persons

5.10 The Code requires only your financial interests to be registered. You also, however, have to consider whether you should declare any financial interest of certain other persons.

You must declare if it is known to you any financial interest of:-

(i) a spouse, a civil partner or a co-habitee;
(ii) a close relative, close friend or close associate;
(iii) an employer or a partner in a firm;
(iv) a body (or subsidiary or parent of a body) of which you are a remunerated member or director;
(iv) a person from whom you have received a registerable gift or registerable hospitality;
(v) a person from whom you have received registerable expenses.

There is no need to declare an interest if it is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

You must withdraw from the meeting room until discussion of and voting on the relevant item where you have a declarable interest is concluded. There is no need to withdraw in the case of an interest which is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

5.11 This Code does not attempt the task of defining “relative” or “friend” or “associate”. Not only is such a task fraught with difficulty but is also unlikely that such definitions would reflect the intention of this part of the Code. The key principle is the need for transparency in regard to any interest which might (regardless of the precise description of relationship) be objectively regarded by a member of the public, acting reasonably, as potentially affecting your responsibilities as a member of the public body and, as such, would be covered by the objective test.

The Non-Financial Interests of Other Persons

5.12 You must declare if it is known to you any non-financial interest of:-

(i) a spouse, a civil partner or a co-habitee;
(ii) a close relative, close friend or close associate;
(iii) an employer or a partner in a firm;
(iv) a body (or subsidiary or parent of a body) of which you are a remunerated member or director;
(v) a person from whom you have received a registerable gift or registerable hospitality;
(vi) a person from whom you have received registerable election expenses.

There is no need to declare the interest if it is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

There is only a need to withdraw from the meeting if the interest is clear and substantial.

Making a Declaration

5.13 You must consider at the earliest stage possible whether you have an interest to declare in relation to any matter which is to be considered. You should consider whether agendas for meetings raise any issue of declaration of interest. Your declaration of interest must be made as soon as practicable at a meeting where that interest arises. If you do identify the need for a declaration of interest only when a particular matter is being discussed you must declare the interest as soon as you realise it is necessary.

5.14 The oral statement of declaration of interest should identify the item or items of business to which it relates. The statement should begin with the words "I declare an interest". The statement must be sufficiently informative to enable those at the meeting to understand the nature of your interest but need not give a detailed description of the interest.

Frequent Declarations of Interest

5.15 Public confidence in a public body is damaged by perception that decisions taken by that body are substantially influenced by factors other than the public interest. If you would have to declare interests frequently at meetings in respect of your role as a board member you should not accept a role or appointment with that attendant consequence. If members are frequently declaring interests at meetings then they should consider whether they can carry out their role effectively and discuss with their chair. Similarly, if any appointment or nomination to another body would give rise to objective concern because of your existing personal involvement or affiliations, you should not accept the appointment or nomination.

Dispensations

5.16 In some very limited circumstances dispensations can be granted by the Standards Commission in relation to the existence of financial and non-financial interests which would otherwise prohibit you from taking part and voting on matters coming before your public body and its committees.

5.17 Applications for dispensations will be considered by the Standards Commission and should be made as soon as possible in order to allow proper consideration of the application in advance of meetings where dispensation is sought. You should not take part in the consideration of the matter in question until the application has been granted.

SECTION 6: LOBBYING AND ACCESS TO MEMBERS OF PUBLIC BODIES

Introduction

6.1 In order for the public body to fulfil its commitment to being open and accessible, it needs to encourage participation by organisations and individuals in the decision-making process. Clearly however, the desire to involve the public and other interest groups in the decision-making process must take account of the need to ensure transparency and probity in the way in which the public body conducts its business.

6.2 You will need to be able to consider evidence and arguments advanced by a wide range of organisations and individuals in order to perform your duties effectively. Some of these organisations and individuals will make their views known directly to individual members. The rules in this Code set out how you should conduct yourself in your contacts with those who would seek to influence you. They are designed to encourage proper interaction between members of public bodies, those they represent and interest groups.

Rules and Guidance

6.3 You must not, in relation to contact with any person or organisation that lobbies do anything which contravenes this Code or any other relevant rule of the public body or any statutory provision.

6.4 You must not, in relation to contact with any person or organisation who lobbies, act in any way which could bring discredit upon the public body.

6.5 The public must be assured that no person or organisation will gain better access to or treatment by, you as a result of employing a company or individual to lobby on a fee basis on their behalf. You must not, therefore, offer or accord any preferential access or treatment to those lobbying on a fee basis on behalf of clients compared with that which you accord any other person or organisation who lobbies or approaches you. Nor should those lobbying on a fee basis on behalf of clients be given to understand that preferential access or treatment, compared to that accorded to any other person or organisation, might be forthcoming from another member of the public body.

6.6 Before taking any action as a result of being lobbied, you should seek to satisfy yourself about the identity of the person or organisation that is lobbying and the motive for lobbying. You may choose to act in response to a person or organisation lobbying on a fee basis on behalf of clients but it is important that you know the basis on which you are being lobbied in order to ensure that any action taken in connection with the lobbyist complies with the standards set out in this Code.

6.7 You should not accept any paid work:-

(a) which would involve you lobbying on behalf of any person or organisation or any clients of a person or organisation.

(b) to provide services as a strategist, adviser or consultant, for example, advising on how to influence the public body and its members. This does not prohibit you from being remunerated for activity which may arise because of, or relate to, membership of the public body, such as journalism or broadcasting, or involvement in representative or presentational work, such as participation in delegations, conferences or other events.

6.8 If you have concerns about the approach or methods used by any person or organisation in their contacts with you, you must seek the guidance of the public body.

ANNEX 6.1

SANCTIONS AVAILABLE TO THE STANDARDS COMMISSION FOR BREACH OF THE CODE

(a) Censure – the Commission may reprimand the member but otherwise take no action against them;

(b) Suspension – of the member for a maximum period of one year from attending one or more, but not all, of the following:

i) all meetings of the public body;
ii) all meetings of one or more committees or sub-committees of the public body;
(iii) all meetings of any other public body on which that member is a representative or nominee of the public body of which they are a member.

(c) Suspension – for a period not exceeding one year, of the member's entitlement to attend all of the meetings referred to in (b) above;

(d) Disqualification – removing the member from membership of that public body for a period of no more than five years.

Where a member has been suspended, the Standards Commission may direct that any remuneration or allowance received from membership of that public body be reduced, or not paid.

Where the Standards Commission disqualifies a member of a public body, it may go on to impose the following further sanctions:

(a) Where the member of a public body is also a councillor, the Standards Commission may disqualify that member (for a period of no more than five years) from being nominated for election as, or from being elected, a councillor. Disqualification of a councillor has the effect of disqualifying that member from their public body and terminating membership of any committee, sub-committee, joint committee, joint board or any other body on which that member sits as a representative of their local authority.

(b) Direct that the member be removed from membership, and disqualified in respect of membership, of any other devolved public body (provided the members' code applicable to that body is then in force) and may disqualify that person from office as the Water Industry Commissioner.

In some cases the Standards Commission do not have the legislative powers to deal with sanctions, for example if the respondent is an executive member of the board or appointed by the Queen. Sections 23 and 24 of the Ethical Standards in Public Life etc. (Scotland) Act 2000 refer.

Full details of the sanctions are set out in Section 19 of the Act.

ANNEX 6.2

DEFINITIONS

"Chair" includes Board Convener or any person discharging similar functions under alternative decision making structures.

"Code" code of conduct for members of devolved public bodies

"Cohabitee" includes a person, whether of the opposite sex or not, who is living with you in a relationship similar to that of husband and wife.

"Group of companies" has the same meaning as "group" in section 262(1) of the Companies Act 1985. A "group", within s262 (1) of the Companies Act 1985, means a parent undertaking and its subsidiary undertakings.

"Parent Undertaking" is an undertaking in relation to another undertaking, a subsidiary undertaking, if a) it holds a majority of the rights in the undertaking; or b) it is a member of the undertaking and has the right to appoint or remove a majority of its board of directors; or c) it has the right to exercise a dominant influence over the undertaking (i) by virtue of provisions contained in the undertaking's memorandum or articles or (ii) by virtue of a control contract; or d) it is a councillor of the undertaking and controls alone, pursuant to an agreement with other shareholders or councillors, a majority of the rights in the undertaking**.**

"A person" means a single individual or legal person and includes a group of companies.

"Any person" includes individuals, incorporated and unincorporated bodies, trade unions, charities and voluntary organisations.

"**Public body"** means a devolved public body listed in Schedule 3 of the Ethical Standards in Public Life etc. (Scotland) Act 2000, as amended.

"Related Undertaking" is a parent or subsidiary company of a principal undertaking of which you are also a director. You will receive remuneration for the principal undertaking though you will not receive remuneration as director of the related undertaking.

“Remuneration” includes any salary, wage, share of profits, fee, expenses, other monetary benefit or benefit in kind. This would include, for example, the provision of a company car or travelling expenses by an employer.

“Spouse” does not include a former spouse or a spouse who is living separately and apart from you.

“Undertaking” means:
a) a body corporate or partnership; or
b) an unincorporated association carrying on a trade or business, with or without a view to a profit.

DATE OF MEETING:	16 May 2019
TITLE OF REPORT:	Internal Audit Progress Report and Summary of Reports (Item 11)
EXECUTIVE LEAD:	Tony Gaskin, Chief Internal Auditor
REPORTING OFFICER:	Barry Hudson, Regional Audit Manager

Purpose of the Report (delete as appropriate)		
		For Assurance

SBAR REPORT

Situation and Background

The aim of this paper is to brief the Audit and Risk Committee on the audits completed since the last meeting and provide an update on progress towards the completion of the audit 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 2018/19 plan under the supervision of the Chief Internal Auditor. Audit work is planned to allow the Chief Internal Auditor to provide the necessary assurances prior to the signing of the Board's annual accounts.

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

Assessment

Progress Report

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

As of 3 May 2019 actual input against the 2018/19 NHS Fife plan stood at 356 days (75%) of the updated planned audit input of 473 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.

Over the previous five years of the strategic plan the number of carried forward days has been significant. The accumulated carry forward to the 2018/19 audit year was 120 days. Whilst client response to audits has improved

and we are now fully staffed, some audits will not be reported by year-end. Fieldwork on these audits will be substantially complete by the end of June, with the exception of those that will be risk assessed for potential inclusion in the 2019/20 internal audit plan. Having recognised that circumstances and risk have evolved since the 2018/19 plan was approved; and in line with best practice recognised by Public Sector Internal Auditors, this position has been strategically addressed by the FTF Partnership Board who concluded that:

- Across FTF, any 2018/19 audits not yet started will not automatically be carried forward. Instead, they will be risk assessed for inclusion within the 2019/20 internal audit plan;
- Adequate time will be included within the 2019/20 plan to enable Internal Audit to complete 2018/19 audits currently in progress.

This will enable the internal audit service to start the 2019/20 work with a realistic and achievable audit plan based on current risks, against which progress will be reported through our KPIs, which will now be reported to each Audit and Risk Committee meeting.

We can assure the Audit and Risk Committee that work completed will be sufficient to allow the Chief Internal Auditor to provide robust assurance to the Audit and Risk Committee within his Annual Internal Audit Report.

Improvement Activities

FTF's service to NHS Fife and NHS Forth Valley was subject to External Quality Assessment (EQA) by Midlothian Council on behalf of the Scottish Local Authorities Chief Internal Auditors' Group. Actions from the report are monitored by the FTF Partnership Board who will provide assurance at year-end to be included in our Annual Internal Audit Report.

In response to the EQA recommendations and to ensure key messages are effectively communicated and actioned, we have introduced a new style of progress report. In addition, all audit reports issued from May 2019 onwards will be in an improved, more visual format, with revised opinion definitions and risk assessments for each audit finding and recommendation. We will continue to review our progress and audit report formats and seek feedback from clients to ensure that they effectively communicate key findings, assurances and risks.

We also introduced a new format for our Internal Control Evaluation which received a positive response and will similarly be revising our Annual Internal Audit Report.

Recommendation

The Audit and Risk Committee is asked to:

I. Note the ongoing delivery of the 2018/19 NHS Fife internal audit plan.
II. Note the audits identified for risk assessment and considered for inclusion in the 2019/20 internal audit plan.
III. Provide feedback on the format of this report and, going forward, on the full Internal Audit reports available to Audit and Risk Committee members

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 1 May 2019.

Internal Audit Activity up to 3 May 2019

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 14 March 2019. Each review completed has been categorised within one of the five strands of corporate governance. A summary of each report is included for information within the 'Summary of Audit findings' section.

Audit 2017/18	Opinion on Assurance	Recommendations	Draft issued	Finalised
Audit Process				
B02/19 – Audit Management and Liaison with Directors	N/A	N/A	N/A	Year end position
B03/19 – Liaison with External Auditors	N/A	N/A	N/A	Year end position
B04/19 – Audit Committee	N/A	N/A	N/A	Year end position
B05/19 – Clearance of Prior Year	N/A	N/A	N/A	Year end position

Audit 2018/19	Opinion on Assurance	Recommendations	Draft issued	Finalised
Clinical Governance				
B16/19 - Adverse Event Management	B	One Priority 2	27 Feb 2019	14 March 2019
Financial Governance				
B22/19 – Losses and Compensations	B	Six Priority 3	6 March 2019	11 April 2019

NHS Fife Draft Reports Issued

Audit 2018/19	Draft issued
B01/19 Annual Audit Planning	8 May 2019
B15/18 – Strategic Planning	7 March 2019
B33/19 - Endowments	17 April 2019

NHS Fife Work in Progress and Planned:

Audit 2018/19 and 2019/20		Status (In progress/ planning)	Target Audit Committee
B06/20	Annual Internal Audit Report	In progress	June 2019
B11/19	Staff and Patient Environment	In progress – draft report to be issued by 24 May.	Sept 2019
B23/19	Savings Programme	In Progress – draft report to be issued by 31 May.	Sept 2019
B24/19	Financial Planning	In Progress - draft report to be issued by 31 May.	Sept 2019
B25/19	Financial Management	Planning - draft report to be issued by 31 May.	Sept 2019
B29/19	Service Contract Expenditure	In Progress	Sept 2019
B31/19	Information Assurance and Security	In Progress	Sept 2019
B32/19	eHealth Strategic Planning and Governance	In Progress	Sept 2019

Amendments to Internal Audit Plan 2018/19

B19/19 – Risk Management

This audit was planned as a detailed review of the Risk Management Framework and risk management processes. Revision of the Framework is ongoing and this internal audit review will now be undertaken in the 2019/20 Internal Audit Plan, as agreed with the Director of Finance.

B14/19 - Organisational Performance Management

Following meetings with the Associate Director of Planning and Performance, we were made aware that changes and improvements to organisational performance management were in progress, and this was also raised at the Audit planning meeting with the Chair of the Performance, Financial and Performance Committee, with the suggestion that an audit review would be beneficial to NHS Fife later in 2019/20. The removal of this review has been agreed with the Director of Finance.

Outstanding audits from the 2018/19 annual plan, where audit work has not commenced, will be risk assessed for potential inclusion in the 2019/20 internal audit plan. The rationale and reasons are contained within the draft Internal Audit Strategic and Annual Plan. These audits are detailed below:

Audit 2018/19	Planned days
B35/19 Departmental Review - Estates	20
B17/19 Infection Control	12
B20/19 Medicine Management	15
B21/19 Capable and Effective Workforce	30
B26/19 Property Management Strategy	14

Year End Reports

B02/19 – Audit Management and Liaison

Meetings were held with the Directors to discuss audit issues throughout the year.

B03/19 - Liaison with External Auditors

Ongoing liaison and sharing of audit reports with Audit Scotland.

B04/19 - Audit Committee

Attendance at each Audit and Risk Committee including preparation of required papers.

B05/19 - Clearance of Prior Year

Time spent to clear outstanding reports from the previous year's audit plan.

Summary of Audit Findings

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

B16/19 Adverse Event Management

Audit Opinion – B (Broadly Satisfactory)

Link to strategic / operational risk – The audit considered the adverse events management and Duty of Candour aspects of Risk ID 1416 (current Risk Rating - High, Probability - Possible), which is being monitored under the strategic objective relating to Quality and Safety within the Board Assurance Framework. It specifies that:

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

Executive Summary & Agreed Management Action:

Organisational Procedures for Dealing with Adverse Events

NHS Fife has organisational procedures in place to deal with adverse events in accordance with Health Improvement Scotland (HIS) guidance, 'Learning from adverse events through reporting and review – A national framework for Scotland, July 2018'. These include:

◊ a formal procedure - GP/I9 – Adverse Events Policy;

◊ the DATIX incident reporting system coding being configured to enable more accurate, reliable and consistent reporting, review and monitoring of adverse events; and

◊ staff training being available in a number of different formats to meet individual needs.

The application of the organisational procedures for dealing with adverse events is monitored on an ongoing basis by divisional management and reported within their individual monthly Performance Reports.

Adverse Event Reviews

The number and type of adverse events are reported in the Quality Report submitted to each meeting of the Clinical Governance Committee (CGC). The January 2019 Quality Report highlighted that for the 12 months to October 2018 there were 696 (4.3%) events classified as major or extreme

out of a total of 16,006 adverse events. Key performance indicators detailing compliance with timescales for investigating and processing major and extreme adverse events, as detailed in the GP/19 – Adverse Events Policy, are not reported within the Quality Report. Management are currently reviewing this position to consider what measures can be adopted and appropriate actions will be created.

Lessons Learnt from Adverse Events

Learning from adverse events forms part of the procedures within the GP/I9 Adverse Events Policy, which stipulates the groups with whom reports and learning summaries on adverse events are to be shared, to ensure lessons learnt are appropriately communicated to relevant staff. Following a recent review of information sharing at the November 2018 Adverse Events Group / Duty of Candour (AEG/ DoC) meeting, this stipulation has been extended to include additional steering groups for wider consideration of individual adverse events.

Duty of Candour

Arrangements to implement the legal requirement for organisational Duty of Candour provisions required by the Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill have been put in place by NHS Fife. Significant progress has been made, with the AEG/ DoC Group as the oversight group and regular updates are being provided to the Clinical Governance Committee. This Internal Audit review concluded that the actions taken to revise NHS Fife's procedures for dealing with adverse events are in accordance with Scottish Government guidance. Steps are being taken to incorporate Duty of Candour reporting into the adverse events reporting process and the most appropriate key performance indicators to include have still to be decided.

At the time this audit was completed, and as reported to the December 2018 AEG/ DoC meeting, there were 14 instances during 2018/19 where Duty of Candour applied. It was reported to the December 2018 AEG meeting that the Clinical Governance team is at the preliminary stages of implementing the new procedures, with due diligence checks still being completed to confirm the accuracy of the data. The Executive Directors Group is being kept informed of all such instances. Using the current data will inform changes to existing procedures to ensure compliance with HIS guidance in the future.

Agreed management actions from this review were:

- Work has commenced to report to the Adverse Events/ Duty of Candour Group against key measures outlined in the Policy GP/I9;
- The Adverse Events/ Duty of Candour Group will consider this issue and will discuss the information to be included in the Quality Report for CGC.

B22/19 – Losses and Compensations

Audit Opinion – B (Broadly Satisfactory)

Link to strategic / operational risk – The strategic risk – Financial Sustainability, is relevant to this review:

'There is a risk that failure to implement, monitor and review an effective financial planning, management and performance framework will result in the Board not being able to deliver on its required financial targets.'

- ✧ Losses may not be reported, recorded or authorised in line with policies and procedure
- ✧ Failure to monitor and investigate the cause of losses and instigate proportionate remedial action could result in further loss.

Executive Summary & Agreed Management Action:

In the current financial year to 7th February 2019, 158 losses, totalling £2.274M, have been recorded within the losses register maintained by financial services. Twenty of these losses, totalling £2.120M, related to medical claims which were out with the scope of this audit.

The processes for initial reporting of losses and for the recording of these, and authorisation of payments associated with them were found to be generally operating as per Financial Operating Procedure (FOP) 16a with minor exceptions noted.

Monitoring and Investigation to Prevent Recurrence of Losses

FOP16a does not include a specific section on the prevention of recurrence of losses but the losses form appended to it includes a section for recording '*Results of any further investigation and/or comments/recommendations*'. Testing a sample of losses forms found that this was not being used consistently and none of our sample included details of action identified to prevent recurrence of the loss in future. The inclusion of processes to prevent losses recurring in FOP16a, and communication of this to the relevant managers, will allow these processes to be implemented and evidenced. Examples of such processes include trend identification and route cause analysis.

The incidents module in the Datix system includes incident sub-categories related to the recording of losses, but does not include provision for recording where incidents are of a nature where compliance with FOP16a isd required and does not include a prompt to direct the incident reporter to follow FOP16a regarding the recording and reporting of the loss.

Financial Operating Procedure 16a – Losses, Special Payments and Compensations

During our review we communicated to Financial Services management a number of potential changes to be made to FOP16a, in addition to those referred to above, to reflect current practice and to improve processes.

Agreed management actions from this review were:

- A communication to managers will be issued reminding them of their responsibilities under FOP 16a Losses and Compensations.
- A prompt will be added to the existing sub categories in Datix, under which these incidents may be reported, for managers reporting incidents under these sub categories to consider the requirements of FOP16a. This will also include a hyperlink to the FOP.
- The losses and compensation form will be updated to include provision for a cross reference to the related Datix incident and will be included in the next iteration of FOP 16a.
- Managers will 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.
- A section will be added to FOP16a regarding the prevention of recurrence of losses.

Definitions of assurance categories and recommendation priorities

Categories of Assurance:

A	Good	There is an adequate and effective system of risk management, control and governance to address risks to the achievement of objectives.
B	Broadly Satisfactory	There is an adequate and effective system of risk management, control and governance to address risks to the achievement of objectives, although minor weaknesses are present.
C	Adequate	Business objectives are likely to be achieved. However, improvements are required to enhance the adequacy/ effectiveness of risk management, control and governance.
D	Inadequate	There is increased risk that objectives may not be achieved. Improvements are required to enhance the adequacy and/or effectiveness of risk management, control and governance.
E	Unsatisfactory	There is considerable risk that the system will fail to meet its objectives. Significant improvements are required to improve the adequacy and effectiveness of risk management, control and governance and to place reliance on the system for corporate governance assurance.
F	Unacceptable	The system has failed or there is a real and substantial risk that the system will fail to meet its objectives. Immediate action is required to improve the adequacy and effectiveness of risk management, control and governance.

The priorities relating to Internal Audit recommendations are defined as follows:

Priority 1 recommendations relate to critical issues, which will feature in our evaluation of the Governance Statement. These are significant matters relating to factors critical to the success of the organisation. The weakness may also give rise to material loss or error or seriously impact on the reputation of the organisation and require urgent attention by a Director.

Priority 2 recommendations relate to important issues that require the attention of senior management and may also give rise to material financial loss or error.

Priority 1 and 2 recommendations are highlighted to the Audit Committee and included in the main body of the report within the Audit Opinion and Findings

Priority 3 recommendations are usually matters that can be corrected through line management action or improvements to the efficiency and effectiveness of controls.

Priority 4 recommendations are recommendations that improve the efficiency and effectiveness of controls operated mainly at supervisory level. The weaknesses highlighted do not affect the ability of the controls to meet their objectives in any significant way.

DATE OF MEETING:	16 May 2019
TITLE OF REPORT:	Annual Internal Audit Plan
EXECUTIVE LEAD:	Tony Gaskin, Chief Internal Auditor
REPORTING OFFICER:	Tony Gaskin, Chief Internal Auditor

Purpose of the Report (delete as appropriate)		
		For Approval

SBAR REPORT

Situation and Background

The purpose of this paper is for the Audit and Risk Committee to discuss and comment on the draft Annual Internal Audit Plan for 2019-20 (Appendix 1), which commences on 1 May 2019 within the context of the updated Strategic Annual Plan 2019-24 (Appendix 2).

The attached report summarises the process taken to produce the Annual Internal Audit Plan for 2019-20.

The plan is in draft and is considered an early version subject to Audit and Risk Committee, Chief Executive and Executive Director Group input and approval.

Assessment

The plan is designed to provide the Chief Internal Auditor with sufficient evidence to form an opinion on the adequacy and effectiveness of internal controls. This opinion is one of the assurance sources required by the Accountable Officer in their annual review of internal controls and also informs the considerations of the Audit and Risk Committee and Board prior to finalising the Governance Statement.

Recommendation

The Audit and Risk Committee is asked to:

I. **Consider** the Annual Internal Audit Plan for 2018/19 and **Agree** that it be taken forward for discussion with the Executive Directors Group. The plan will then be presented to the Audit and Risk Committee for formal approval at the June 2019 meeting.

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.

Annual Internal Audit Plan 2019/20

Introduction

The internal audit service will be delivered in accordance with the Internal Audit Charter. A summary of our approach to undertaking the risk assessment and preparing the Annual Internal Audit Plan (the plan) is set out below. The plan is driven by NHS Fife's organisational objectives and priorities, and the risks that may prevent NHS Fife from meeting those objectives.

PSIAS

The Operational Plan 2019/20 has been developed in accordance with Public Sector Internal Audit Standard 2010 – Planning, to enable the Chief Internal Auditor to meet the following key objectives:

- The need to establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organisation's goals;
- Provision to the Accountable Officer of an overall independent and objective annual opinion on the organisation's governance, risk management, and control, which will in turn support the preparation of the Annual Governance Statement;
- Audits of the organisation's governance, risk management, and control arrangements which afford suitable priority to the organisation's objectives and risks;
- Improvement of the organisation's governance, risk management, and control arrangements by providing line management with recommendations arising from audit work;
- Effective co-operation with external auditors and other review bodies functioning in the organisation;

Internal Audit Planning Process

As in previous years, our Strategic Plan is structured around an audit universe based on a 5 year cycle (Appendix B) which has been mapped and contains overt links to the Board Assurance Framework (BAF) Risks. This year, we have enhanced the process so that it demonstrates cyclical coverage of all BAF risks over the 5 year cycle (Appendix C - G) and also incorporates views in areas for inclusion from the Chairs of Standing Committees and Executive Directors. The resultant draft operational plan (Appendix A), which is Year 1 of the 5 year cycle, overtly links to the BAF risk(s) which will be the focus of our work, together with any key governance or assurance elements required in order to provide a view on the overall adequacy and effectiveness of internal controls.

As in previous years, we will prioritise audits to ensure that work which provides assurance on the highest risk areas, or is likely to be relied upon by External Audit, is undertaken first wherever practicable.

The plan should focus on the most risky areas of the business. As a result each auditable area is allocated corporate importance, corporate sensitivity, inherent risk and control risk ratings.

The prioritisation of audit coverage across the audit universe is based on the organisation's assessment of corporate importance and sensitivity and internal audit assessment of risk. The maturity of these risk and assurance systems allows us to consider both inherent risk (impact and likelihood) and mitigation (adequacy and effectiveness of internal control). Our assessment also takes into account corporate risk, materiality or significance, system complexity, previous audit findings, potential for fraud and sensitivity.

These factors are used to calculate the audit requirement rating with the highest graded audits being covered three times in the cycle, medium two and low risk items once. Some areas are not graded as they are required for external audit assurance, by regulation or are designed to add value.

Appendices from Excel Workbook

Appendix A: Annual Plan 2019/20

Appendix B: Strategic Plan

Appendix C: BAF – Quality & Safety

Appendix D: BAF Environmental Sustainability

Appendix E: BAF Financial Sustainability

Appendix F: BAF Strategic Planning

Appendix G: BAF Workforce Sustainability

Main-Heading	Sub-Heading	Rating	543 2019/20	473 2020/21	473 2021/22	473 2022/23	473 2023/24			
					Days			**BAF Risks - Link to Plan**	**Prior Year Risk assessment - Jobs not started**	**Client meetings - Priority Identified**
AUDIT PROCESS			**79**	**59**	**59**	**59**	**59**			
Audit Management	Audit Risk Assessment & Planning		10	10	10	10	10	Mandatory Work Each year		
	Audit Management & Liaison with Directors		18	18	18	18	18	Mandatory Work Each year		
	Liaison with External Auditors and other review bodies		5	5	5	5	5	Mandatory Work Each year		
	Audit Committee		16	16	16	16	16	Mandatory Work Each year		
	Clearance of Prior Year		30	10	10	10	10	Mandatory Work Each year		
CONTINGENCY			**40**	**25**	**25**	**25**	**25**			
Contingency	Contingency reserve for investigations and reviews			5	5	5	5			
	Departmental Reviews		40	20	20	20	20		B35/19 Estates Departmental Review - discussed with Chief Executive and job will be undertaken as part of 2019/20. Specific focus on Fire Safety due to recent incidents at Victoria Hospital around exacuation planning. Also include follow up of Fire Safety review undertaken in 2018/19	Brexit implications were discussed at most client meetings
										Audit and Risk Committee
GOVERNANCE AND ACCOUNTABILITY			**113**	**68**	**104**	**82**	**88**			
Assurance	Annual Internal Audit Report		10	10	10	10	10	Mandatory Work Each year		
	Governance Statement		10	10	10	10	10	Mandatory Work Each year		
	Interim Review		28	28	28	28	28	Mandatory Work Each year		
	Audit Follow-up		20	20	20	20	20	Mandatory Work Each year		More time for Audit follow Up
Control Environment	Code of Corporate Governance (SOs, SFIs and SoD)	L	17							Governance Blueprint
	Board, Operational Committees and Accountable Officer	M			18		20			
	Assurance Framework	M	18		18					Assurance mapping
	Policies and Procedures	M	10			14		Quality and Safety		
RISK MANAGEMENT			**35**	**42**	**17**	**27**	**17**			
Risk Management	Risk Management Strategy, Standards and Operations		17	10	17	10	17	Quality and Safety - Mandatory Work Each Year		Annual review of risk management
	Staff and Patient Environment	M	18			17		Environmental Sustainability and Quality and Safety		
	NHS Resilience; Business Continuity and Emergency Planning	L		17				Environmental Sustainability and Quality and Safety		
Sustainability	Environmental costs	L		15				Environmental Sustainability		
HEALTH PLANNING			**73**	**70**	**45**	**55**	**25**			
	Strategic planning	H	15	15		15		Strategic Planning		
	Improvement, innovation and operational planning	H	15	15		15		Strategic Planning		
Service Monitoring	Organisational Performance Reporting	L		15				Quality and Safety		Request for this to be done in 2020/21
	Organisational Performance Management	M	18		20			Quality and Safety		
Effective Partnerships and Integrated Care	Health and Social Care Integration		25	25	25	25	25	IJB		
										Clinical Governance Committee
CLINICAL GOVERNANCE			**42**	**48**	**65**	**53**	**96**			
Clinical Governance Committee	Clinical Governance Strategy and Assurance	H		15	25		18	Quality and Safety		
Quality of care	Patient safety programme	M		18		18				
	Clinical Effectiveness	L					18	Quality and Safety		
	Adverse Event Management	M	15			15		Quality and Safety		Adverse events management focussing on actions to address issues identified

Main-Heading	Sub-Heading	Rating	543 2019/20	473 2020/21	473 2021/22	473 2022/23	473 2023/24			
					Days			**BAF Risks - Link to Plan**	**Prior Year Risk assessment - Jobs not started**	**Client meetings - Priority Identified**
Patient safety	Infection Control	M	12				20	Environmental Sustainability and Quality and Safety -operational risks only	B17/19 - planning started later in 2018/19 and specific scope not agreed with client to undertakeke in 2018/19. cheif executive wants work undertaken and will continue to liaiase with director of nursing to define scope for work to be done in 2019/20.	
	Medical Equipment and Devices	H		15	25		20			
	Food, Fluid and Nutritional Standards	L				20				
	Medicines Management	H	15		15		20			Medicines Management - movement of medicines
STAFF GOVERNANCE			**57**		**25**	**25**				**Staff Governance Committee**
Staff Governance arrangements	Staff Governance (inc Remuneration sub-Committee)	L	20		10			Every 2 years Remuneration Committee Self Assessment		Review of staff governance standards and Remuneration Committee Self Assessment, Follow up of staff lottery B21c/18
	Workforce planning including capable and effective workforce	H	37		15	25		Workforce Sustainability	B21/19 - discussions held during last quarter of 2018/19 around reviewing supplementary staffing and departmental absence. Delays in specific scoping from client has moved this review into 2019/20	Supplementary staffing and departmental absence
										Finance, Performance and Resources Committee
FINANCIAL ASSURANCE			**20**	**20**		**35**	**17**			
Accountability	Fraud & Probity Arrangements	L					17			
	Losses and Compensations	L				15				
Use of resources	Savings programme	H	20	20		20		Financial Sustainability		Transformation and savings
FINANCIAL MANAGEMENT				**30**	**15**		**30**			
Financial Control	Financial Planning	H		15	15		15	Financial Sustainability		
	Financial Management	M		15			15	Financial Sustainability		
CAPITAL INVESTMENT			**29**	**30**	**15**	**30**	**29**			
Capital Strategy	Property Management Strategy	M		15		15			B26/19 - concerns raised by Finance Resource and Performance Committee late in 2018/19. Assessed as medium for 2019/20 and will include in year 1 of 5 year plan	
Capital and Property	Management	L	15							1. Winter Planning - closing/merging wards and lessons learnt; 2. Planning for Ward Changes including Post project evaluation, feedback processes and signage/website
	Property Transaction Monitoring and Property disposals		14	15	15	15	15	Mandatory		
Capital Finance	Asset control	L					14			
TRANSACTION SYSTEMS			**12**	**26**	**52**	**12**	**52**			
Central Financial Systems	Financial Process Compliance		12	12	12	12	12	Mandatory - External audit		
Non Pay Expenditure	Ordering, Requisitioning & Receipt	L		14						
	Service contract expenditure	M			20		20			

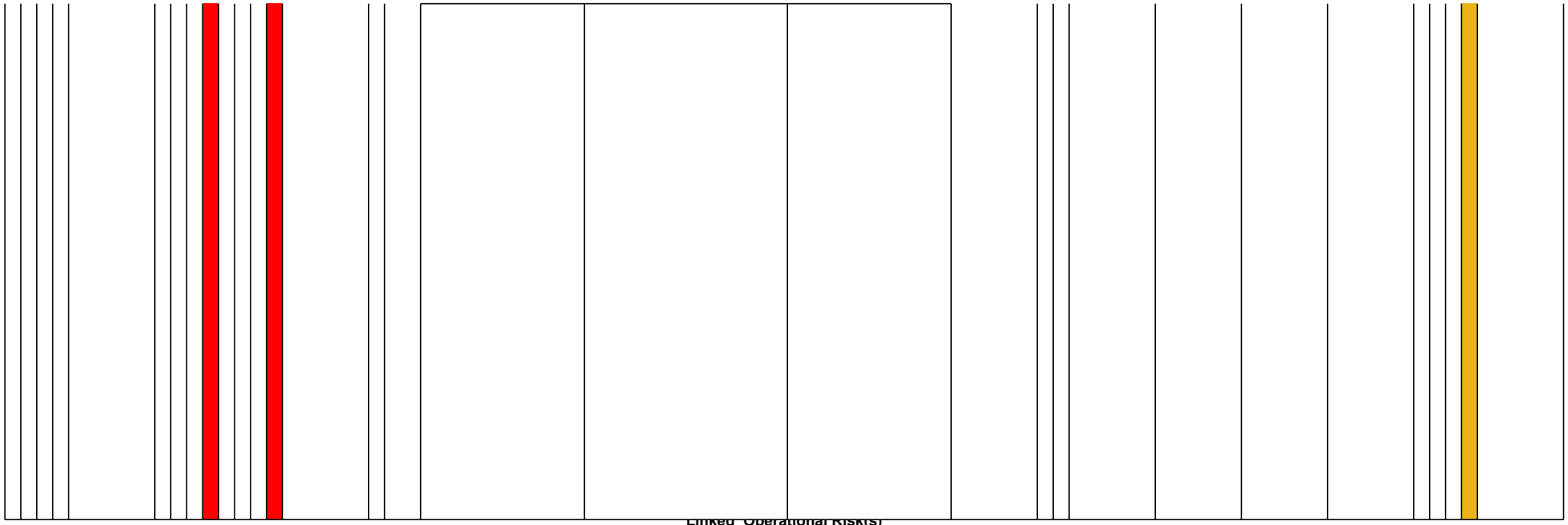
				543	473	473	473	473			
	Main-Heading	Sub-Heading	Rating	2019/20	2020/21	2021/22	2022/23	2023/24			
						Days					
									BAF Risks - Link to Plan	**Prior Year Risk assessment - Jobs not started**	**Client meetings - Priority Identified**
	Income	Non SGHSCD Income	L			20					
		Service Contract income	L					20			
ENDOWMENT FUNDS					**15**		**15**				
	Endowment Funds	Endowment Funds/Patients funds	M		15		15				
				43	**40**	**51**	**55**	**35**			
	Information Governance Standards	Information Assurance/Information Security Framework	H	25	25	6	30	5	eHealth		
	eHealth	eHealth Strategic Planning and Governance	M	10		15			eHealth		
		eHealth Project Management, Development, Procurement, Implementatio	M			20		20	eHealth		
		eHealth Service Management	L				25		eHealth		
	Data	Data quality	L		15				Quality and Safety		
		NHS Scotland Waiting Times Methodology		8		10		10	Mandatory - every 2 years		
TOTAL				543	473	473	473	473			
				1086	946	946	946	946			
				TRUE	TRUE	TRUE	TRUE	TRUE			
			9								
			14								
			16								
			39								

			NHS Fife Operational Internal Audit Plan 2019/2020						
Ref.			Description	Scope	Days	Indicative Timing			
			Audit Process		**79**	Qtr 1	Qtr2	Qtr 3	Qtr4
			Audit Management						
B	1	20	Audit Risk Assessment & Planning	Audit Risk Assessment & Operational Planning	10				
B	2	20	Audit Management & Liaison with Directors	Audit Management, liaison with Director of Finance and other officers	18				
B	3	20	Liaison with External Auditors	Liaison and co-ordination with External Audit	5				
B	4	20	Audit Committee	Briefings, preparation of papers, attendance and action points	16				
B	5	20	Clearance of Prior Year	Provision for clearance and reporting of 2018-2019 Audit Reports	30				
			Corporate Governance		**148**				
			Accountability and Assurance						
B	6	20	Annual Internal Audit Report	CIA's annual assurance to Audit Committee	10				
B	7	20	Governance Statement	Preparation of portfolio of evidence to support Governance Statement	10				
B	8	20	Interim Review	Mid Year assurance for Audit Committee on specific agreed governance areas	28				
B	9	20	Audit Follow-up	Review of the audit follow-up mechanism & selective examination of implementation of recommendations	20				
			Control Environment						
B	10	20	Code of Corporate Governance	Review of application of governance requirements and NHSF response to Governance Blueprint	17				
B	11	20	Assurance Framework & Assurance Mapping	Assurance structures (inc Audit Committee); relevance, reliability, timeliness and quality of evidence and developments to meet new Audit Committee Handbook requirements	18				
B	12	20	Policies and Procedures	Follow Up of B10/19 Safety Alerts and Identification; review, approval, communication and implementation of clinical policies	10				
B	13	20	Risk Management	Development of assurance on risk, required under PSIAS guidance	17				
B	14	20	Staff & Patient Environment	Including Health and Safety, Fire and Security	18				
			Health Planning		**73**				
			Health Plan						
B	15	20	Strategic planning	Review of IMPACT, Executive Board and implementation of recommendations arising from External Audit review	15				
B	16	20	Improvement, innovation and operational planning		15				
			Service Monitoring						
B	16	20	Organisational Performance Management	Identification of priorities for improvement and effective remedial action	18				
			Effective Partnerships and Integrated Care						
B	17	20	Health and Social Care Integration	Working with Fife Council to deliver IJB Internal Audit plan. Ongoing review of Health Board BAF risk and associated controls.	25				
			Clinical Governance		**42**				
			Quality of Care						
B	18	20	Adverse Event Management	Recording and learning from incidents, complaints and feedback	15				
			Patient Safety						
B	19	20	Infection Control	Operational risk 637 - SAB Heat target	12				
B	20	20	Medicines Management	Continued support to Medicines Management Action Plan and specific review of movement of medicines within the organisation	15				
			Staff Governance		**57**				
			Staff Governance Arrangements						

B	21	20	Staff Governance Arrangements	Review of staff governance standards and Remuneration Committee Self Assessment, Follow up of staff lottery B21c/18	20					
B	22	20	Workforce planning including capable and effective workforce	Supplementary staffing and departmental absence	37					
		Financial Assurance			**20**					
			Use of Resources							
B	23	20	Management of Savings Programme	Identification, delivery and reporting of savings relating to the Transformation Programme	20					
		Capital Investment			**29**					
			Capital Strategy							
B	24	20	Capital Management	From :Winter Planning - closing/merging wards and lessons learnt; Planning for Ward Changes including Post project evaluation, feedback processes and signage/website	15					
			Capital & Property							
B	25	20	Property Transaction Monitoring and Property Disposals	Post Transaction Monitoring. Efficient effective planning for property disposal.	14					
		Transaction Systems			**12**					
B	26	20	Financial Process Compliance	Central, payroll, travel, accounts payable, accounts receivable, banking arrangements.	12					
		Information Governance			**43**					
			Information Governance Standards							
B	30	20	Information Assurance/Information Security Framework	Implementation of NHS Scotland Information Security Policy Framework including ICT Asset Security, eHealth Business continuity and Disaster Recovery.	25					
B	31	20	eHealth Strategic Planning and Governance	Alignment of local eHealth strategic plans with the Board's overall strategy, the National eHealth Strategy and review of governance processes to ensure eHealth supports Strategic and transformational change	10					
B	32	20	NHS Scotland Waiting Times Methodology	Annual independent assurance over the monthly audit process	8					
		Departmental / Whole System Reviews			**40**					
B	33	20	Departmental Reviews	Estates	25					
B	34	20	Discretionary Aspects	Specific review of controls in place to mitigate risks to NHSF arising from Brexit.	15					
B	35	20	Contingency							
		TOTAL			**543**					

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?)	Mitigating actions - what more should we do?	Strategic Audit Universe Links	Gaps in Control	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	07/11/2018	16/01/2019	There is a risk that due to failure of clinical governance, performance and management systems (including information & information systems), NHS Fife may be unable to provide safe, effective, person centred care.	4 - Likely - Strong possibility this could occur	5 - Extreme	20	High	3 - Possible	5 - High	15	High	Failure in this area could have a direct impact on patients' health, organisational reputation and exposure to legal action. While it is recognised that several adverse events ranging from minor to extreme harm can occur daily, the proportion of these in relation to overall patient activity is very small.	Medical Director	Clinical Governance Chair: Dr Les Bisset	*Ongoing actions designed to mitigate the* *1. Strategic Framework* *2. Clinical Strategy* *3. Clinical Governance Structures and operational Governance arrangements* *4. Clinical & Care Governance Strategy* *5. Participation & Engagement Strategy* *6. Risk Management Framework* *This is supported by the following:* *7. Risk Registers* *8. Quality Report, Performance reports and availability of data through dashboards* *9. Performance Review incl focus on Clinical Governance* *10. Adverse Events Policy* *11. Scottish Patient Safety Programme implementation* *12. Implementation of SIGN and other evidence based guidance* *13. Staff Learning & Development incl corporate induction and In House Core Training, Quality Improvement, Leadership Development, Clinical Skills Training, Interspecialty Programmes* *14.System for writing and reviewing all clinical policies and procedures* *15. Participation in national and local audit* *16.Complaints handling process* 17.Enhancing monitoring of our systems with use of data.• Relevant data is currently being collected in relation to DofC and mechanisms for sharing this locally with divisions is in discussion and development through the Adverse 18.HIS Quality of Care Approach & Framework,Sept 2018.	*The Clinical Governance Steering Group (CGSG) has oversight of the Quality Report, SPSP Stakeholders and the Adverse Events/ Duty of Candour Group* minutes.Consideration should be given to the role and remit of this group(CGSG) in light of the requirements of the Quality of Care Approach. There is now an established combined group. This group is working through a plan of* *Further develop Datix Risk Management system. Develop dashboards and other means of* *1. The content of the Quality Report has evolved and contains information on key priorities. There is now a Quality Report within the Health & Social Care Partnership (HSCP); there is also a version being tested within specialties in the Acute Services Division (ASD)* *Our commitment to learn will be demonstrated in a number of ways e.g . Case study learning sessions to be delivered in 2019 to aid decision making and DoC implementation. SAER / LAER Learning Summaries are to be shared with topic specific*	Strategic Planning Year 1 Clinical Governance Committee Year 2,5 Clinical Governance Committee Year 3 Clinical Governance Committee Year Over the 5 year cycle - consider each year Over the 5 year cycle - consider each year Organisational Performance Reporting Year 2 - ASD included but HSCP part will need to be requested by NHSF as part of IJB audit Plan Organisational Performance Management year 1,3 Adverse Event Management Year1,4 Patient Safety Programme Year2,4 N/A to audit plan Workforce Planning year 3,4 Policies and Procedures Year 1 - focus on clinical policies N/A to audit plan Adverse Event management - include in year 4 Adverse Event Management Year1,4 Clinical Governance Committee Year 2	Triangulation across all elements of our quality and safety activities, specifically patient experience, complaints, adverse events and risk to provide an overview of performance and identify priorities for action to improve care and experience.	Medical Director	31/10/2018	1. Reporting to clinical & clinical & care governance groups and committees.I. 2. Reporting on acute adult, maternity, mental health, neonates, paediatrics and primary care to SPSP Stakeholder Group. 3. Reporting bi annually on adequacy of risk management systems and processes to Audit & Risk Committee. 4. Annual Assurance Statement. 5. HEAT target reports. 6. Portfolio of performance review data. 7. Accreditation systems. 8.Locally designed subject specific audits. 9.Requirement for DoC Annual Report 10.From Feb 2018, NHS Fife Committee Self assessment checklist 11. Compliance monitoring of policies & procedures to ensure these are up to date.	1. Internal Audit reviews and reports on controls and process; including annual clinical governance review / departmental reviews. 2. External Audit reviews. 3. HIS visits and reviews. 4. Healthcare Environment Inspectorate (HEI) visits and reports. 5. Health Protection Scotland (HPS) support. 6. Health & Safety Executive 7. Scottish Patient Safety Programme (SPSP) visits and reviews. 8. Scottish Govt DoC Annual Report	1.Risk management KPIs to be developed. 2.Improvements as recommended in Internal Audit Clinical Governance Strategy and Assurance Report B15-17 + B18-18 3.Compliance with DoC legislation	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	Enhanced controls and continuing improvements to the systems and processes for monitoring,reporting and learning are being put in place.



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
43	Vascular access for haematology/Oncology	High 20	Shirley-Anne Savage
521	Capacity Planning	High 16	Valerie Hatch
529	Information Security	High 16	Jann Gardner
637	SAB HEAT TARGET	High 16	Christina Coulombe
1365	Cancer Waiting Times Access Standards	High 15	Jann Gardner
356	Clinical Pharmacy Input	High 15	Frances Elliot

Previously Linked Operational Risk(s)

Risk ID	Risk Title		Current Risk Rating	Risk Owner
1366	T34 syringe drivers in the Acute Division		Low 6	Shirley-Anne Savage
1297	Obsolete Equipment In Use – No Replacement Plan In Place (Graseby 3000 Series)		Moderate 10	David Lowe
528	Pandemic Flu Planning		Moderate 12	Dona Milne

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?)	Mitigating actions - what more should we do?	Strategic Audit Universe Links	Gaps in Control	Responsible Person	Timescale	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Environmental Sustainability																														
1414	Sustainable, Clinically Excellent	25/06/2018	31/08/2018	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 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.	1. Capital funding is allocated depending on the E&F risks rating 2. Increase number of site audits	Department Review Year 1 will be a holistic review of the Estates Department which will include the relevant controls in place Department Review Year 1 will be a holistic review of the Estates Department which will include the relevant controls in place Department Review Year 1 will be a holistic review of the Estates Department which will include the relevant controls in place Department Review Year 1 will be a holistic review of the Estates Department which will include the relevant controls in place Environment Costs Year 2 Department Review Year 1 will be a holistic review of the Estates Department which will include the relevant controls in place	Nil	Director of Estates, Facilities & Capital Services	Ongoing as limited funding available	1. Capital Investment delivered in line with budgets 2. Sustainability Group minutes. 3. Estates & Facilities risk registers. 4. SCART & EAMS 5. Adverse Event reports	1. Internal audits 2. External audits by Authorising Engineers 3. Peer reviews	None	High risks still exist until remedial works have been undertaken, but action plans and processes are in place to mitigate these risks.	1 - Remote - Can't believe this event would happen	5 - Extreme	5	Low	All estates & facilities risk can be eradicated with the appropriate resources but there will always be a potential for failure i.e. component failure or human error hence the target figure of 5.

Linked Operational Risk(s)

Risk ID	Risk Title		Current Risk Rating	Risk Owner
1296	Emergency Evacuation - VHK- Phase 2 Tower Block		High 20	A Fairgrieve
1384	Microbiologist Vacancy		High 20	J Gardner
1473	Stratheden Hospital Fire Alarm System		High 20	G Keatings
1207	Water system Contamination STACH		High 20	A Fairgrieve
1306	Risk of pigeon guano on VHK Ph2 Tower Windows		High 16	D Lowe
735	Medical Equipment Register		High 15	D Lowe
1007	Theatre Phase 2 Remedial work		High 15	M Cross

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Reason for unlinking from BAF	Current Risk Rating	Risk Owner
749	VHK Phase 2 - Main Foul Drainage Tower Block	Risk Closed		
1083	VHK CL O2 Generator - Legionella Control	Risk Closed		
1252	Flexible PEX hoses Phase 3 VHK - Legionella Risk	No longer high risk	Moderate 12	A Fairgrieve
1275	South Labs loss of service due to proximity of water main to plant room	No longer high risk	Moderate 8	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	D Lowe
1352	Pinpoint malfunction	Risk Closed		

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Mitigating actions - what more should we do?	Gaps in Control	Strategic Audit Universe Links	Responsible Person	Timescale	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Financial Sustainability																													
1413	Sustainable	07/01/2019	28/02/2019	There is a risk that the funding required to deliver the current and anticipated future service models will exceed the funding available. Thereafter there is a risk that failure to implement, monitor and review an effective financial planning, management and performance framework would result in the Board being unable to deliver on its required financial targets.	4 - Likely - Strong possibility this could occur	4 - Major	16	High	4 - Likely - Strong possibility this could occur	4 - Major	16	High	Current financial climate across NHS/public sector	Director of Finance Chair: Rona Laing Finance, Performance & Resources (F,P&R)		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 2. Transformation programme established to support redesign; reduce unwarranted variation and waste; and to implement detailed efficiency initiatives across the system 3. Engage with external advisors as required (e.g. property advisors) to support specific aspects of work. .	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 3. Continue to scrutinise and review any potential financial flexibility. 4. Engage with H&SC / Council colleagues on the risk share methodology	Nil	Linked Operational Risks 1364 and 1357 (see below) will be considerd as part of finanacial planning and efficency savings within 5 year plan Financial Management Year2,5 Savings Programme Year 1,2,4 Possible consideration under Property Strategy work in year 2 Financial Planning Year 3 Financial Management Year2,5, Financial Planning Years ,3,5 Not amenable to meaningful audit	Director of Finance / Chief Operating Officer / Director of Health & Social Care	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	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 highlighted in 2016/17 and 2017/18 continued into 2018/19, with an anticipated £19.7m gap, including £17m carried forward as unachieved recurring savings in 2017/18. Since the end of May, the forecast outturn has been held at breakeven, per the Annual Operational Plan. However, given the extent of the risks that remain as the year has progressed, in relation to delivery and identification of value & sustainability and cost reduction efficiencies across acute services and health services delegated through the H&SC Partnership to the IJB, a forecast overspend was reported following both the month 7 (October) and month 8 (November) results. The non delivery of savings and resultant overspend have been mitigated in part	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
1363	Health & Social Care Integration - Overspend	High 20	M Kellett
1364	Efficiency Savings - failure to identify level of savings to achieve financial balance	High 16	C Potter
1357	Financial Planning, Management & Performance	High 16	C Potter

Previously Linked Operational Risk(s)

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

NHS Fife Board Assurance Framework (BAF)

Strategic Planning

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Mitigating actions - what more should we do?	Gaps in Control	Strategic Audit Universe Links	Responsible Person	Timescale	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
1417	Person Centred, Clinically Excellent, Exemplar Employer, Sustainable	15/01/2019	06/03/2019	There is a risk that NHS Fife will not deliver the recommendations made by the Clinical Strategy within a timeframe that supports the service transformation and redesign required to ensure service sustainability, quality and safety at lower cost. Key Risks 1. Community/Mental Health redesign is the responsibility of the H&SCP/IJB which hold the operational plans, delivery measures and timescales 2. Governance of the JSTG remains with 4 committees - 2 from the IJB and 2 from NHS. This may impact on effectiveness of scrutiny. 3. Regional Planning. There is a challenge in alignment of strategic plans of partner boards with those of the Regional lead. 4. Development and recommendations of the East Region Health and Social Care Delivery Plan	4 - Likely - Strong possibility this could occur	4 - Major	16	High	4 - Likely - Strong possibility this could occur	4 - Major	16	High	The transformation programmes have been agreed and reports to the Joint Strategic Transformation Group. Organisational challenges have impacted on the meeting schedule and full programme implementation. Regular meeting are now taking place. The workplans is at varying stages of development with some programmes more advanced than others. Reporting of progress of transformation programmes has improved with written updates to Executive Board and JSTG for two of the programmes. Papers to IJB produced about the other two programmes.	Director of Planning and Strategic Partnerships (DoP&SP)	Clinical Governance Chair	Ongoing actions designed to mitigate the risk including:		Nil		Chief Officer Health and Social Care Partnership	31/03/2018	1. Minutes of meetings record attendance, agenda and outcomes. 2. Action Plans and highlight reports from the Joint Strategic Transformation Group. 3. Action plans, minutes and reports from the SEAT Regional Planning meetings and East Region Programme Board. 4.Performance Assessment Framework is in place and assures committees on acute services division performance and winter planning monitoring.	1. Internal Audit Report on Strategic Planning (no. B10/17) 2. SEAT Annual Report 2016 3.Governance committee oversight of performance assurance framework	Nil at present	Current challenges associated with delivery of our strategic objectives include the focus on the 4 strategic priorities (Site Optimisation, Community Redesign, Mental Health Redesign and Medicines Efficiencies), the interdependencies of workplans (NHS Fife/H&SCP/ Region) in terms of the whole system oversight of operational plans, delivery measures and timescales. Site Optimisation Programme is progressing on track. Reconfiguration of acute beds has completed phase 1 and 2 with phase 3 due in May 2019.	3 - Possible - May occur occasionally - reasonable chance	4 - Major	12	Moderate	Once governance and monitoring is in place and transformation programmes are being realised, the risk level should reduce.
																1. Establishment of IMPACT in 2016 - a small internal business unit which provides focussed, co-ordinated, client tailored support to accelerate delivery of NHS Fife's strategic objectives. Provides a programme management framework to ensure the programme is delivered.			Strategic Planning year 1											
																2. Establishment of the Joint Strategic Transformation Group (JSTG) to drive the delivery of the H&SC Strategic Plan and the Clinical Strategy.	ToR of JSTG has been reviewed but is being reviewed again reflecting changes in structure.		As only 1 of these strategic priorites is NHF specific this will be covered in year 1 savings programme. The other 3 will require NHSF to request the work as part of the IJB audit Plan.											
																3. 3 of the 4 key strategic priorities are being taken forward by the H&SCP/IJB. The remaining priority is being taken forward by Acute services and progress shared through regular highlight reports. Programme Boards provide oversight and strategic guidance to the programme. Collaborative oversight is provided by the JSTG.			As only 1 of these strategic priorites is NHF specific this will be covered in year 1 operational planning. The other 3 will require NHSF to request the work as part of the IJB audit Plan.											
																4. NHS Fife is a member of SEAT with executive attendance at Regional Planning meetings. Progress is being made in some areas.			Strategic Planning year 4											
																5. NHS Fife is a member of the East Region Programme Board established to develop the East Region Health and			Strategic Planning year 4											
																6. Establishment of the Executive Board to provide strategic and operational oversight of the health boards services including the transformation programmes.	Establishment of the Executive Board providing leadership to strategic planning		Strategic Planning year 1											
																7. Fife Health Services Service Planning exercise underway for 2019/20 -21/22 which will inform actions to deliver Clinical Strategy and prioiritise transformation programmes.	Clinical Strategy progress update to be produced to review progress to date and plans against recommendations.		Strategic Planning Year 2											
																	1. The NHS Fife CEO chairs the Acute Services workstream of the East Region Health and Social Care Delivery Plan 2. Director of Planning and Chief Operating Officer participate in Regional		.											

Linked Operational Risk(s)

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

Previously Linked Operational Risk(s)

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

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Mitigating actions - what more should we do?	Gaps in Control	Strategic Audit Universe Links	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	09/01/2019	31.03.2019	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	Chair: Margaret Wells Staff Governance	Ongoing actions designed to mitigate the risk including				Director of Workforce/Partnership								1 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.
																1. • Development of the Workforce Strategy to support the Clinical Strategy and Strategic Framework.	Implementation of the Workforce Strategy to support the Clinical Strategy and Strategic Framework	Nil	Workforce Planning Year 2; 2. Health and Social Care aspects will require NHS Fife to request for inclusion as part of the IJB Audit Plan			1. Regular performance monitoring and reports to EDG, 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. • Implementation of the Health & Social Care Workforce and Organisational Development Strategy to support the Health & Social Care Strategic Plan for 2016/19			Health and Social Care aspects will require NHS Fife to request for inclusion as part of the IJB Audit Plan											
																3. • Implementation of the NHS Fife Strategic Framework particularly the "exemplar employer"		Nil												
																4. • A Brexit Steering Group has been established to consider the impact on the workforce with regard to these arrangements once they are known. •An Assurance Group has also been established which will link to existing resilience planning arrangements	Implementation of proactive support for the workforce affected by Brexit.	Nil Nil	Brexit included as separate Departmental Review in year 1. Further review may be undertaken under Resilience in Year 2											
																5. • Implementation of eESS as a workforce management system within NHS Fife	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	Nil	Workforce Planning year 3 or 4											
																6. • 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	Strengthen workforce planning infrastructure ensuring co-ordinated and cohesive approach taken to advance key workforce strategies	Nil	Workforce Planning year 3 or 4											
																7 • 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.	Strengthen workforce planning infrastructure ensuring co-ordinated and cohesive approach taken to advance key workforce strategies	Nil	Capable and Effective workforce Year 1											
																8. • 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	Strengthen workforce planning infrastructure ensuring co-ordinated and cohesive approach taken to advance key workforce strategies	Nil	Strategic Planning year Year 4											
																9. Review of risks related to Mental Health recruitment with Risk owners	Strengthen workforce planning infrastructure ensuring co-ordinated and cohesive approach taken to advance key workforce strategies	Nil	Recruitment Review requested year 2 under capable and effective workforce											
																An Assurance Group has also been established which will link to existing resilience planning arrangements	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	Nil	Capable and Effective workforce Year 1											
																11. • The roll out and implementation of iMatter across the organisation, to support staff engagement and organisational values.	Optimise use of iMatter process and data to improve staff engagement and retention	Nil	Recruitment Review requested year 2 under capable and effective workforce											

12. • Staff Governance and Partnership working underpins all aspects of workforce activity within NHS Fife and is key to development of the workforce.	Continue to implement and promote Staff Governance Action plans and staff engagement	Nil	Staff governance Committee Year 1			
13. • Training and Development	Continue to implement and promote Staff Governance Action plans and staff engagement	Nil	Staff governance Committee Year 1			
14. • Development of the Learning and Development Framework strand of the Workforce Strategy 15. • Leadership and management development provision is constantly under review and updated as appropriate to ensure continuing relevance to support leaders at all levels	Implementation of the Learning and Development Framework strand of the Workforce Strategy.	Nil	Consideration of Learning and Devlopment in furture years of 5 year plan			
16. • The improvement made in Core Skills compliance to ensure NHS Fife meets its statutory obligations	Review of L&D processes , planning and resources to ensure alignment to priorities	Nil	Consideration of Learning and Devlopment in furture years of 5 year plan			
17. • 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	Full roll out of learning management self service	Nil	Consideration of Learning and Devlopment in furture years of 5 year plan			
18. • Continue to address the risk of non compliance with Staff Governance Standard and HEAT standard requirements relating to	Continuing implementation of the KSF Improvement and Recovery Plan	Nil	Staff governance Committee Year 1			
19. • 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	Staff governance Committee Year 1			
20. • 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	Consideration of Learning and Devlopment in furture years of 5 year plan			

Linked Operational Risk(s)

Risk ID	Risk Title	Current Risk Rating	Risk Owner
1375	Breast Radiology Service	High 16	M Cross
90	National shortage of radiologists	High 16	J Burdock
1420	Loss of consultants	High15	H Bett

Previously Linked Operational Risk(s)

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

Audit & Risk Committee

DATE OF MEETING:	16 May 2019
TITLE OF REPORT:	Internal Audit – Follow Up Report on Audit Recommendations
EXECUTIVE LEAD:	Carol Potter, Director of Finance
REPORTING OFFICER:	Carol Potter, Director of Finance

Purpose of the Report (delete as appropriate)

		For Assurance

SBAR REPORT

Situation

As part of the Accountable Officer duties the Chief Executive is responsible for ensuring that the Board has in place effective systems to safeguard public funds. This responsibility includes the requirement to follow up any matters raised by the external and internal auditors, which includes reviewing implementation of Action Plan recommendations. The Audit & Risk Committee monitors management actions taken in response to the audit recommendations through the process articulated in the follow-up protocol. The protocol requires the Director of Finance to present a report on progress with Action Plans to the Audit and Risk Committee

Background

Responsibility for the management of the follow up process is discharged on a day-to-day basis on behalf of the Chief Executive by the Director of Finance. A follow up was conducted at the end of April with any overdue recommendations reviewed and action taken.

Assessment

The attached schedule provides a summary of all outstanding actions arising from Internal Audit reports (excluding any related to the Chief Internal Auditor's Annual Report for 2017/18). This schedule has been be amended, per the revised Follow Up Protocol, to provide details of each specific recommendation and expected action.

A total of 22 are identified, covering 10 different audit reports. From the list of outstanding action points there is 1 priority 1 actions. The distribution of actions by each priority (where 1 is highest risk and 4 is lowest) is:

Priority	**No.**
1	1
2	5
3	16
4	0

As previously reported, a revised approach is being implemented for 2019/20, using Datix as the mechanism to record and monitor progress on audit recommendations. This will be administered in the first instance by the Internal Audit team, as and when audit reports are finalised; and responsible managers / Directors will be required to update Datix when actions are completed. This will ensure detailed reports can be easily and timeously prepared with reduced manual intervention. This approach is well established in another Board and Internal Audit colleagues are supportive of this change. A potential query has been raised, however, in relation to the system functionality and this is being clarified.

Recommendation

The Audit & Risk Committee is asked to:

- **note** the actions taken

Objectives: (must be completed)	
Healthcare Standard(s):	Governance and assurance is relevant to all Healthcare Standards.
HB Strategic Objectives:	All
Further Information:	
Evidence Base:	N/A
Glossary of Terms:	SGHSCD – Scottish Government Health and Social Care Directorates
Parties / Committees consulted prior to Health Board Meeting:	Executive Directors Group
Impact: (must be completed)	
Financial / Value For Money	Financial Governance is a key component of the assurance process.
Risk / Legal:	Actions taken in response to audit recommendations seek to address / mitigate any risks identified
Quality / Patient Care:	Quality & patient care are a core consideration in all aspects of governance including financial governance.
Workforce:	Workforce issues are a core consideration in all aspects of governance including financial governance.
Equality:	Equalities issues are a core consideration in all aspects of governance including financial governance.

Fife NHS Board
Follow-up on NHS Fife Internal Audit Reports
Summary Status of Outstanding Issues as at 30 April 2019

Report No.	Assignment Description	Responsible Director	Responsible Individual	Rec No.	Priority	Action By Date	Follow-up Date	Response Due by	Follow-up reminder sent	Reminder Sent	Control Issue	Recommendation	Action Required
B11/14	Risk Management Framework	Nurse Director	Risk Manager	4	3	31.10.18	14.11.18	21.01.19	26.02.19	04.05.19			
B08/16	Interim Evaluation of Internal Control Framework 2015/16	Chief Executive	Nurse Director	5	3	31.10.18	14.11.18	21.11.18	26.02.19	04.05.19	IJBs were established during 2015/16 and went live on 1 April 2016. However, there is currently no formal agreement of the precise responsibilities of the Health Board, Council and the Integrated Joint Board (IJB) in relation to operational activities which has been communicated to staff and considered by the Board and its Standing Committees. Therefore, whilst there are is acceptance at Executive Director level that operations and therefore operational risks will transfer to the IJB, there is still considerable uncertainty around the exact nature of the delegation of functions to the IJBs and the implications for risk management, governance and assurance	The Board and its Standing Committees should be presented with a paper outlining the responsibility for operational activities and the consequences for risk, control, governance and assurance.The risk management framework will need to be revised considerably, with particularly consideration to the treatment of residual risks i.e. those where responsibility has passed to the IJB but which could still have a significant legal, reputational or financial impact on the Board or seriously affect its ability to achieve its operational and strategic objectives.	A report will be provided as set out in the Audit recommendation, for consideration by the Audit & Risk Committee of both the IJB and Health Board and then the NHS Fife Board. A meeting has been established with the appropriate risk staff from IJB, Health and Audit Scotland to review the risk management framework and the management of residual risks within the organisation.
B08/17	Interim Evaluation of Interal Control Framework 2016/17	Chief Executive	Director of Nursing	1b	1	31.10.18	14.11.18	21.11.18	26.02.19	04.05.19	The latest progress report on NHS Fife IG and ISMS Plan 2016-2018, to be presented to the ISGG at its meeting on 7 December 2017, states that no objectives for information security have yet been agreed but this is a requirement of the NHS Scotland Information Security Policy Framework issued under DL 17 (2015).	NHS Fife should agree strategic objectives for information security and should use these to inform the prioritisation of actions for NHS Fife to comply with this framework and GDPR.	Agreed. This will be picked up under the refresh of the IGG.
B08/18	Interim Evaluation of Internal Control Framework 2017/18	Chief Executive	Director of Planning & Strategic Partnerships	6	2	31.08.18	14.09.18	21.09.18	26.02.19	04.05.19	The status of one of the actions to address one of the recommendations sampled was reported to the Follow-Up Co-ordinator as complete but, although we obtained evidence from the responsible officer to support two parts of the agreed action, evidence was not available to support the introduction of tabletop testing of Fire Evacuation Plans in AU1 at VHK.	The relevant manager should be requested to update EDG regarding completion of this action.	The Clinical Nurse Manager / Service Manager for Emergency Care will be requested to provide an update to EDG on the introduction and future scheduling of tabletop testing of Fire Evacuation Plans in AU1 at VHK.
B09/18	Audit Follow Up	Chief Executive	Interim Chief Operating Officer	1b	2	31.07.18	14.08.18	21.08.18	26.02.19	04.05.19			
B11/18	Policies & Procedures	Director of Workforce	Head of Partnership	1	3	31.10.18	14.11.18	21.11.18	26.02.19	04.05.19			
		Director of Planning & Strategic Partnership	General Manager - IMPACT	3b	3	31.10.18	14.11.18	21.11.18	26.02.19	04.05.19			
		Director of Planning & Strategic Partnership	General Manager - IMPACT	10	3	31.10.18	14.11.18	21.11.18	26.02.19	04.05.19			
		Director of Workforce	Head of Partnership	11a	3	31.10.18	14.11.18	21.11.18	26.02.19	04.05.19			
		Director of Workforce	Head of Partnership	11b	3	31.10.18	14.11.18	21.11.18	26.02.19	04.05.19			
		Director of Workforce	Head of Partnership	14	3	31.10.18	14.11.18	21.11.18	26.02.19	04.05.19			
		Director of Workforce	Head of Partnership	15	3	31.10.18	14.11.18	21.11.18	26.02.19	04.05.19			
B21B/18	Staff Remuneration	Chief Executive	Director of Workforce	1b		31.05.18	14.06.18	21.06.18	26.02.19	04.05.19			
B29/18	NHS Scotland Waiting Times Methodology	Director of Planning & Strategic Partnerships	Information Analyst	5	3	30.09.18	14.10.18	21.10.18	26.02.19	04.05.19			
B06/19	Annual Internal Audit Report	Chief Executive	Director of Planning & Strategic Partnerships	2	3	30.09.18	14.10.18	21.10.18	26.02.19	04.05.19			
		Chief Executive	Director of Workforce	3	3	30.09.18	14.10.18	21.10.18	26.02.19	04.05.19			
B43/12	Data Quality - Information Governance Action Plan	Director of Planning and Strategic Parnerships	Head of Corporate Services	1a	2	31.12.18	14.01.19	21.01.19	26.02.19	04.05.19	An Information Asset Register has not been yet established to identify information owners for the personal identifiable information held in NHS Fife, in line with the requirements set out in the Scottish Government Records Management: NHS Code Of Practice (Scotland).	An Information Asset Register should be established, in line with the Scottish Government Records Management: NHS Code Of Practice (Scotland), to capture records and media containing business or personal identifiable information and details of the responsible manager.	A significant project is to be initiated to address the requirements of the Public Records (Scotland) Act 2011 which will address all of the issues raised.
B13/13	Communication	Director of Planning and Strategic Parnerships	Communications Manager	5	3	31.12.18	14.01.19	21.01.19	26.02.19	04.05.19			
B21C/18	Staff Lottery	Chief Executive	Director of Finance	1	3	31.12.18	14.01.19	21.01.19	26.02.19	04.05.19			
B28/18	Service Contract Income	Director of Finance	Assistant Director of Finance (Management Accounts)	1	3	30.11.18	14.12.18	21.12.18	26.02.19	04.05.19			
B11/14	Risk Management Framework	Nurse Director	Risk Manager	4	3	31.10.18	14.11.18	21.01.19	26.02.19		Processes are in place to review and update Board policies covering General Policies, Clinical Policies and Human Resources Policies. There are currently no Clinical Policies that have lapsed review dates but 48% of General Policies and 30% of Human Resources Policies have lapsed. B08/16 highlighted issues around lapsed policies and it was agreed that the percentage of lapsed polices should be included in the updates for Human Resources and Clinical Policies to the required committee/group but the current reporting on policies to these standing committees, and to the SGC, does not explicitly state the percentage of policies with lapsed review dates.	The reporting to the FP&RC for General Policies, to the SGC for Human Resources Policies and to the CGC for Clinical Policies and Procedures should be updated to explicitly state the percentage of policies that have lapsed review dates.	Human Resources report will be taken to the SGC in May. Clinical Policies report will be taken to the CGC in May.
B08/18	Interim Evaluation of Internal Control Framework 2017/18	Chief Executive	Director of Workforce	3b	2	30.05.18	14.06.18	21.06.18	26.02.19		The status of one of the actions to address one of the recommendations sampled was reported to the Follow-Up Co-ordinator as complete but, although we obtained evidence from the responsible officer to support two parts of the agreed action, evidence was not available to support the introduction of tabletop testing of Fire Evacuation Plans in AU1 at VHK.	The relevant manager should be requested to update EDG regarding completion of this action.	The Clinical Nurse Manager / Service Manager for Emergency Care will be requested to provide an update to EDG on the introduction and future scheduling of tabletop testing of Fire Evacuation Plans in AU1 at VHK.
B09/18	Audit Follow Up	Chief Executive	Interim Chief Operating Officer	1b	2	31.07.18	14.08.18	21.08.18	26.02.19				

Fife NHS Board
Internal Audit Report
COMPLETED ACTIONS

Report No.	Assignment Description	Responsible Director	Responsible Individual	Rec No.	Priority	Action By Date	Completed	Completed by	Date Notified
B18/14	Workforce Planning - Nurse Bank Arrangements	Director of Human Resources	Deputy Director of HR	6b	2	31.10.18	14.11.18	21.11.18	
B28a/17	Departmental Review - AU1	Chief Operating Officer - Acute Services	Clinical Nurse Manager - Emergency Care	3c	2	31.08.17	Yes	Service Manager	29.08.18
B28b/17	Departmental Review - Endoscopy	Chief Operating Officer - Acute Services	Clinical Nurse Manager - Planned Care	1	3	30.11.17	Yes	Acting Head of Nursing	27.08.18
		Chief Operating Officer - Acute Services	Clinical Nurse Manager - Planned Care	4a	3	30.11.17	Yes	Acting Head of Nursing	27.08.18
		Chief Operating Officer - Acute Services	Clinical Nurse Manager - Planned Care	4b	3	30.11.17	Yes	Acting Head of Nursing	27.08.18
B08/18	Interim Evaluation of Internal Control Framework 2017/18	Chief Executive	Director of Planning & Strategic Partnerships	1	2	31.05.18	Yes	Interim Associate Director of Planning	30.08.18
		Chief Executive	Medical Director	3c	3	31.05.18	Yes	Medical Director	03.09.18
B08/18	Interim Evaluation of Internal Control Framework 2017/18	Chief Executive	Director of Workforce	3b	2	30.05.18	Yes	21.06.18	26.02.19
B09/18	Audit Follow Up	Director of Finance	Follow up Coordinator	1a	2	31.07.18	Yes	Follow up Co-ordinator	23.08.18
		Director of Finance	Follow up Coordinator	2b	3	31.07.18	Yes	Follow up Co-ordinator	23.08.18
		Director of Finance	Follow up Coordinator	3	3	31.07.18	Yes	Follow up Co-ordinator	23.08.18
B11/18	Policies & Procedures	Director of Planning & Strategic Partnership	General Manager - IMPACT	4	3	31.08.18	Yes	Interim Associiate Director of Planning	30.08.18
B25/18	Financial Process Compliance	Director of Finance	Assistant Director of Finance	1	3	31.07.18	Yes	Assistant Director of Finance	02.11.18
		Director of Finance	Assistant Director of Finance	2	2	31.07.18	Yes	Assistant Director of Finance	02.11.18
B26/18	Brookson Locum Invoice Approval Process	Director of Workforce	HR Manager	2a	2	30.06.18	Yes	21.07.18	07.05.19
		Director of Workforce	HR Manager	3	2	30.06.18	Yes	21.07.18	07.05.19
B29/18	NHS Scotland Waiting Times Methodology	Director of Planning & Strategic Partnerships	Divisional Head of Health Records (Acute Services Division)	1c	3	31.08.18	Yes	Divisional Head of Health Records (Acute Services Division)	31.08.18
		Director of Planning & Strategic Partnerships	Divisional Head of Health Records (Acute Services Division)	2b	2	31.07.18	Yes	Divisional Head of Health Records (Acute Services Division)	31.08.18
		Director of Planning & Strategic Partnerships	Information Services Manager	3	3	30.06.18	Yes	Information Services Manager	24.08.18
		Director of Planning & Strategic Partnerships	Information Services Manager	4a	3	30.06.18	Yes	Information Services Manager	24.08.18
		Director of Planning & Strategic Partnerships	Divisional Head of Health Records (Acute Services Division)	4b	3	31.07.18	Yes	Divisional Head of Health Records (Acute Services Division)	31.08.18
		Director of Planning & Strategic Partnerships	Divisional Head of Health Records (Acute Services Division)	6a	3	31.07.18	Yes	Divisional Head of Health Records (Acute Services Division)	31.08.18
		Director of Planning & Strategic Partnerships	Divisional Head of Health Records (Acute Services Division)	6b	3	31.07.18	Yes	Divisional Head of Health Records (Acute Services Division)	31.08.18
		Director of Planning & Strategic Partnerships	Divisional Head of Health Records (Acute Services Division)	7	3	31.07.18	Yes	Divisional Head of Health Records (Acute Services Division)	31.08.18
		Director of Planning & Strategic Partnerships	Divisional Head of Health Records (Acute Services Division)	8	3	31.07.18	Yes	Divisional Head of Health Records (Acute Services Division)	31.08.18
		Director of Planning & Strategic Partnerships	Divisional Head of Health Records (Acute Services Division)	9	3	31.07.18	Yes	Divisional Head of Health Records (Acute Services Division)	31.08.18
		Director of Planning & Strategic Partnerships	Information Services Manager	10	3	30.06.18	Yes	Information Services Manager	24.08.18
B06/19	Annual Internal Audit Report	Director of Planning & Strategic Partnerships	Head of eHealth & IM&T	6	3	31.07.18	Yes	Head of eHealth & IM&T	21.08.18
		Chief Executive	Director of Health & Social Care	4	2	31.08.18	Yes	Chief Finance Officer	31.08.18
		Chief Executive	Director of Health & Social Care	5	1	31.08.18	Yes	Chief Finance Officer	31.08.18
B27/19	Post Transaction Monitoring	Chief Executive	Director of Estates, Facilities & Capital Services	1	3	31.08.18	Yes	Director of Estates, Facilities & Capital Services	23.08.18
		Chief Executive	Director of Estates, Facilities & Capital Services	2	3	31.08.18	Yes	Director of Estates, Facilities & Capital Services	23.08.18

DATE OF MEETING:	16 May 2019
TITLE OF REPORT:	External Quality Assessment – FTF Audit
EXECUTIVE LEAD:	Tony Gaskin, Chief Internal Auditor
REPORTING OFFICER:	Tony Gaskin, Chief Internal Auditor

Purpose of the Report (delete as appropriate)		
		For Discussion

SBAR REPORT

Situation and Background

The Audit and Risk Committee is asked to review the findings, recommendations and action plan arising from the independent review of Internal Audit undertaken by Chief Internal Auditor, Midlothian Council and Scottish Borders Council, on behalf of the Chief Internal Auditors' Group.

Public Sector Internal Audit Standards (PSIAS) require an independent external assessment of internal audit functions once every five years.

Assessment

The methodology for this EQA takes the form of a validated self-assessment with the following approach taken:

- A review of the latest self-assessment completed in November 2018 and supporting evidence provided by the Chief Audit Executive (CAE) and the Regional Audit Managers;
- Canvassing the opinions of key stakeholders which included a sample of members of the Audit Committee / Audit and Risk Committee, the Chief Executives, and Directors, using the standard review questionnaire;
- Completing a series of tests using the standard checklist; and
- Completing a review of guidance, process documents, audit working papers, and finalised reports for FTF.

Overall the EQA assessment undertaken concluded that "following completion of the comprehensive EQA Checklist and, based on the work undertaken, it is my opinion that the FTF Internal Audit service for Fife and Forth Valley generally conforms with the PSIAS."

The Chief Internal Auditor is actively progressing the recommendations and the report has been discussed at the FTF Partnership Board.

Recommendation

The Audit and Risk Committee is asked to:

1. Consider the final EQA report. 2. **Approve** the process that progress of the recommendations is reported as part of the Internal Audit Annual Report and Interim Control Evaluation. 3. Specifically consider action point 4 within the EQA report which requires Audit and Risk Committee approval.

Objectives: (must be completed)	
Healthcare Standard(s):	The breadth of internal audit work cuts across all Healthcare Standards.
HB Strategic Objectives:	The breadth of internal audit work cuts across all of the strategic objectives within the Board's Strategic Framework.
Further Information:	
Evidence Base:	N/A
Glossary of Terms:	SGHSCD – Scottish Government Health and Social Care Directorates
Parties / Committees consulted prior to Health Board Meeting:	Director of Finance
Impact: (must be completed)	
Financial / Value For Money	Financial Governance is a key pillar of the Annual Internal Audit Plan and value for money is a core consideration in planning all internal audit reviews.
Risk / Legal:	The internal audit planning process which produces the Annual Internal Audit Plan takes into account inherent and control risk for all aspects of the Audit Universe. Individual internal audit assignments identify the key risks at the planning stage and our work is designed to evaluate whether appropriate systems are in place and operating effectively to mitigate the risks identified. Legal requirements are a core consideration in planning all internal audit reviews.
Quality / Patient Care:	The Triple Aim is a core consideration in planning all internal audit reviews.
Workforce:	Management responsibilities, skill sets and structures are a core consideration in planning all internal audit reviews.
Equality:	All internal audit reviews which involve review of policies and procedures examine the way in which equality and diversity is incorporated in Board documentation. In addition, equality and diversity is included as a specific topic within our Audit Universe.

SCOTTISH LOCAL AUTHORITIES
Chief Internal Auditors' Group

EXTERNAL QUALITY ASSESSMENT OF THE INTERNAL AUDIT SERVICE OF NHS FIFE AND NHS FORTH VALLEY

ISSUED BY JILL STACEY, CHIEF INTERNAL AUDITOR, MIDLOTHIAN COUNCIL AND SCOTTISH BORDERS COUNCIL, ON BEHALF OF THE CHIEF INTERNAL AUDITORS' GROUP

8 May 2019

Index and Report Distribution List

Date of Visit	**31 January 2019**
Draft Report Issued	**23 February 2019**
Management Response Received	**11 March 2019**
Final Report Issued	**8 May 2019**

Issued to:
Tony Gaskin, Chief Internal Auditor **Barry Hudson, Regional Audit Manager** **Jocelyn Lyall, Regional Audit Manager** **Carolyn Martin, Office Manager**

1. EXECUTIVE SUMMARY

1.1 Background

1.1.1 This report has been prepared following a review of compliance with the Public Sector Internal Audit Standards (PSIAS) 2013 (amended 2017) and the International Professional Practices Framework (IPPF) on which PSIAS has been based. The purpose of this report is to provide an overview of FTF's arrangements for the operation and management of its Internal Audit service for **NHS Forth Valley** and **NHS Fife**.

1.1.2 PSIAS applies to all internal audit service providers, whether in-house, shared services or outsourced. Indeed, it should be acknowledged that internal audit within public bodies in Scotland became a statutory function on 10 October 2014, which brings Scotland into line with the rest of the United Kingdom. PSIAS contains the following definition:

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

1.1.3 PSIAS requires, as outlined in Standard 1300 "Quality Assurance and Improvement Programme", that:

"External assessments must be conducted at least once every five years by a qualified, independent assessor or assessment team from outside the organisation. External assessments can be in the form of a full external assessment or a self-assessment with independent external validation".

1.1.4 To meet this requirement, a reciprocal arrangement to complete a programme of inspections has been developed by the Scottish Local Authorities Chief Internal Auditor's Group (SLACIAG). This process identified the Midlothian Council (MLC) as the Authority to undertake the independent review of the level of compliance with PSIAS by FTF's Internal Audit function. In addition, SLACIAG developed a standard approach for the External Quality Assessment (EQA) which has been used during this review.

1.2 Scope

1.2.1 The methodology for this EQA takes the form of a validated self-assessment. As such, I have undertaken the following work in arriving at my opinion:

- A review of the latest self-assessment completed in November 2018 and supporting evidence provided by the Chief Audit Executive (CAE) and the Regional Audit Managers;
- Canvassed the opinions of key stakeholders which included a sample of members of the Audit Committee / Audit and Risk Committee, the Chief Executives, and Directors, using the standard review questionnaire;
- Completed a series of tests using the standard checklist; and
- Completed a review of guidance, process documents, audit working papers, and finalised reports for FTF.

Note: The Chief Audit Executive (CAE) is the terminology used by PSIAS to describe a senior person responsible for effectively managing the internal audit activity in accordance with the Internal Audit Charter and the *Definition of Internal Auditing* and the *Code of Ethics and Standards*.

FTF reports to an Audit and Risk Committee for NHS Fife, and an Audit Committee for NHS Forth Valley. For the purpose of this report, and for simplicity, these committees will both be referred to as Audit Committees in this report.

1.3 Areas of Good Practice Identified

1.3.1 Fully qualified Chief Internal Auditor (CAE) with extensive NHS experience who is supported by experienced and knowledgeable Regional Audit Managers;

1.3.2 FTF staff hold relevant professional qualifications where required for the post;

1.3.3 A robust planning methodology 'Audit Universe' is in place on which the annual and strategic Audit Plans are based;

1.3.4 Comprehensive process notes, templates, and guidance are in place, outlining the risk based auditing approach used by FTF in line with PSIAS;

1.3.5 Regular and comprehensive reporting of activity to the Audit Committees;

1.3.6 From meetings held with FTF, the staff are motivated in delivering a high quality internal audit service;

1.3.7 Substantial compliance with PSIAS and IPPF.

1.4 Conclusion and Main Findings

1.4.1 The overall conclusion is arrived at following completion of the comprehensive EQA Checklist and, based on the work undertaken, it is my opinion that the FTF Internal Audit service for Fife and Forth Valley **generally conforms** with the PSIAS. As detailed at Appendix A, there are 8 areas where the service fully conforms and 5 where it generally conforms.

1.4.2 Some areas for improvement have been identified and these are referred to in the action plan at section 3.

2. DETAILED FINDINGS AND RECOMMENDATIONS

The findings are detailed below under each heading within the checklist.

2.1 Section A: Definition of Internal Auditing

2.1.1 The FTF Internal Audit Service is considered to **fully conform** with the PSIAS definition detailed at 1.1.2 above. This definition has also been adopted within the Internal Audit Charter.

2.2 Section B: Code of Ethics

2.2.1 The Internal Audit function of FTF is considered to **fully conform** to this Assessment Area. The standards expected for ethical conduct are specified in the Audit Charter for each client, and a process is in place for auditors to declare any interests annually.

2.3 Section C: Attribute Standards

1000 Purpose, Authority and Responsibility

The standard sets out that the purpose, authority and responsibility of the internal audit activity must be defined in an Internal Audit Charter. It should define the nature of assurance services and consulting activities as well as internal audit's position in the organisation and relationships between the Chief Audit Executive and the Board.

2.3.1 The revised Internal Audit Charter was approved for NHS Fife on 13 September 2018, and on 9 October 2018 for NHS Forth Valley. The Audit Charters were reviewed and it was noted that the Charters meet the main requirements of PSIAS.

2.3.2 The FTF Internal Audit Service is considered to **fully conform** in terms of its purpose, authority and responsibility.

1100 Independence and Objectivity

The standard sets out the organisational and reporting lines expected to promote and preserve the organisational independence of the internal audit activity. It also sets out the arrangements expected to achieve individual objectivity and for dealing with potential and actual conflicts of interest.

2.3.3 The FTF Internal Audit Service provides the internal audit service to NHS Fife and NHS Forth Valley as part of a shared service which is hosted by NHS Fife. A Partnership Board comprising the Directors of Finance for NHS Fife, Forth Valley, and Tayside is chaired by the NHS Forth Valley Director of Finance. Approval of resource to the FTF Internal Audit Service is made by the Partnership Board. The Charter specifies that the Audit Committee will advise the Accountable Officer and the NHS board if the level of audit resources limit the scope of internal audit.

2.3.4 The organisational independence of the internal audit function within FTF is outlined within the Audit Charter. The Chief Internal Auditor is line managed by the NHS Fife Director of Finance. The Charter specifies that the Chief Internal Auditor functionally reports to the Audit and Risk Committee (Fife) / Audit Committee (Forth Valley), and appropriate functions have been delegated from the board including approving the internal audit charter, approving the risk based audit plan, receiving the work of internal audit, and reviewing the performance of internal audit relative to the plan. The Chief Internal Auditor has unrestricted access to the Board and Senior Management.

2.3.4 The internal auditors within FTF have no executive or operational responsibility or authority over any of the activities they review. Additionally, from review of the planning methodology, a sample of working papers and reports, the audit team has full freedom to plan their work and access relevant records and employees as specified in the audit charter.

2.3.4 Consideration should be given to reviewing the arrangements in terms of the allocation and approval of audit resource, as approval of budget and resource plan is not a function that has been delegated to the Audit Committees but it is a recommended Audit Committee function from PSIAS 1100, and to make it explicit in the charter how the Chief Executives (e.g. through counter signature or feedback) and Audit Committees (e.g. through representation by the Chair of the committee) contribute to the CAE's appraisal as is the recommended approach in PSIAS 1100 (**recommendation 1**).

2.3.5 Review of the questionnaires from stakeholders identified that the FTF internal audit service is generally held in high regard for both Fife and Forth Valley. However, some responses indicated that it was felt that FTF needs a higher profile within the organisations, and is only partly considered a strategic partner. Our view is that this will be substantially addressed by the ongoing involvement of senior management and members of the Board in the alignment of the audit plan for 2019/20, further explained in section 2.4 of the this report.

2.3.6 As a result of the findings above, the FTF Internal Audit Service is considered to **generally conform** with this standard.

1200 Proficiency and Due Care

The standard sets out the necessary requirements to ensure that the internal audit team possesses the knowledge, skills and other competencies to effectively carry out their professional responsibilities applying due professional care.

2.3.7 The majority of FTF employees have appropriate professional qualifications and the staffing and skills mix is reported annually to members in the Annual Internal Audit Reports. A very experienced, qualified, Chief internal Auditor is in place for FTF, supported by Regional Audit Managers who both have extensive NHS experience and relevant professional qualifications. Additionally, FTF have employed auditors with relevant IT Audit qualifications and experience. Both Forth Valley and Fife exceed the staffing and skills mix target of 50% qualified staff as reported in their Annual Internal Audit Reports.

2.3.8 An annual training day is coordinated by the Chief Internal Auditor, and future training plans include business assurance mapping. However, it was noted during the review that the budget for all of FTF's training is relatively small given the size of the team (£2,000 covering all auditors for Forth Valley, Tayside, and Fife), and the majority of this will be utilised to pay for the qualification of a part-qualified member of staff (**recommendation 2**).

2.3.9 The FTF Internal Audit Service is considered to **generally conform** in terms of its proficiency and due care.

1300 Quality Assurance and Improvement Programme

The standard sets out the necessary requirements for the internal and external assessment of performance and compliance against PSIAS, including the arrangements for reporting on results and disclosure of non-performance.

2.3.10 Arrangements are in place to monitor the performance of the internal audit function within FTF and this is evident throughout the audit process, from the audit planning phase to client reporting. Client satisfaction forms are used to obtain feedback on from managers after each audit. A summary of these surveys is reported in the Annual Internal Audit Reports, and the outcome of these are on average very positive.

2.3.11 The Standard requires the CAE to develop and maintain a Quality Assurance and Improvement Programme (QAIP) that covers all aspects of the Internal Audit activity and report this at least annually to senior management and the Audit Committee. An update on FTF's compliance with PSIAS and forthcoming external assessments was

reported to the Audit Committee within the Annual Internal Audit Reports. Additionally, as part of this validated self-assessment review, a completed, detailed, PSIAS self-assessment with identified improvement actions was received from FTF. From review of the Annual Internal Audit Reports, it was noted that whilst the performance of the audit service is reported on, no explicit comment is made on the Quality Assurance Improvement Programme (**recommendation 3**).

2.3.12 The FTF Internal Audit Service is considered to **generally conform** in terms of its Quality Assurance and Improvement Programme.

2.4 Section D: Performance Standards

2000 Managing the internal audit activity

The standard sets out the necessary requirements for the overall management of the internal audit activity, the preparation of the risk based Audit Plan including delivery and reporting of the Audit Plan.

2.4.1 A detailed 'Audit Universe' planning methodology is in place for FTF to assist the Chief Internal Auditor in developing the Internal Audit Plan, assessing the level of risk when compared to the clients' strategic risk registers, and ensuring sufficient coverage to deliver the annual opinion on the internal control framework.

2.4.2 FTF – NHS Tayside recently underwent a separate EQA conducted by the Institute of Internal Auditors during 2018/19. It was identified during their review that the linkage between the Internal Audit Plan and the client Strategic Risk Registers could be improved, as could client contribution to the alignment of audit priorities to address strategic and emerging risks. FTF have taken this recommendation forward for all clients. Reports have been issued to the respective Senior Leadership Teams/Chief Executive of both Fife and Forth Valley in January 2019 outlining the revised approach to audit planning to address the concerns raised by the Institute of Internal Auditors.

2.4.3 There is a suite of comprehensive process notes, templates, and guidance available for staff. Collectively these set out the standards, procedures and practice of risk based auditing to be followed by all staff.

2.4.4 The Internal Audit Strategic Annual Plan was approved by the Audit Committee on 08/06/2018 (with a draft approved 23/03/2018) for NHS Forth Valley and 17/05/2018 for NHS Fife, and progress updates are reported to each Audit Committee.

2.4.5 Internal Audit Progress reports were reviewed as part of the EQA. It was noted from review of the December 2018 progress report there was carry forward from the prior year's 2017/18 plan for NHS Fife with reports from this plan to be submitted to committees in 2019. Consideration should be given at the time of reporting the next year's Audit Plan to closing off in full the previous year's Audit Plan. Prior year audits would then either be added to the current year plan after reassessing the risk and priority of these, or dropping these audits entirely in favour of current year proposals. This would allow the plan to be more reactive to emerging risks, the views of senior management, and the board (**recommendation 4**). From review of the Annual Assurance Reports, and discussion with the Chief Audit Executive, it was noted that carried forwards audits are taken into account for the purpose of the annual internal audit opinion by ensuring high risks have been reviewed as part of the planned audit activity and governance arrangements reviewed as part of the Annual Report and Interim Control Evaluation half year report.

2.4.6 The FTF Internal Audit Service is considered to **generally conform** in terms of managing the internal audit activity, taking into account the action taken thus far by FTF to further improve the planning process.

2100 Nature of work

The standard sets the internal audit activity that needs to be undertaken to evaluate and contribute to the improvement of governance, risk management and control processes using a systematic and disciplined approach.

2.4.7 From an examination of the staffing structure, the 2018/19 audit plan, and audit reports issued, the FTF internal audit service is considered to **fully conform** in terms of the nature of its work. The processes involved in preparing the Interim Control Evaluation were reviewed as part of the EQA, and it was recognised that this approach to auditing the key themes of organisational governance in a single review adds value in providing the board with holistic assurance across all the key elements of governance, whether or not they are included within the audit cycle for that year.

2200 Engagement Planning

The standard sets the requirements necessary to develop and plan for each engagement including the objectives, scope, timing and resource allocations.

2.4.8 Based on the sample of individual audits examined, the FTF Internal Audit Service is considered to **fully conform** with the Engagement Planning standards.

2300 Performing the Engagement

The standard sets the requirements necessary to gather, document, analyse and evaluate evidence to achieve the engagement objectives. Supervision arrangements and records management are also covered.

2.4.9 The suite of audit procedure notes and templates sets out a standard risk based approach to performing audits and the management review of results. This was verified through the sample of audit files examined.

2.4.10 The internal audit function within FTF is considered to **fully conform** with Performing the Engagement standards.

2400 Communicating Results

The standard sets the requirements necessary for the communication of results for individual engagements and the overall annual opinion.

2.4.11 From review of a sample of audit reports, the report format is clear, succinct, and risk based, with the conclusions in the report supported by appropriate evidence. Annual overall annual opinion is appropriately delivered for both clients.

2.4.12 It was noted the report format has recently been revised, and one report with the revised format was reviewed. Whilst the report format is still clear, succinct, and well structured, consideration should be given to reviewing the colour scheme of Section 2 (dark blue box on black text in the Findings section of the report).

2.4.13 The FTF Internal Audit Service is considered to **fully conform** in terms of communicating results.

2500 Monitoring Progress

The standard sets out the expected arrangement for monitoring the implementation of agreed actions or the acceptance of the risk of not implementing.

2.4.14 For both Forth Valley and Fife, the Directors of Finance coordinate the audit recommendation tracking process. A record of all audit recommendations is held by the Directors, and updates on the progress of recommendations are reported by relevant managers to the Directors. Progress in implementing recommendations is then regularly reported to the Audit Committee.

2.4.15 A sample of recommendations is followed up on annually by FTF as part of the audit plan, and when an audit is carried out again in the same area (e.g. as part of the Internal Control Evaluation or Annual report).

2.4.16 A follow-up of recommendations audit report completed for NHS Fife in 2018/19 has highlighted some issues with the follow-up process. Some issues were identified with the management of this process, partly due to staff absence, and actions have been raised in the report to help address the issues.

2.4.17 For NHS Forth Valley, previous Audit Follow Up audits have concluded positively on the central operation of the Audit Follow Up (AFU) system in line with the extant Follow Up Procedures. However, internal audit reports and discussions at Audit Committee have highlighted the risk that responsible officers do not always confirm the status of recommended actions and do not provide appropriate evidence which accurately reflects the implementation status of recommendations. NHS Forth Valley currently have an audit assignment underway to provide assurance to the Audit Committee that agreed action has been taken in response to a sample of audit recommendations.

2.4.18 The Regional Audit Managers have indicated that there is scope to in the future use a risk management information system, such as Datix, to more effectively track audit recommendations. Such a system would make it easier for the FTF audit team to review the progress of recommendations in real time and allow reports to be extracted directly from the system on recommendation progress. Additionally, this approach would give FTF more direct control over the follow-up process, without significantly increasing the level of resource allocated to follow-up activity.

2.4.19 Our view is that the FTF internal audit service **generally conforms** in terms of monitoring progress, taking into account the work underway to further improve the follow-up process, and assignments currently underway.

2600 Communicating the Acceptance of Risk
The standard sets out the expected arrangement for the escalation of unacceptable risk to the Board.

2.4.20 There are no issues to report. The FTF internal audit service is considered to **fully conform** in terms of communicating the acceptance of risk.

I would like to thank all NHS Fife and NHS Forth Valley for the co-operation and goodwill I received during the course of my review.

James Polanski, FCCA, CIA, BAcc

Auditor, Midlothian Council

Jill Stacey, ACMA CGMA

Chief Internal Auditor, Midlothian Council and Scottish Borders Council

For and on behalf of:

SLACIAG, 8 May 2019

3. ACTION PLAN

Ref. No.	Finding	Recommendation	Priority	Management Comment	Manager Responsible	Date to be Completed
1	Approval of resource to the FTF Internal Audit Service is made by the Partnership Board comprising the Directors of Finance of NHS Fife, Tayside and Forth Valley.	The Partnership Board should review the requirements of PSIAS standard 1100 with Senior Management, Chairs of the Audit Committee, and the Chief Internal Auditor, with a view to improving compliance, in line with local circumstances.	3	The Partnership Board will consider this recommendation and, if suitable, actions will be agreed by both Audit Committees as part of the presentation of this report to them.	Directors of Finance and the Chief Internal Auditor	30/06/2019
	The Charter does not specify how the Chief Executives and Audit Committees contribute to the CAE's appraisal.	The Charter should specify how the Chief Executives and Committees contribute to the CAE's appraisal.		Client Directors of Finance already contribute to the CIA's appraisal through the NHS Fife Director of Finance. In future, these contributions will be informed by formal consideration of the CIA's TURAS appraisal by client DOFs who will take the views of the Audit Committee Chair.	Directors of Finance	31/05/2019
2	The training budget for FTF's internal audit service is relatively small considering the number of auditors employed, and there is no resource for appointment of short-term specialist auditors.	The level of resource put aside for training and development for specialist audits should be reviewed to ensure the skillset of auditors remains appropriate for the organisations.	2	This has been considered by the Partnership Board as part of discussions around the FTF budget 2019/20 and onwards.	Directors of Finance and the Chief Internal Auditor	Complete
3	FTF currently do not explicitly report to the Audit Committee on progress in implementing the Quality Assurance Improvement Programme.	In future, within the Annual Internal Audit Report, or through periodic update of the Audit Charter, the Quality Assurance Improvement Programme should be reported on to the Audit Committees.	3	This will be included in all future Annual Internal Audit reports.	Chief Internal Auditor	30/06/2019

Ref. No.	Finding	Recommendation	Priority	Management Comment	Manager Responsible	Date to be Completed
4	For both NHS Fife and NHS Forth Valley's Audit plans, there were audits carried forward from the prior year and these were reported after the prior year's Annual Internal Audit Opinion.	Consideration should be given at the time of reporting the next year's Internal Audit Plan to closing off in full the previous year's Audit Plan. Prior year audits would then either be added to the current year plan after reassessing the risk and priority of these, or dropping these audits entirely in favour of current year proposals. This would allow the plan to be more reactive to emerging risks, the views of senior management, and the Audit Committee.	2	This recommendation has been approved in principle by the Partnership Board and will considered for approval by each Audit Committee as part of the consideration of this report.	Chief Internal Auditor and Regional Audit Managers	30/06/2019

Key to Grading of Recommendations Priority:

1. **Critical**
2. **Requires addressing**
3. **Housekeeping**
4. **Value for Money**

SUMMARY OF CONFORMANCE WITH THE PSIAS **APPENDIX A**

Reference	Assessment Area	Fully Conforms	Generally Conforms	Partially Conforms	Does Not Conform
Section A	Definition of Internal Auditing				
Section B	Code of Ethics				
Section C	Attribute Standards				
1000	Purpose, Authority and Responsibility				
1100	Independence and Objectivity				
1200	Proficiency and Due Professional Care				
1300	Quality Assurance and Improvement Programme				
Section D	Performance Standards				
2000	Managing the internal Audit Activity				
2100	Nature of Work				
2200	Engagement Planning				
2300	Performing the Engagement				
2400	Communicating Results				
2500	Monitoring Progress				
2600	Communicating the Acceptance of Risks				

APPENDIX B

Specification for Internal Audit Services

APPENDIX B

CONTENTS

Page

1. Introduction

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

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

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

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

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

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

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

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

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

2. Internal Audit Responsibilities

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

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

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

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

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

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

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

3. Internal Audit Standards

3.1. Public Sector Internal Audit Standards (PSIAS)

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

4. Planning

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

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

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

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

4.5. **Strategic Audit Plan**

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

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

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

The Strategic Plan should set out the audit areas categorised by type of activity, risk rating, frequency of audit, and an assessment of resources to be applied. It should be prepared in conjunction with Audit Committee members and management, and be presented by the Chief Internal Auditor for formal approval by the Audit Committee by 31st March. The Strategic Plan should be updated annually in order to inform the Annual Audit Plan.

4.6. **Annual Audit Plan**

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

4.7. **Audit Assignment Plans**

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

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

5. Managing Audit Work

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

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

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

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

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

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

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

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

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

6. Reporting

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

6.2. The aim of every internal report should be to:

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

6.3. In addition, Internal Audit should provide the Director of Finance and Audit Committee with regular reports on progress (see 6.9 below)

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

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

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

6.7. **Individual Audit Project Reporting**

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

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

6.8. **Annual Audit Reporting**

The principal report to be produced by Internal Audit will be the Annual Internal Audit Report for each audit year. This needs be prepared in time for submission to the Audit Committee not later than the target date specified in Appendix I following the end of the audit period. The Annual Internal Audit Report should contain:

- ✧ An opinion on whether:
  - ✧ Based on the work undertaken, there were adequate and effective internal controls in place throughout the year
  - ✧ The Accountable Officer has implemented a governance framework in line with required guidance sufficient to discharge the responsibilities of this role
- ✧ The Internal Audit plan has been delivered in line with PSIAS
- ✧ analysis of any changes in control requirements during the year
- ✧ comment on the key elements of the control environment
- ✧ summary of performance against this service specification
- ✧ progress in delivering the Quality Assurance Improvement Programme.

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

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

6.9. **Progress reporting**

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

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

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

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

7. Quality Control and Quality Measurements

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

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

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

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

7.5. Client Satisfaction Survey

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

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

8. Liaison with External Audit

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

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

9. Best Value Reviews

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

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

10. Suspected Criminal Offences

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

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

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

11. Freedom of Information

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

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

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

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

12. Staffing

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

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

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

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

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

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

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

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

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

Non-Qualified Auditors: appropriately skilled staff including those training towards

CCAB or IIA or an appropriate alternative qualification.

During each successive twelve month period of the Agreement, FTF shall maintain, in the performance of the services, the skill mix of staff outlined in Appendix IV.

Actual performance against this specified skill mix should be reported within the Annual Internal Audit Report.

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

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

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

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

Appendix I

INTERNAL AUDIT SPECIFICATION

Performance Measures

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

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

Appendix II

INTERNAL AUDIT SPECIFICATION

INTERNAL AUDIT REPORTING PROTOCOL

Item%206d%20-%20
Appendix%203%20-%

Appendix III

INTERNAL AUDIT SPECIFICATION

Follow-up of agreed Internal Audit Recommendations

Protocol agreed by Client Audit Committee:

Item%2010a%20-%2
0Follow%20Up%20Pr

INTERNAL AUDIT SPECIFICATION
AUDIT SERVICE

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

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

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

INTERNAL AUDIT SPECIFICATION
AUDIT SERVICE

Public Sector Internal Audit Standards


PSAIS 2017.pdf

NHS FIFE

Management report 2018/19

AUDIT SCOTLAND

Prepared for NHS Fife
May 2019

Audit findings

Introduction

1. This report contains a summary of the key issues identified during the interim audit work carried out at NHS Fife (the Board). This work included testing of key controls within financial systems to gain assurance over the processes and systems used in preparing the financial statements. We will use the results of this testing to determine our approach during the 2018/19 financial statements audit.

2. Our responsibilities under the Code of Audit Practice require us to assess the system of internal control put in place by management. We seek to gain assurance that the audited body:

- has systems of recording and processing transactions which provide a sound basis for the preparation of the financial statements
- has systems of internal control which provide an adequate means of preventing and detecting error, fraud or corruption
- complies with established policies, procedures, laws and regulations.

3. We have also under the *Code of Audit Practice*, carried out work on the wider dimension audit. This focussed on financial management, financial sustainability, governance and transparency and value for money.

Conclusion

4. Overall, we found the key controls in place within NHS Fife's main financial systems operate satisfactorily. We identified several control weaknesses as summarised in Exhibit 1 where we will be carrying out additional work in response to these findings. This enables us to take planned assurance for our audit of the 2018/19 financial statements.

5. In terms of our wider dimension audit work we concluded that the Board continues to face a number of challenges in delivering financial and performance targets. The governance arrangements for the Board's transformation programme are not operating effectively and some improvements to governance arrangements on openness and transparency, health and social care partnership arrangements, data recovery procedures and monitoring progress in implementing resilience standards are required. NHS Fife had identified risks arising from EU withdrawal on 29 March 2019 but we have not identified any significant progress in implementing the mitigating actions.

6. Specific areas for improvement in respect of our wider dimension work are set out in Exhibit 1.

7. The contents of this report have been discussed with relevant officers to confirm factual accuracy. The co-operation and assistance we received during the course of our audit is gratefully acknowledged.

Work summary

Key financial controls

8. Our 2018/19 testing covered key controls in a number of areas including bank reconciliations, payroll validation and exception reporting, authorisation of journals,

change of supplier bank details and IT access controls. Additionally, our testing covered budget monitoring and control and feeder system reconciliations. Areas for further improvement are detailed at Exhibit 1.

Bank reconciliations

Payroll controls

IT access

Budgets

9. In accordance with *ISA 330: the auditor's response to assessed risk*, our audit judgements are based on current year testing of controls and where appropriate prior year results. Our risk based audit approach allows us to take a three-year cyclical approach to controls testing. This approach enables us to place reliance on previous years' audit work where controls remain unchanged and no significant weaknesses had been identified. Also, where possible we place reliance on the work of internal audit to avoid duplication of effort.

10. We reported last year that an external quality review of the FTF Internal Audit Service, the Board's internal audit service, had not been completed. This should have been done by 31 March 2018 to meet the five year cycle recommended by the Public Sector Internal Audit Standards (PSIAS). This was due to be completed by 30 June 2018 but was delayed several times and we have recently been informed that a report has been drafted and will be presented to the Audit and Risk Committee (ARC) in May 2019.

Wider dimension audit work

Financial management and financial sustainability

11. We followed up the findings from our prior year work on financial planning and financial management including reviewing progress on the delivery of savings plans and the effectiveness of in-year budget reporting. We also considered the reliance on and nature of non recurrent savings.

The transparency of budgetary reports has improved

12. The financial position section of the Integrated Performance Report (IPR) has been revised for 2018/19 to increase transparency. The changes include:

- a more comprehensive narrative summary
- an updated savings table
- new appendices which provide a breakdown of financial flexibility and efficiency savings, adjustments to revenue resource limit allocations, budget variances across corporate directorates and details of payments to other healthcare providers.

13. Members have been encouraged to comment on any areas for improvement in the format and content of the report and/ or clarification on specific issues. The narrative included in the IPR is now provided to the Scottish Government as part of the monthly Financial Performance Return (FPR) which ensures consistency of reporting.

The concept of NHS Fife's "run-rate" is still not fully understood by members

14. Our meetings with members confirmed the technical terms included in the IPR are understood when these are supported by presentations from the Director of Finance. Most of the members interviewed could not provide an explanation for the run rate which corresponded with our understanding of the term (budget prior to removal of efficiency savings).

NHS Fife continues to be reliant on non recurrent savings, including financial flexibility of £11.1 million, to meet financial targets

15. Total savings of £24 million were required in 2018/19 and as at end February 2019 £8.1 million was still to be achieved. Of the total savings achieved £7.4 million was non recurrent. The high level workstreams, including service redesign, to support the savings required are reported in Appendix 6 of the IPR. However the majority of savings have no detailed plans on how these are to be delivered. The appendix identifies the extent of recurrent/ non recurrent savings at workstream level but there are no detailed proposals to address shortfalls. On the basis that there were no details on the majority of savings required to close the budget gap, we find it difficult to see how the Board was able to conclude that it had a balanced budget agreed for 2018/19. (see Exhibit 1 – Delivery of savings)

16. We have reported for a number of years that the Board continues to rely on non recurrent savings, including financial flexibility, to deliver against the statutory financial target of break even and this has continued in the current year. Financial flexibility is expenditure within the financial plan that is not incurred (or turns out to be less than estimated) in the year and unspent Scottish Government allocations. The forecast underspend on the Board's acute budget includes financial flexibility of £11.1 million which more than offsets the forecast overspend of £9.2 million in the Acute Services Division. (see Exhibit 1 – Reliance on non recurrent savings)

The year end forecast outurn is for an overspend of £2.5 million

17. At 28 February 2019 the forecast outturn for 2018/19 is an overspend of £2.5 million. This is made up of an underspend on acute and other health board budgets of £4.5 million and an overspend, including risk share, on budgets delegated to the Integration Joint Board (IJB) of £7 million.

Medium term financial planning is being developed but there are no long term financial plans

18. A paper on the financial outlook 2019/20 to 2021/22 was presented to the Finance, Performance and Resources Committee (FP&RC) in September 2018. This paper provided a high level "first cut" financial outlook for the three year period.

19. Income and expenditure assumptions were refined over the financial year and an update presented to the FP&RC in March 2019. This update noted an improvement in the projected in-year budget gaps to £3 million, £6 million and £3 million in each of the three years respectively. This is between 0.5% and 1% of the annual budget. These projected gaps exclude the impact of non recurrent savings brought forward from previous years which could represent a further 1% of the annual budget. (see Exhibit 1 – Reliance on non recurrent savings)

The role of the Regional Development Plan (RDP) in financial planning is still unclear

20. The Board and FP&RC were provided with updates on progress with the RDP during the year but these updates do not include details of financial plans.

21. We were informed that a draft RDP has been submitted to the Scottish Government but we have not had sight of this document and we are unable to comment on the financial planning information it may contain. As reported in 2017/18, progress with the RDP has stalled and the Board is waiting for feedback from the Scottish Government before taking this further.

There is uncertainty over the IJB risk share agreement with Fife Council

22. The March 2019 IPR highlights that "the risk share arrangement as set out in the Integration Scheme for the Fife Integration Joint Board presents a specific challenge for financial management and reporting within NHS Fife and specifically the extent to which the Director of Finance can provide Board members with robust assurance on the likely year end forecast and eventual outturn throughout the financial year."

23. The existing risk share arrangement means that NHS Fife would fund 72% and Fife Council 28% of the IJB's overspend. For 2018/19 the IJB overspend is mainly attributable to social care costs. This results in an estimated cost of £7 million for NHS Fife and is a significant factor in the forecast overspend of NHS Fife as a whole of £2.5 million. In previous years the Board has benefitted from the risk share arrangement receiving £2 million and £0.3 million from Fife Council in 2016/17 and 2017/18 respectively, primarily due to overspends in prescribing.

24. The FP&RC agreed at its March 2019 meeting to support the Director of Finance and Chief Executive in entering discussion with colleagues to review the terms of the Integration Scheme with the aim of removing the risk share clause. Any changes to the agreement would need to be agreed with Fife Council and the IJB and approved by the Scottish Government. The current risk share arrangement is not typical of most integration schemes but in our view it is a positive indicator of partnership working and risk ownership across the partners.

Governance and transparency

25. We reviewed leadership and openness within NHS Fife. This involved reviewing Board and Committee minutes, observing several Board and Committee meetings and considering the information made available to the public. We met with the Board Chair, Chairs of the four Board governance committees and several other non executive members to discuss a range of issues including the opportunity for scrutiny of financial and performance information, members understanding of the scale, timescales and intended outcomes for the transformation programme and the organisation's attitude to openness and transparency. Members comments on the transformation programme were consistent with our findings from other work in this area as reported in the section on the transformation programme at paragraph 52 below.

There is scope to improve the openness and transparency of the NHS Fife website

26. We have commented previously on a lack of timeliness in uploading committee papers to the NHS Fife website and there were still some issues with this during 2018/19. This is an area that has also been picked up by the local media. Several members of the public as well as non executive members have highlighted difficulties in finding documents on the website. We have also been unable to find some documents we would expect to be available to the public such as the Participation and Engagement Strategy for Fife 2016-19. (see Exhibit 1: Openness and transparency)

Committee items escalated to the Board aren't always subject to clear evidence of discussion

27. A new governance structure was introduced in 2017 with more scrutiny being delegated to committees rather than Board level. This relies on the committees escalating matters for consideration to the Board. We noted on several occasions the discussion of items escalated to the Board was limited to a reference to ongoing work but there was no indication that the outcome from this work would be brought back to the Board at a later date. For example, the Clinical Governance Committee (CGC) meeting in May 2018 identified five issues to be escalated to the Board. The Board consideration of three of these issues, including a report on the Board's preparation for cyber resilience, was limited to being informed that they "are still on-going with discussion in various groups." (see Exhibit 1: Escalation of issues to the NHS Fife Board)

The new committee self-assessment process provides assurance that committees are operating effectively

28. A new online committee self-assessment process was introduced for the four governance committees in 2018/19. The response rate for each committee was high and the majority of participants welcomed the new format. Members agreed the questions were more relevant and structured than previous assessments although it was noted that a few changes could be made to aid clarity and relevance. The results of the self-assessments were reported to each of the

committees in March 2019. The results of the committee self-assessments were generally positive.

There are specific areas from the self-assessment process to be considered further

29. The following responses were provided by more than one member:

- information provided to committee members is excessive
- papers are not always provided on a timely basis
- there is a need for committee-specific training
- there is a lack of feedback from the Board and Accountable Officer.

30. There were a significant number of neutral responses, where members neither agreed or disagreed with the question being asked. Some of these questions may merit more focussed discussion as the number of participants selecting this response was often quite high. There is some variation between the committees in how the results of the self assessment will be taken forward. (see Exhibit 1: Committee self assessment process)

Non executive members have concerns about the operation of the health and social care partnership arrangements

31. Several members highlighted the challenges facing the IJB and commented this is due in part to the way in which the partnership arrangements were established nationally. Some of these challenges, around operational and governance arrangements, are local issues which have not been fully resolved yet. From our meetings with members and discussions with staff within the health board and IJB there appears to be further work to be done to ensure that staff, senior management and members work in partnership. (see Exhibit 1: Health and social care partnership arrangements)

The PFI provider for Victoria Hospital is the only key supplier by value

32. We obtained a list of the top 15 suppliers by value in 2017/18 and out of a total non pay expenditure of £879 million these accounted for £51 million (6%) excluding payments to public sector bodies. The major suppliers were:

- PFI contractors – Consort Healthcare for Victoria Hospital, Kirkcaldy (£25 million) and Projco for St Andrews Community Hospital (£3 million)
- Goods and services supplied under a national contract or framework agreement. This includes the patient management system, Trakcare, provided by Intersystems (£2 million), out of hospital healthcare provided by Lloyds Pharmacy Clinical Homecare and Healthcare at Home Ltd (£7 million), agency services provided by Brookson Medical Supplies Ltd (£4 million),pharmaceutical supplies supplied by Aah Pharmaceuticals and Alliance Healthcare Ltd (5 million) and other (£5 million).

33. A range of services are provided by NSS National Procurement for national contracts and reliance is placed on the governance and business continuity arrangements within that organisation.

34. NHS Fife's Procurement Department carries out financial viability checks before awarding local contracts and continues to monitor the financial viability of suppliers on an ongoing basis. Possible issues with the supply chain are also being considered as part of NHS Fife's preparations for EU withdrawal (see paragraph 39 below).

There are14 critical IT systems but some of these do not have technical recovery procedures

35. The eHealth Department has identified a list of 14 critical IT systems. The Top 3 most critical systems identified by the Head of IT Operations and the Business Continuity Manager are:

- Trakcare – Patient Management System (PMS)
- Patientrack – patient safety and communication system
- Labcentre - Laboratory Information Management System (LIMS).

36. Data recovery testing has not been carried out for several years. There is no technical recovery procedure for either Trakcare or Patientrack at the present time. (see Exhibit 1: IT data recovery)

Business continuity arrangements are reasonable but there is scope to improve monitoring of progress in implementing resilience standards

37. Business continuity arrangements are being developed at a corporate level. An NHS Fife Corporate Business Continuity Plan is currently being finalised and will go to the April 2019 meeting of the NHS Fife Resilience Forum. Business continuity is considered at service level and each service' business continuity plan identifies critical IT systems, suppliers, staff, equipment etc and the action to be taken if any of these become unavailable.

38. NHS Boards have legal responsibilities under the Civil Contingencies Act 2004 as a Category 1 Responder to be prepared to respond to major incidents. Scottish Government through its NHS Scotland Health Resilience Unit (NHRU) requires Boards to undertake an annual self-assessment exercise against 41 specified national Standards. The standards include a section on digital health which relates to resilience within the Board's Information and Communications Technology (ICT) portfolio and a section on the supply chain which is designed to ensure the Board has appropriate risk mitigation measures to deal with the loss of its main suppliers. The Board completed this self assessment in August 2018. No formal action plan has been prepared to monitor progress in respect of those areas where the standards are not yet fully implemented. (see Exhibit 1: Organisational resilience self assessment)

NHS Fife had identified risks arising from EU withdrawal on 29 March 2019 but we have not identified any significant progress in implementing the mitigating actions

39. The UK was due to leave the EU on 29 March 2019. EU withdrawal will inevitably have implications for devolved government in Scotland and for Scottish public bodies including NHS boards. As a minimum, Audit Scotland expected all public bodies to have assessed the potential impact of EU withdrawal on their operations and identified any specific risks and how they would respond to them by the end of 2018/19.

40. A Brexit Assurance Group (BAG) has been established which is supported by the NHS Fife Resilience Forum. The first meeting of the BAG was held in February 2019 and the next meeting is planned for April 2019. The BAG reports directly to the NHS Fife Board. Previously, a Brexit working group identified and considered a number of areas which could be affected by EU withdrawal, including "workforce", "medicines and medical technologies" and "procurement and supply chain". The associated risks are recognised in the NHS Fife Brexit Risk Register. Each of the risk areas has been allocated to an Executive Director and appropriate scrutiny committee to monitor. There are three high, four moderate and one low risk included in the register. None of the Board's management actions had reduced the risk levels by 6 February 2019 (latest risk register provided).

41. In relation to workforce the Board undertook a sample audit of recruitment forms and estimated non-UK EU citizens accounted for 2-3%of the workforce.

Non-UK EU national staff within the Board were then asked to complete an online survey to identify those requiring additional legal or immigration support because of EU withdrawal.

42. NSS National Procurement has been asked to set up a response service that Boards can contact where they have specific medicines shortages relating to EU withdrawal, both in terms of consumables held within the National Distribution Centre (NDC) but also for products held in the UK contingency stocks. This service is expected to extend to access medicines which is also being managed on a UK wide basis. NHS Fife's Procurement Department continue to monitor and challenge costs and services are reviewing contracts to establish possible hidden costs within the supply chain. Other management actions within NHS Fife are limited at the present time as a number of these are dependent both on the final withdrawal agreement and reviewing the outcome of national actions, including legislative changes.

43. There remains significant uncertainty covering the arrangements under which the UK will leave the EU or the point at which this will become clear. At the time of writing the deadline for withdrawal has been extended to 31 October 2019. We will continue to monitor NHS Fife's preparations for EU withdrawal and provide an update in our 2018/19 Annual Audit Report.

NHS Fife has not yet achieved cyber essentials accreditation or compliance with the General Data Protection Regulation (GDPR) 2018

44. The Board failed its assessment for cyber essentials accreditation in October 2018. Progress is being made in respect of the issues identified from the assessment but there are still a number of challenges to be addressed before the next assessment takes place. We previously reported there was a lack of updates on cyber security to the Board and this has not improved this year. (see Exhibit 1: Cyber security)

45. We reported in our 2017/18 Annual Audit Report that NHS Fife had identified concerns with progress on meeting the requirements of GDPR which came into effect on 25 May 2018. A target date for compliance by 30 October 2018 was revised to December 2018 but has since been delayed again and the Board is not expected to be fully compliant until December 2019. (see Exhibit 1: GDPR compliance)

Value for money

NHS Fife are taking steps to improve performance but targets are still not being met

46. We reviewed a sample of performance targets and considered what improvement action is being taken and how planned improvements are monitored. The three targets selected for review were:

- Sickness absence - NHS Fife had the worst performance in Scotland in 2017/18
- Child and Adolescent Mental Health Services (CAMHS) waiting times - below Scottish average in 2017/18
- Patient Treatment Time Guarantee (TTG) - deteriorating performance during 2018/19

47. We reviewed the monthly updates on performance provided in the IPR and more detailed progress reports provided to the relevant committees. We also discussed how the performance targets are managed with officers.

48. The Board's sickness absence in 2017/18 was 5.76% compared to the Scottish average of 5.39%. This was well above the national target of 4%. The Board has a number of improvement actions in place to improve sickness absence including

data collection and analysis, HR interventions, training for managers and promotion of wellbeing. Review and Improvement Panels have been introduced to ensure that senior management are involved and promote good attendance management.

49. Despite ongoing efforts to improve attendance, sickness absence rates continue to be above the national target. NHS Fife recognises that it needs to develop a better understanding of the underlying reasons behind sickness absence levels. There is a high level list of actions at the end of the update reports but this does not contain clear objectives and milestones, which would help to monitor progress and enable the Staff Governance Committee (SGC) to scrutinise the process. (see Exhibit 1: Sickness absence)

50. The CAMHS service has improved its waiting times performance to 77.7% by building support through other services (services which don't predominantly provide mental health services such as schools, social services or GP practices) for all children and young people. This includes providing training to professionals such as teachers who support children and young people. It also includes putting in place extra staff to reduce the waiting list. The Board is currently delivering above the Scottish average of 69% but isn't yet at the 90% target level and the number of referrals to the service continues to be high.

51. Meeting the TTG for all eligible patients to receive inpatient or day case treatment within 12 weeks of such treatment being agreed is a challenge nationally, and Scottish Government is providing support to health boards to improve performance. The Board's performance, as at January 2019, was 69% of patients seen on time. NHS Fife received funding in 2018/19 and has submitted plans to secure further funding in 2019/20 and 2020/21. This is expected to achieve the target over the next two years.

There is no consistent governance or reporting framework for the transformation programme and the programme is not progressing as planned

52. We followed up the findings from internal audit report B10/18 - Transformation Programme and also considered the processes for community engagement including the completion of equality impact assessments.

53. The agreed actions, in response to the points raised in the internal audit report, included:

- the basis for a framework for reporting of the transformation programmes will be presented to the CGC
- the proposed reporting framework will provide assurance over the governance role assigned to the Joint Strategic Transformation Group (JSTG) and the assurance lines to NHS Fife in respect of the programmes reported through the IJB
- an update on the Clinical Strategy will be produced similar to the Clinical Strategy One Year On document for Two Years On.

54. The latest date for implementing agreed management action was 31 March 2019, but we found that none of these action points have been fully implemented. We were provided with a structure for the revised governance arrangements, but this has not been formally agreed by the Board, any committee of the Board, or IJB.

55. There is a lack of consistency in the understanding of the assurance lines to NHS Fife and its governance committees on the programmes reported separately through the IJB. This was highlighted when we obtained a different governance structure from the IJB Divisional General Managers.

56. Members of the CGC were expecting a written update on the role and remit of the JSTG in March 2019 but were informed at the meeting that the JSTG has been paused as it was not fulfilling its remit and there was uncertainty over its purpose. We also noted that the Community Transformation Programme Board, which is the board responsible for the IJB-led programmes, did not meet between December 2018 and April 2019. The minutes of the December meeting only refer to the joining-up care programme. There were no updates in respect of mental health redesign or the IJB managed elements of the medicines efficiencies programme. (see Exhibit 1:Transformation programme governance framework)

57. The form and content of reports to the CGC vary in nature, including whether they are verbal or written. There is a lack of focus on targets, milestones and timescales. Papers to support agenda items are sometimes not available and on other occasions they are provided late which does not allow time for effective scrutiny. There was a lack of regular, written updates on progress in completing the transformation projects against performance measures to the JSTG. (see Exhibit 1: Reporting on progress with the transformation programme)

58. The Clinical Strategy was published in December 2016 and the "One Year On" report was presented to the FP&RC and CGC in October 2017. The "Two Year On" update is overdue. We have been informed this report will be a priority for the newly appointed Planning and Performance Manager. Previous updates on the Clinical Strategy recommendations summarise 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. (see Exhibit 1: Update on the Clinical Strategy)

Risks identified

59. The key control and wider dimension risks identified during the interim audit are detailed in Exhibit 1. These findings will inform our approach to the financial statements audit where relevant.

60. Any weaknesses identified represent those that have come to our attention during the course of normal audit work and therefore are not necessarily all the weaknesses that may exist. It is the responsibility of management to decide on the extent of the internal control system appropriate to NHS Fife.

Additional follow-up work

61. Interim testing has identified additional audit work to be carried out during our financial statements audit as follows:

- We will test a small sample of PECOS payments focussing on the five users with inappropriate access to confirm entries are appropriate. (see Exhibit 1: PECOS access controls).
- We will select a sample of changes to supplier bank details and request confirmation through officers that changes are valid and have been confirmed with suppliers where appropriate. (see Exhibit 1: Changes to supplier details).
- We reported last year that individuals outwith the procurement team were placing orders on the Emis pharmacy system. This practice continued in the current year until October 2018. We will undertake specific testing to obtain assurance over the expenditure posted through Emis by individuals outwith the procurement team from April 2018 to October 2018.

Exhibit 1
Key findings and action plan 2018/19

Issue/ risk	Recommendation	Agreed management action/ timing
Audit findings		
PECOS access controls In 2017/18 we found three users with approval permissions on the PECOS purchasing system that were not appropriate to their job role. Audit testing this year found one of the users identified last year still had inappropriate access, a further three users had approval rights despite having left the health board and one user had changed roles and access to PECOS was no longer appropriate. **There is a risk that users have inappropriate access to PECOS and erroneous or fraudulent entries could be made.**	User access permissions for PECOS should be reviewed on a regular basis to ensure that the permissions granted are appropriate to job roles and relate only to current employees.	On occasion, individuals may remain on the system with authorisations delegated to their deputy, pending the replacement starting. We will work with eHealth colleagues to ensure the IT access termination documentation also covers PECOS; and with HR colleagues to remind line managers of the requirement to advise on movers/leavers. ***Head of Procurement*** ***31 July 2019***
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***

Issue/ risk	Recommendation	Agreed management action/ timing
Audit dimensions - issues and risks		
Financial management and financial sustainability		
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***
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.
Governance and transparency		
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

Issue/ risk	Recommendation	Agreed management action/ timing
		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***
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***
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*** ***October 2019***

Issue/ risk	Recommendation	Agreed management action/ timing
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***
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***

Issue/ risk	Recommendation	Agreed management action/ timing
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*** ***July 2019***
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***
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***

Issue/ risk	Recommendation	Agreed management action/ timing
Value for money		
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***
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***

Issue/ risk	Recommendation	Agreed management action/ timing
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
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***

Source: Audit Scotland

62. All our outputs and any matters of public interest will be published on our website: www.audit-scotland.gov.uk.

NHS FIFE

Management report 2018/19

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AS.2.0

Fife Health Board Patients' Private Funds Audit Planning Memorandum

To the Board

Audit of Accounts

Year Ended 31 March 2019

Introduction

Purpose and Scope

International Standard on Auditing 260 requires auditors to communicate by effective means, matters concerning an entity's audit to those charged with the governance of that organisation.

The purpose of this report is to provide the Board (as those charged with the governance of Fife Health Board Patients Private Funds) with information regarding:

- the planned audit approach;
- the proposed means and modes of communication throughout the audit assignment; and
- to provide the Board with the opportunity to discuss the assignment and the audit approach prior to the commencement of audit field work.

Over the past two years there have been a number of developments in the auditing and financial reporting framework. We have provided details of these developments in the Audit Planning Memorandum for the Fife Health Board Endowment Fund.

This report is addressed to the Board of Fife Health Board Patients' Private Funds and is intended for internal use only for the purpose of planning and discussing the audit of the financial statements for the year ended 31 March 2019. This report may not be reproduced in whole or in part without the prior, written consent of Thomson Cooper.

Background to Appointment

General

As part of our quality control procedures, we review and update out Letters of Engagement on a regular basis, therefore, an electronic copy of our most recent engagement letter is shown at Appendix 2. A paper copy of this letter has been sent to you for signing separately. As detailed in our engagement letter, it remains effective until it is replaced.

Independence

We can confirm that Thomson Cooper are independent within the context of relevant regulatory and professional requirements and that there are no circumstances of which the firm is aware which might lead to impairment in the objectivity of either the audit engagement partners or audit staff.

Staff Independence

All our Staff must adhere to strict regulatory, professional and internal independence requirements related to investments or business relationships with clients. All staff and partners must certify their compliance with independence rules on an annual basis.

Thomson Cooper is authorised by ICAS to carry out statutory audits. Members of ICAS and other Accounting Bodies are bound by the Ethical Code which covers, objectivity, independence, confidentiality and integrity.

Money Laundering Regulations

All our staff are briefed in the current Money Laundering Regulations. As part of these regulations, and determining the risk to our audit, we consider the nature of your business, where you operate, your products and services and the appropriateness of your internal controls.

Quality

Independent quality reviews of our audit work are performed throughout the year. The reviews include testing of the effectiveness and quality of our audit work and we maintain a continuous improvement programme to ensure that our standards are maintained and improved. In addition, external reviews are also carried out periodically by the Institute of Chartered Accountants of Scotland (ICAS).

We are members of Accelerate, a community of relationship-focused, technology-driven, value-based accounting firms. Accelerate is a Business Associate of Crowe Global, meaning we can access accounting firms in more than 130 countries throughout the world. As part of that membership we receive visits every two years to review our audit approach and to discuss current auditing issues. Accelerate also provides technical courses and material on auditing throughout the year.

All Audit Staff undertake ongoing Continuous Professional Development via attendance at internal and external training courses and seminars.

Background to Appointment (continued)

Ethical Standards

The APB's 6 Ethical Standards have been replaced with a single Ethical Standard issued by the FRC. The aim of the Standard is to strengthen auditor independence and limit the range of services auditors can provide. The new Standard sees the independence threat changed from 'reduced to an acceptable level', to that of 'a level at which it is probable that an objective, reasonable and informed third party would not conclude that independence would be compromised'. At present, we assist in the preparation of the Statutory Accounts as required. There is no need to disclose this in the Annual Accounts if the organisation has "informed management". Based on our knowledge and experience of the Board we are satisfied that Fife Health Board Patients' Private Funds has "informed management" and therefore no disclosures will be required in the accounts.

Thomson Cooper Audit Approach

General

Thomson Cooper adopts a risk based approach to audit assignments.

The starting point for each assignment is to identify the key issues and risks facing the organisation including a review of internal control strengths and weaknesses. This involves close liaison with clients in order to obtain a good understanding of the client's business before detailed audit work commences.

Following this initial assessment the audit work to be undertaken can be fully planned.

Effective planning facilitates:

- concentration of audit effort in areas of high risk;
- maximisation of overall efficiencies in audit work; and
- the drawing of suitable conclusions concerning the truth and fairness of the financial statements.

Detailed Audit Procedures

The extent of testing undertaken on the detailed records depends upon the continued adequacy of key internal accounting and operational controls, the materiality of the item involved and the information and support provided by management.

Detailed audit testing will be performed to test the reliability of the accounting system in operation and to provide additional audit assurance.

Relationship with Internal Audit

Introduction

NHS Fife has an internal audit service which conducts periodic reviews of the Patients' Private Funds.

International Standard on Auditing 610 (ISA 610) entitled "Considering the Work of Internal Audit" establishes standards and provides guidance to external auditors in considering the work of internal audit. The standard requires external auditors to "consider the activities of internal auditing and their affect, if any, on external audit procedures".

The following sets out our audit approach for the current year and our relationship with NHS Fife internal audit function.

International Standard on Auditing 610

As stated above, the standard requires the auditor to consider the activities of internal audit. Section 5 of the standard indicates that internal audit normally has specific regard to the following:-

1. Monitoring of internal control.
2. Examination of financial and operating information.
3. Review of the efficiency and effectiveness of operations including non financial controls.
4. Review of compliance with laws and regulations.

The role of internal audit is set by management and clearly its objectives will differ from the external auditor whose appointment is to report independently on the annual financial statements. The standard recognises, however, that some of the means of achieving the respective objectives are similar and therefore certain aspect of internal audit work may be useful in determining the nature, timing and extent of external audit procedures. It follows therefore that we are obliged to obtain a sufficient understanding of the work carried out by internal audit to enable us to identify and assess the risks of material misstatements of the financial statements and accordingly to design and perform further audit procedures.

Based on our review of the work carried out by NHS Internal Audit Service in previous years, the principal area upon which we can place reliance on the work of internal audit function, has been in relation to the overall control environment within which the Patients' Private Funds operates.

The process of communication between external and internal auditors is two way and we will ensure that any instances of non compliance with the Financial Operating Procedures detected during our external audit work are brought to the attention of internal audit. The Board are asked to note and confirm their approval with the way in which we intend working with internal audit.

Staffing

Partner in Charge of Assignment

The current lead partner is Alan Mitchell. The audit of the financial statements for the year ended 31 March 2019 will be Alan's sixth year as lead partner following the rotation of the audit engagement partner from Andrew Croxford to Alan Mitchell.

Support Partners

Andrew Croxford will be called upon to undertake concurring reviews where required and will be available to discuss any issues which may arise throughout the audit.

Other Staff

In order to maximise efficiency and minimise disruption to the company, the firm, as far as possible will try to maintain continuity in the other staff deployed on the assignment.

Staff members involved in the audit have previous experience of the assignment, and are suitably qualified and trained.

The senior staff member this year is Billy Leitch, a qualified Accountant. He will be assisted by Peter Ratomski who is also a qualified Accountant.

Audit Risks

Introduction

Audit risk comprises three elements:

- Inherent risk
- Control risk
- Detection risk

Thomson Cooper aim to plan and perform sufficient audit work so as to ensure that detection risk is minimised and that the conclusion drawn regarding the truth and fairness of Fife Health Board Patients Private Fund's accounts is valid.

This involves Thomson Cooper in a wide evaluation of risk areas (per ISA 300 - Planning, ISA 250A – Consideration of Laws and Regulations and ISA 330 - Auditor's Response to Assessed Risks) and also a detailed evaluation, at the level of account class, of the risk of material misstatement.

The areas detailed below have been limited to those, based on previous audit experience, which carry the highest risk of material misstatement either because the balances are so significant in the overall context of Fife Health Board Patients Private Fund's accounts or the account class is subject to a degree of estimation or relies upon the work of an expert.

The list is not exhaustive and has been prepared based upon our previous experience prior to the commencement of the detailed planning work for the audit for the year ended 31 March 2019.

The Board remain ultimately responsible for the integrity of the financial statements and risk management in the widest context. Thomson Cooper, as external auditor, are responsible for providing the Board of Fife Health Board Patients' Private Funds reasonable assurance that the accounts are free from material misstatement and that the accounts give a true and fair view of the state of the affairs of Fife Health Board Patients' Private Funds at 31 March 2019. While the audit work performed may involve consideration of such issues as the impact of failure of IT equipment for example, the work performed will be limited to considering the extent to which the breach might impact upon the financial statements. Hence risks of this nature have been excluded from those listed below.

Audit Risks (continued)

Security of Patients Funds

Due to the nature of the fund's assets i.e. cash, there is an increased susceptibility of the assets to loss through theft or misappropriation. A key focus of our audit will be the testing of the adequacy of the controls in place governing the security of patient funds on the wards.

Compliance with Agreed Operating Procedures

The Board has in place a series of control and authorisation procedures for patient funds which are documented in the Board's Financial Operating Procedure. This report details the various forms which should be used by staff in order to adequately record and control patient funds on the wards and is a key source of internal control. Our audit will include tests to assess the extent to which members of staff have adhered to the documented procedures, including visiting various hospital wards on a rotational basis (see Appendix 2).

We shall also consider any areas of potential non-compliance with procedures that were identified and communicated to the Board in the previous year's audit, and follow up with regard to how each item has been subsequently dealt with. In addition, where considered relevant, we will seek to re-visit any wards attended in the previous year where issues were identified to perform updated tests to re-assess the extent to which staff have been advised of the issues and have acted upon the recommendations.

Management Override

In every organisation, senior management may be in a position to override the routine day-to-day financial controls. For all of our audits, we consider this risk and adapt our audit procedures accordingly.

Fraud

The auditor's responsibility to consider the audit risk of fraud is laid down in ISA 240 "The auditor's responsibility to consider fraud in an audit of financial statements".

In accordance with ISA 200, 'the auditor shall maintain professional scepticism throughout the audit, recognising the possibility that a material misstatement due to fraud could exist, notwithstanding the auditor's past experience of the honesty and integrity of the entity's management and those charged with governance'.

Audit Risks (continued)

Fraud (continued)

As part of the planning process, we are obliged to make enquiries of management and those charged with governance regarding:

a) Management's assessment of the risk that the financial statements may be materially misstated due to fraud, including the nature, extent and frequency of such assessments;
b) Management's process for identifying and responding to the risks of fraud in the entity, including any specific risks of fraud that management has identified or that have been brought to its attention, or classes of transactions, account balances, or disclosures for which a risk of fraud is likely to exist;
c) Management's communication, if any, to those charged with governance regarding its processes for identifying and responding to the risks of fraud in the entity;
d) Management's communication, if any, to employees regarding its views on business practices and ethical behaviour; and
e) Whether Management have knowledge of any actual, suspected or alleged fraud affecting the entity.

We can confirm that if we identify any fraud or obtain information that indicates that a fraud may exist, we will communicate this to the appropriate level of management as soon as practicable. If the fraud involves management, employees who have significant roles in internal control or where the fraud results in a material misstatement in the financial statements, we will communicate these matters to the Board as soon as practicable.

At the conclusion of our audit work, we will request written confirmation in our letter of representation that the Board acknowledge their responsibility for the design and implementation of internal control to prevent and detect fraud and that it has disclosed to ourselves the results of its risk assessment and disclosed any instances or allegations of fraud which have arisen.

Materiality

Concept and definition

The concept of materiality is fundamental to the preparation of the financial statements and the audit process and applies not only to monetary misstatements but also to disclosure requirements and adherence to appropriate accounting principles and statutory requirements.

- According to International Standard on Auditing 320 Audit Materiality, 'misstatements, including omissions, are considered to be material if they, individually or in aggregate, could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements; and judgements about materiality are made in light of surrounding circumstances, and are affected by the size or nature of a misstatement, or a combination of both'.

  The Clarified ISA 320 on Audit Materiality establishes the concept of 'performance materiality'. Performance materiality means the amounts set by the auditor at less than materiality for the financial statements as a whole to reduce to an appropriately low level the probability that the aggregate of uncorrected and undetected misstatements exceeds materiality for the financial statements as a whole.

An item may also be considered material for reasons other than size, if for example, it had an impact on:

- trends;
- compliance with loan covenants; or
- instances when greater precision is required.

Calculation and determination

We have determined materiality based on professional judgement in the context of our knowledge of Fife Health Board Patients' Private Funds, including consideration of factors such as member expectations, industry developments, financial stability and reporting requirements for the financial statements.

We determine materiality in order to:

- estimate the tolerable level of misstatement in the financial statements;
- assist in establishing the scope of our audit engagement and audit tests;
- calculate sample sizes; and
- assist in evaluating the effect of known and likely misstatements on the financial statements.

We will finalise our materiality figure prior to the commencement of our audit.

Materiality (continued)

If, in the specific circumstances of Fife Health Board Patients' Private Funds, we believe there are particular transactions, account balances or disclosures where misstatement of less than materiality for the financial statements as a whole could be expected to influence the decisions of the users, we shall also determine the performance materiality level to be applied to those particular transactions.

Reassessment of materiality

We will reconsider materiality if, during the course of our audit engagement, we become aware of facts and circumstances that would have caused us to make a different determination of planning materiality if we had been aware of those facts and circumstances when we made our initial determination.

Further, when we have performed all our substantive tests and are ready to evaluate the results of those tests, including any misstatements we detected, we will reconsider whether materiality, in combination with the nature, timing and extent of our auditing procedures, provided a sufficient audit scope. If we conclude that our audit scope was sufficient, we will use materiality to evaluate whether uncorrected misstatements, individually or in aggregate, are material.

Unadjusted errors

In accordance with auditing standards, we will communicate to the Board all unadjusted items identified during our audit, other than those which we believe are "clearly trivial".

Clearly trivial is defined as matters which will be of a wholly different (smaller) order of magnitude than the materiality thresholds used in the audit, and will be matters that are clearly inconsequential, whether taken individually or in aggregate.

Auditing standards do not place numeric limits on the meaning of 'clearly trivial', however, we consider the 'clearly trivial' limit to be less than 1% of materiality.

We will obtain written representations from the Board confirming that after considering all these unadjusted items, both individually and in aggregate, no adjustments are required.

There are a number of areas where we would strongly recommend or request any misstatements identified during the audit process being adjusted. These include:

- misstatements that we believe were intentionally made to achieve targeted earnings or similar goals;
- clear cut-off errors whose correction would cause non-compliance with loan covenants, management compensation agreements, other contractual obligations or governmental regulations that we consider are significant; and
- other misstatements that we believe are material or clearly wrong.

Reporting of Audit Findings

Communication

As external auditor, we have direct access to the Board should the need arise. Audit findings will be communicated orally at the meeting of the Board at which the annual accounts are reviewed.

In addition, on completion of the audit field work an Audit Completion Memorandum will be prepared summarising the main audit findings which will be addressed to the Board for their responses.

Audit Adjustments

Any misstatements identified as a result of the audit work performed, which have not already been adjusted, will be reported to the Board. If, after discussion, there remain any material unadjusted misstatements written representation from the Board may be sought setting out the reasons for non-adjustment.

Misstatements which have been found, but adjusted, will only be brought to the attention of the Board where it is believed that an awareness is required for the Board to be able to fulfil their governance responsibilities or where adjustments indicate significant weaknesses in the system of internal controls.

Timetable

	Date
Issue Bank Confirmation Letter	5 March 2019
Audit Planning Meeting with Client	14 March 2019
Issue Audit Planning Memorandum	18 March 2019
Audit Staff Planning Meeting	6 May 2019
Audit Fieldwork Commences	7 May 2019
Audit Clearance Meeting	20 May 2019
Provide Completion Documents	3 June 2019
Board Papers Issued	5 June 2019
Audit Committee Meeting	26 June 2018
Board Meeting	TBC June 2018

Proposed Fees

	Proposed 2019	Actual 2018
	£	£
On completion of audit fieldwork	1,500	1,500
On signing of accounts	900	800
	2,400	2,300

Should we anticipate that our costs will exceed our budget due to additional work that we may require to undertake, we shall notify you immediately in order that we may agree what action, if any, is required by you and to agree the basis for any additional charges.

The above fees are exclusive of VAT and expenses.

Appendix 1 – Engagement Letter

An electronic copy of our Engagement Letter dated 18 April 2014 follows:

CF15B.1041146.BL.KLH

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15 March 2019

The Trustees
Fife Health Board Patients' Private Fund
Evans Business Centre
Mitchelston Industrial Estate
Mitchelston Drive
Kirkcaldy
Fife
KY1 3NB

Dear Sirs

We are pleased to continue the instruction to act as your advisers and are writing to confirm the terms of our appointment.

The purpose of this letter together with the attached terms and conditions is to set out our terms for carrying out the work and to clarify our respective responsibilities.

We are bound by the ethical guidelines of the Institute of Chartered Accountants Scotland and accept instructions to act for you on the basis that we will act in accordance with those guidelines.

1. Engagement letter

1.1 Thank you for engaging us as your advisers. Alan Mitchell will be your main point of contact and will have primary responsibility for this assignment. This letter and the attached schedule(s) of services together with this firm's standard terms and conditions set out the basis on which we will act.

2. Who we are acting for

2.1 For the avoidance of doubt Carol Potter is acting as nominated first point of contact. Any change to the nominated person should be notified to us in writing and will not be effective until acknowledged by us in writing.

3. Period of engagement

3.1 This engagement will start from the date this letter is signed. It replaces all previous engagements that we have had with you.

4. Our responsibility to you

4.1 We have set out the agreed scope and objectives of your instructions within this letter of engagement. Any subsequent changes will be discussed with you and where appropriate a new letter of engagement will be agreed. We shall proceed on the basis of the instructions we have received from you and will rely on you to tell us as soon as possible if anything occurs which renders any information previously given to us as incorrect or inaccurate. We shall not be responsible for any failure to advise or comment on any matter which falls outside the specific scope of your instructions. We cannot accept any responsibility for any event, loss or situation unless it is one against which it is the expressed purpose of these instructions to provide protection.

5. Your responsibility to us

5.1 The advice that we give can only be as good as the information upon which it is based. Insofar as that information is provided by you, or by third parties with your permission, your responsibility arises as soon as possible if any circumstances or facts alter as any alteration may have a significant impact on the advice given. If the circumstances change therefore or your needs alter, advise us of the alteration as soon as possible in writing.

6. Services

6.1 Attached is the schedule of services listed below which records the work we are instructed to carry out. This also states your and our responsibilities in relation to the work to be carried out.

Schedules

Unincorporated Charity Audit (April 2015 version 2)

6.2 You may request that we provide other services from time to time. We will issue a separate schedule of service or, if necessary, a new letter of engagement and scope of work to be performed accordingly.

6.3 Because rules and regulations frequently change you must ask us to confirm any advice already given if a transaction is delayed or a similar transaction is to be undertaken.

7. Fees

7.1 Our fees will be charged in accordance with our standard terms and conditions. Please review these to ensure you understand the basis of our charges and our payment terms.

8. Limitation of liability

8.1 You have agreed that our liability as auditors to the company will be limited in accordance with sections 532 to 538 of the Companies Act 2006. The terms of this agreement are in our standard terms and conditions which are attached to this engagement letter.

8.2 We specifically draw your attention to paragraph 23 of our standard terms and conditions which sets out the basis on which we limit our liability to you and to others. You should read this in conjunction with paragraph 11 of our standard terms and conditions which excludes liability to third parties.

8.3 There are no Third Parties that we have agreed should be entitled to rely on the work done pursuant to this engagement letter.

9. Your agreement

9.1 Once it has been agreed, this letter will remain effective until it is replaced.

9.2 We shall be grateful if you could confirm your agreement to the terms of this letter, the schedule of services and the standard terms and conditions by signing the enclosed copy and returning it to us immediately.

9.3 If this letter and schedule of services is not in accordance with your understanding of the scope of our engagement or your circumstances have changed, please let us know.

Yours sincerely

Thomson Cooper

Acceptance

We confirm that we have read and understood the contents of this letter, schedules and related terms and conditions and agree that it accurately reflects our fair understanding of the services that we require you to undertake.

Signed ..... Date .....

For and on behalf of
Fife Health Board Patients' Private Fund

SCHEDULE OF SERVICES

This schedule should be read in conjunction with the engagement letter and the standard terms and conditions.

UNINCORPORATED CHARITY AUDIT

1. Your responsibilities as trustees of the charity

1.1 In agreeing to these engagement terms, you acknowledge your responsibilities and confirm that you understand them.

1.2 As trustees of the charity you are responsible for:

a) ensuring that adequate accounting records are maintained which disclose the charity's financial position with reasonable accuracy at any time;

b) preparing financial statements for each financial year that:

i) give a true and fair view of the charity's state of affairs at the end of the financial year and of its incoming resources and application of resources for that year; and

ii) are in accordance with the Charities and Trustee Investment (Scotland) Act 2005 and regulations thereunder;

c) preparing an annual report on the activities of the charity during the year that complies with the requirements of the relevant regulations.

1.3 In preparing the financial statements (or arranging for them to be prepared) you are required to:

a) select suitable accounting policies and then apply them consistently;

b) make judgements and estimates that are reasonable and prudent;

c) prepare the financial statements on the going concern basis unless it is inappropriate to assume that the charity will continue in business; and

d) have regard to applicable accounting standards and the relevant statement of recommended practice.

1.4 You are responsible for such internal controls as you consider necessary to enable the preparation of the financial statements that are free from material misstatement, whether due to fraud or error.

1.5 Under the Charities Accounts (Scotland) Regulations 2006 (as amended) and the Charities SORP you are required to report as to whether you have given consideration to the major risks to which the charity is exposed, and to the systems designed to manage those risks. We are not required to audit this statement, or to form an opinion on the effectiveness of the risk management and control procedures.

1.5 You are responsible for safeguarding the assets of the charity and to ensure their proper application, and hence for taking reasonable steps to prevent and detect fraud and other irregularities.

1.6 You are responsible for ensuring that the charity complies with laws and regulations that apply to its activities, and for preventing non-compliance and detecting any that occurs.

1.7 You undertake to make available to us, as and when required, all the charity's accounting records and related financial information, including minutes of management and members' meetings that we need to do our work. You will disclose to us all relevant information in full. In particular, you agree to provide:

a) access to all information of which management is aware that is relevant to the preparation of the financial statements such as records, documentation and other matters;

b) additional information that we may request from management for the purpose of the audit; and

c) unrestricted access to persons within the entity from whom we determine it necessary to obtain audit evidence.

1.8 If audited financial information is published, which includes a report by us or is otherwise connected to us, on the charity's website or by other electronic means, you must inform us of the electronic publication and obtain our consent before it occurs and ensure that it presents the financial information and auditor's report properly. We have the right to withhold consent to the electronic publication of our report or the financial statements if they are to be published in an inappropriate manner.

1.9 You must set up controls to prevent or detect quickly any changes to electronically published information. We are not responsible for reviewing these controls nor for keeping the information under review after it is first published. You are responsible for the maintenance and integrity of electronically published information and we accept no responsibility for changes made to audited information after it is first posted.

1.10 You are responsible for establishing and controlling any process for electronically distributing Annual Reports and other financial information to members and/or supporters of the charity and to the Office of the Scottish Charity Regulator (OSCR).

1.11 You are responsible for filing the charity's financial statements and an annual report for the financial year complying in its form and content, as well as other relevant documentation, with OSCR in accordance with their requirements, unless otherwise agreed.

1.12 The audited financial statements and annual report are required to be delivered to OSCR within nine months of the end of the charity's financial year end and it is the trustees' responsibility to ensure that this deadline is met.

2. Our responsibilities as auditor

2.1 We have a statutory responsibility to report to you whether, in our opinion, the financial statements give a true and fair view of the state of affairs of the charity at the end of the financial year and of its incoming resources and application of resources in that year and whether they have been properly prepared in accordance with the Charities and Trustee Investment (Scotland) Act 2005 and regulations thereunder. In deciding this, we must consider the following matters, and report on any that we are not satisfied with:

a) whether the charity has kept proper accounting records;

b) whether the charity's balance sheet and statement of financial activities are in agreement with the accounting records and returns;

c) whether we have obtained all the information and explanations which we consider necessary for the purposes of our audit; and

d) whether the information given in the annual report of the charity trustees is not consistent with that contained in the audited financial statements.

2.2 We may also need to deal with certain other matters, according to the circumstances, in our report such as any material concerns we may have relating to the financial effects of any non-compliance with relevant laws and regulations.

2.3 We have a professional responsibility to report if the financial statements do not significantly comply with applicable financial reporting standards or the relevant statement of recommended practice unless, in our opinion, the departure is justified in the circumstances. In deciding whether or not this is the case we consider:

a) whether the non-compliance is necessary for the financial statements to give a true and fair view; and

b) whether the non-compliance has been clearly disclosed.

2.4 Our professional responsibilities also include:

a) describing in our audit report the trustees' responsibilities for the financial statements if the financial statements or accompanying information do not include this information; and

b) considering whether other information in documents containing the audited financial statements is consistent with those financial statements.

2.5 In respect of the expected form and content of our report, we refer you to the most recent bulletin on auditor's reports published by the Auditing Practices Board at http://www.frc.org.uk/apb. The form and content of our report may need to be amended in the light of our findings.

2.6 We have a statutory duty to report to OSCR such matters (concerning the activities or affairs of the charity or any connected institution or body corporate) of which we become aware during the course of our audit which are (or are likely to be) of material significance to OSCR in the exercise of the powers of inquiry into, or acting for the protection of, charities. It is envisaged that the need to make such a report will arise only very rarely, in accordance with the guidance set out in International Standards on Auditing (UK & Ireland) 250 Section B "The Auditor's Right and Duty to Report to Regulators in the Financial Sector".

2.7 We will report solely to the charity's trustees, as a body. Our audit work will be undertaken so that we might state to the trustees those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the trustees, as a body, for our audit work, for this report, or for the opinion we have formed.

2.8 You should be aware that the charity's annual financial statements are for the specific purpose of reporting to the trustees [as well as to the members] at a particular point in time. They may therefore not be suitable for other purposes such as such as making decisions regarding borrowing or investing by you as trustees or by any other party.

3. Scope of audit

3.1 We will carry out our audit in accordance with the International Standards on Auditing (UK and Ireland) issued by the Auditing Practices Board. The audit will include such tests of transactions and of the existence, ownership and valuation of assets and liabilities as we consider necessary.

3.2 We shall obtain an understanding of the accounting and internal control systems to ensure they are adequate as a basis for the preparation of the financial statements and to establish whether the charity has kept proper accounting records. We will gather enough evidence to enable us to reach a reasonable conclusion.

3.3 You are responsible for safeguarding the charity's assets and for preventing and detecting fraud, error and non-compliance with law or regulations. We will plan our audit so that we can reasonably expect to detect significant misstatements in the financial statements or accounting records (including those resulting from fraud, error or non-compliance with law or regulations), but you cannot rely on us finding all such errors.

3.4 We shall not be treated as having notice, for the purposes of our audit responsibilities, of information provided to members of our firm other than those engaged on the audit.

3.5 Once we have issued our audit report we have no further responsibility in relation to the financial statements for that financial year.

3.6 We would appreciate receiving notice of and invitations to attend the meeting of the trustees at which the annual report and financial statements are to be approved.

3.7 To ensure that there is effective two-way communication between us and to comply with the requirements of Auditing Standards we will:

a) contact you prior to the audit to discuss any relevant matters and to agree any required action; and

b) contact you to discuss any matters arising from the audit and to confirm any agreed action.

4. Reporting to the Trustees and Management

4.1 The nature and extent of our procedures will vary according to our assessment of the charity's accounting system and, where we wish to place reliance on it, the internal control system, and may cover any aspect of the charity's operations that we consider appropriate. Our audit is not designed to identify all significant weaknesses in the charity's systems but, if such weaknesses come to our notice during the course of our audit which we think should be brought to your attention, we shall report them to you. Any such report may not be provided to third parties without our prior written consent. Such consent will be granted only on the basis that such reports are not prepared with the interests of anyone other than the charity in mind and that we accept no duty or responsibility to any other party as concerns the reports.

5. Representations by management/trustees

5.1 As part of our normal audit procedures, we may request written confirmation of oral representations which we have received during the course of the audit on matters having a material effect on the financial statements.

6. Documents issued with the financial statements

6.1 In order to assist us with the examination of your financial statements, we shall request sight of all documents or statements, including the trustees' report, which are due to be issued with the financial statements. If it is proposed that any documents or statement which refer to our name, other than the audited financial statements, are to be circulated to third parties, please consult us before they are issued.

7. Irregularities, including fraud

7.1 The responsibility for the prevention and detection of fraud, error and non-compliance with law or regulations rests with yourselves. However, we shall endeavour to plan our audit so that we have a reasonable expectation of detecting material misstatements in the financial statements or accounting records (including those resulting from fraud, error or non-compliance with law or regulations), but our examination should not be relied upon to disclose all such material misstatements or frauds, errors or instances of non-compliance as may exist.

8. Provision of Service Regulations

8.1 Details of our audit registration can be viewed at www.auditregister.org.uk under reference number 0538.

Appendix 2 – Hospitals Visited

Hospital	Gross Receipts	2013	2014	2015	2016	2017	2018	Proposed 2019
Adamson	5							
Levenmouth	8,512			✓				✓
Lynebank	136,329	✓	✓		✓		✓	✓
Queen Margaret *	23,089				✓			
St Andrews	9							
Stratheden	203,265		✓	✓		✓	✓	
Whyteman's Brae	12,506	✓				✓		

* Excludes "QM Acute" of £26,546

Gross Receipts are based on the figures from the accounts for the year ended 31 March 2018.

Note : Queen Margaret will also be visited to review and test the art catalogue

NHS Fife Audit and Risk Committee

DATE OF MEETING:	16 May 2019
TITLE OF REPORT:	NHS Fife Board Assurance Framework (BAF)
EXECUTIVE LEAD:	Helen Wright
REPORTING OFFICER:	Pauline Cumming

Purpose of the Report (delete as appropriate)		
	For Discussion	

SBAR REPORT

Situation

This report provides an update on the BAF since the last report to the Committee on 14 March 2019.

Background

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

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

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

Assessment

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

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

See Table 1

Table 1 - Risk Level and Rating over time

Risk ID	Risk Title	Initial Risk Level & Rating LxC	Likelihood (L)	Consequence (C)	Current Level & Rating Aug - Sept 2018	Current Level & Rating Oct- Nov 2018	Current Level & Rating Dec-Jan 2018	Current Level & Rating Feb- Mar 2019	
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 (4x 4) High	16 (4 x 4) High	16 (4 x 4) High	12 (3x4) Mod	

Each BAF risk is reviewed and updated regularly by the responsible Executive Director to ensure that its scope is current and comprehensive.

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

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

Since the last report to the Committee, the BAF risks have been discussed at the respective standing committees in March 2019. The BAFs are provided separately. The current BAFs are progressing through the May 2019 committee meeting cycle.

Developments:

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

Financial Sustainability

Current Performance

In March 2019, a change was that the single most significant factor in determining whether the forecast outturn per the January results (c£3.1m) could be fully addressed by year end, was the impact of the risk share arrangement for the IJB, as this position was the result of the current estimate of the social care overspend. Whilst the quantum of the overspend was an issue, there was an equally significant risk associated with the uncertainty of this position and the ability of the Finance Directorate to provide an adequately robust forecast.

Environmental Sustainability

Changes in Linked Risks

Three risks have **reduced** their risk level from high to moderate and are no longer on the BAF.

One risk has **increased** its risk level from moderate to high in terms of likelihood.

Workforce Sustainability

Changes in Linked Risks

One risk has **reduced** its risk level from high to moderate and is no longer on the BAF.

Risk 1375 - Breast Radiology Service: Whilst Radiologist vacancies remain the root cause of this risk, additional support from external Radiologists and Surgeons has created additional capacity.NHS Fife have had Specialty Doctor cover within the Breast Service since August 2018; this has brought the Surgical team up to full capacity. The Service has worked in with NHS Lanarkshire to secure locum Radiologist and Breast Surgeon. This has allowed for regular Waiting List Initiatives. NHS Lanarkshire support will remain in place until the Consultant Mammographer has completed their training. On completion, scheduled for April 2020, Radiology within NHS Fife will be able to support all demand in house.

The Urgent Waiting List is down from 5.5 to 4 weeks and the Routine list is down from 19 weeks to 12.5 weeks.

Quality & Safety

Changes in Linked Risks

Two risks were added to this BAF; these relate to Brexit.

Risk 1514 - Impact of the UK's withdrawal from the EU on the availability and cost of medicines and medical devices and

Risk 1515 - Impact of the UK's withdrawal from the EU on Nuclear Medicine and the ability to provide diagnostic and treatment service(s)

The risks are monitored by the NHS Fife Resilience Forum.

Mitigating Actions

One addition was that from April 2019, the organisation would implement the Healthcare

Improvement Scotland (HIS) Quality of Care Approach & Framework, Sept 2018.

Strategic Planning

Mitigating Actions

- A review of the structure of the Joint Strategic Transformation Group (JSTG) is underway with a pause on meetings going forward. The review will cover the role and remit of the group including governance arrangements.

- Leadership to strategic planning is coming from the Executive Directors' Group.

- A Clinical Strategy work stream update has now been produced to reflect progress against recommendations.

- The Chief Executive, Chief Operating Officer and Associate Director of Planning participate in Regional planning via SEAT and appropriate sub/working groups.

Current Performance

The Site Optimisation Programme is progressing on track with Phase 1 complete. This programme is being reviewed following changes in leadership. A full review of the JSTG is due with the group paused until this is complete.

- **Integration Joint Board**

Developments with the IJB BAF will be reported to a future Committee.

eHealth BAF

A draft eHealth BAF has been developed. It will be considered by the eHealth Board on 24 May 2019 with a view to reporting to the Clinical Governance Committee in July 2019.

Recommendation

The Committee is invited to:

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

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

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

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

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Responsible Person	Timescale	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Integration Joint Board																													
1418	Sustainable	28.02.2019	30.04.2019	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 Committee 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	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)

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

Previously Linked Operational Risk(s)

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

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Responsible Person	Timescale	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Workforce Sustainability																													
1415	Exemplar Employer	09.01.2019	31.03.2019	There is a risk that failure to ensure the right composition of workforce, with the right skills and competencies deployed in the right place at the right time will adversely affect the provision of services and quality patient care and impact on organisational capability to implement the new clinical and care models and service delivery set out in the Clinical Strategy	5 - Almost Certain - Expected to occur frequently - more likely than not	4 - Major	20	High	4 - Likely - Strong possibility this could occur	4 - Major	16	High	Failure in this area has a direct impact on patients' health. NHS Fife has an ageing workforce with recruitment challenges in key specialities. Failure to ensure the right composition of workforce with the right skills and competencies gives rise to a number of organisational risks including: reputational and financial risk; a potential adverse impact on the safety and quality of care provision; and staff engagement and morale. Failure would also adversely impact on the implementation of the Clinical strategy. The current score reflects the existing controls and mitigating actions in place.	Director of Workforce/ Partnership	Staff Governance Chair : Margaret Wells	*Ongoing actions designed to mitigate the risk including:* 1. • Development of the Workforce Strategy to support the Clinical Strategy and Strategic Framework. 2. • Implementation of the Health & Social Care Workforce and Organisational Development Strategy to support the Health & Social Care Strategic Plan for 2016/19. 3. • Implementation of the NHS Fife Strategic Framework particularly the	Nil	Implementation of the Workforce Strategy to support the Clinical Strategy and Strategic Framework	Director of Workforce/Partnership		1. Regular performance monitoring and reports to EDG, APF, Staff Governance Committee 2. Delivery of Staff Governance Action Plan is reported to EDG, APF and Staff Governance Committee	1. Use of national data 2. Internal Audit reports 3. Audit Scotland reports	Full implementation of eESS will provide an integrated workforce system which will capture and facilitate reporting including all learning and development activity	Overall NHS Fife Board has robust workforce planning and learning and development governance and risk systems and processes in place. Continuation of the current controls and full implementation of mitigating actions, especially the Workforce strategy supporting the Clinical Strategy and the implementation of eESS should provide an appropriate level of control.	2 - Unlikely - Not expected to happen - potential exists	2 - Minor	4	Low	Continuing improvement in current controls and full implementation of mitigating actions will reduce both the likelihood and consequence of the risk from moderate to low.
																4. • A Brexit Steering Group has been established to consider the impact on the workforce with regard to these arrangements once they are known. 5. An Assurance Group has also been established which will link to existing resilience planning arrangements 6. • Implementation of eESS as a workforce management system within NHS Fife	Nil	Implementation of proactive support for the workforce affected by Brexit. Full implementation of eESS manager and staff self service across the organisation to ensure enhanced real time data intelligence for workforce planning and maximise benefit realisation from a fully integrated information system.											
																7. • A stepped approach to nurse recruitment is in place which enables student nurses about to qualify to apply for certain posts at point of registration. This model could also be applied to AHP, eHealth, Pharmacist, Scientific and Trades recruitment and other disciplines considered. 8 • Strengthening of the control and monitoring associated with supplementary staffing with identification and implementation of solutions to reduce the requirement and/or costs associated with supplemental staffing. 9. • NHS Fife participation in regional and national groups to address national and local recruitment challenges and specific key group shortage areas, applying agreed solutions e.g. SERRIS 10. Review of risks related to Mental Health recruitment with Risk owners	Nil	Strengthen workforce planning infrastructure ensuring co-ordinated and cohesive approach taken to advance key workforce strategies										
																11. • Absence Management Steering Group and local divisional groups established to drive a range of initiatives and improvements aligned to staff health and wellbeing activity, 12. • Well@Work initiatives continue to support the health and wellbeing of the workforce, facilitate earlier interventions to assist staff experience and retain staff in the workplace, along with Health Promotion and the Staff Wellbeing & Safety	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	Nil	Implementation of the Learning and Development Framework strand of the Workforce Strategy.	Director of Workforce/Partnership									
																18. • The improvement made in Core Skills compliance to ensure NHS Fife meets its statutory obligations	Nil	Review of L&D processes , planning and resources to ensure alignment to priorities										
																19. • The implementation of the Learning management System module of eESS to ensure all training and development data is held and to facilitate reporting and analysis	Nil	Full roll out of learning management self service										
																20. • Continue to address the risk of non compliance with Staff Governance Standard and HEAT standard requirements relating to KSF	Nil	Continuing implementation of the KSF Improvement and Recovery Plan										
																21. • Utilisation of the Staff Governance Standard and Staff Governance Action Plans (the "Appropriately trained" strand) is utilised to identify local priorities and drive local actions	Nil											
																22. • The development of close working relationships with L&D colleagues in neighbouring Boards, with NES and Fife Council to optimise synergistic benefits from collaborative working	Nil		Director of Workforce									

Linked Operational Risk(s)

Risk ID	Risk Title	Current Risk Rating	Risk Owner
1420	Loss of consultants	High20	H Bett
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
1324	Medical Staff Recruitment	No longer high risk	Moderate 9	J Kennedy
1349	Service provision- GP locums may no longer wish to work for NHS Fife salaried practices	Risk Closed		
1353	Medical Cover- Community Services West- expected shortfalls on nurse staffing and GP cover	No longer high risk	Moderate 9	C Dobson
1042	Staffing levels Community Services East unable to meet staffing establishment	No longer high risk	Moderate 12	K Nolan
503	Lack of capacity in Podiatry Service unable to meet SIGN/ NICE Guidelines	Risk Closed		
1375	Breast Radiology Service	No longer high risk	Mod 12	M Cross

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Responsible Person	Timescale	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Environmental Sustainability																													
1414	Sustainable, Clinically Excellent	07.03.2019	07.05.2019	There is a risk that Environmental & Sustainability legislation is breached which impacts negatively on the safety and health of patients, staff and the public and the organisation's reputation.	4 - Likely - Strong possibility this could occur	5 - Extreme	20	High	4 - Likely - Strong possibility this could occur	5 - Extreme	20	High	Estates currently have significant high risks on the E&F risk register; until these have been eradicated this risk will remain. Action plans have been prepared and assuming capital is available these will be reduced in the near future.	Director of Estates, Facilities & Capital Services (E,F &CS)	Finance, Performance & Resources (F,P&R) Chair: Rona Laing	*Ongoing actions designed to mitigate the risk including:* 1. Operational Planned Preventative Maintenance (PPM) systems in place 2. Systems in place to comply with NHS Estates 3. Action plans have been prepared for the risks on the estates & facilities risk register. These are reviewed and updated at the monthly risk management meetings. The highest risks are prioritised and allocated the appropriate capital funding. 4. The SCART (Statutory Compliance Audit & Risk Tool) and EAMS (Estates Asset Management System) systems record and track estates & facilities compliance. 5. Sustainability Group manages environmental issues and Carbon Reduction Commitment(CRC) process is audited annually. 6. Externally appointed Authorising Engineers carry out audits for all of the major services i.e. water safety, electrical systems, pressure systems, decontamination and so on.	Nil	1. Capital funding is allocated depending on the E&F risks rating 2. Increase number of site audits	Director of Estates, Facilities & Capital Services Estates Quality Manager	Ongoing as limited funding available Ongoing	1. Capital Investment delivered in line with budgets 2. Sustainability Group minutes. 3. Estates & Facilities risk registers. 4. SCART & EAMS 5. Adverse Event reports	1. Internal audits 2. External audits by Authorising Engineers 3. Peer reviews	None	High risks still exist until remedial works have been undertaken, but action plans and processes are in place to mitigate these risks.	1 - Remote - Can't believe this event would happen	5 - Extreme	5	Low	All estates & facilities risk can be eradicated with the appropriate resources but there will always be a potential for failure i.e. component failure or human error hence the target figure of 5.

Linked Operational Risk(s)

Risk ID	Risk Title		Current Risk Rating	Risk Owner
1296	Emergency Evacuation - VHK- Phase 2 Tower Block		High 20	A Fairgrieve
1384	Microbiologist Vacancy		High 20	TBC
1007	Theatre Phase 2 Remedial work		High 15	M Cross
1207	Water system Contamination STACH		High 15	A Fairgrieve

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Reason for unlinking from BAF	Current Risk Rating	Risk Owner
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
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	D Lowe
1352	Pinpoint malfunction	Risk Closed		

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Responsible Person	Timescale	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)
Financial Sustainability																												
1413	Sustainable	07.01.2019	28.02.2019	There is a risk that the funding required to deliver the current and anticipated future service models will exceed the funding available. Thereafter there is a risk that failure to implement, monitor and review an effective financial planning, management and performance framework would result in the Board being unable to deliver on its required financial targets.	4 - Likely - Strong possibility this could occur	4 - Major	16	High	4 - Likely - Strong possibility this could occur	4 - Major	16	High	Current financial climate across NHS/public sector	Director of Finance	Finance, Performance & Resources (F,P&R) Chair: Rona Laing	*Ongoing actions designed to mitigate the risk including:* 1. Ensure budgets are devolved to an appropriate level aligned to management responsibilities and accountabilities. This includes the allocation of any financial plan shortfall to all budget areas. This seeks to ensure all budget holders are sighted on their responsibility to contribute to the overall requirement to deliver breakeven. 2. Transformation programme established to support redesign; reduce unwarranted variation and waste; and to implement detailed efficiency initiatives across the system. 3. Engage with external advisors as required (e.g. property advisors) to support specific aspects of work.	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	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 highlighted in 2016/17 and 2017/18 continued into 2018/19, with an anticipated £19.7m gap, including £17m carried forward as unachieved recurring savings in 2017/18. Since the end of May, the forecast outturn has been held at breakeven, per the Annual Operational Plan. However, given the extent of the risks that remain as the year has progressed, in relation to delivery and identification of value & sustainability and cost reduction efficiencies across acute services and health services delegated through the H&SC Partnership to the IJB, a forecast overspend was reported following both the month 7 (October) and month 8 (November) results. The non delivery of savings and resultant overspend have been mitigated, in part, through in year non recurring financial flexibility. The single most significant factor in determining whether the forecast outturn per the January results (c£3.1m) can be fully addressed by year end is the impact of the risk share arrangement for the IJB, as this position is the result of the current estimate of the social care overspend. Whilst the quantum of the overspend is an issue, there is an equally significant risk associated with the uncertainty of this position and the ability of the Finance Directorate to provide an adequately robust forecast	3 - Possible - May occur occasionally - reasonable chance	4 - Major	12	Moderate

Linked Operational Risk(s)

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

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Reason for unlinking from BAF	Current Risk Rating	Ris
522	Prescribing & Medicines Management - unable to control Prescribing Budget	No longer a high risk	Moderate 9	F Elliot

Rationale for Target Score
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.

k Owner

k Owner

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Responsible Person	Timescale	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Quality & Safety																													
1416	Person Centred, Clinically Excellent	25.02.2019	20.04.2019	There is a risk that due to failure of clinical governance, performance and management systems (including information & information systems), NHS Fife may be unable to provide safe, effective, person centred care.	4 - Likely - Strong possibility this could occur	5 - Extreme	20	High	3 - Possible	5 - High	15	High	Failure in this area could have a direct impact on patients' health, organisational reputation and exposure to legal action. While it is recognised that several adverse events ranging from minor to extreme harm can occur daily, the proportion of these in relation to overall patient activity is very small.	Medical Director	Clinical Governance Chair: Dr Les Bisset	*Ongoing actions designed to mitigate the risk including:* 1. Strategic Framework 2. Clinical Strategy 3. Clinical Governance Structures and operational Governance arrangements 4. Clinical & Care Governance Strategy 5. Participation & Engagement Strategy 6. Risk Management Framework This is supported by the following: 7. Risk Registers 8. Quality Report, Performance reports and availability of data through dashboards 9. Performance Review incl focus on Clinical Governance 10. Adverse Events Policy 11. Scottish Patient Safety Programme implementation 12. Implementation of SIGN and other evidence based guidance 13. Staff Learning & Development incl corporate induction and In House Core Training, Quality Improvement, Leadership Development, Clinical Skills Training, Interspecialty Programmes 14.System for writing and reviewing all clinical policies and procedures 15. Participation in national and local audit 16.Complaints handling process 17.Enhancing monitoring of our systems with use of data.• Relevant data is currently being collected in relation to DofC and mechanisms for sharing this locally with divisions is in discussion and development through the Adverse Events group. 18.HIS Quality of Care Approach & Framework,Sept 2018.	Triangulation across all elements of our quality and safety activities, specifically patient experience, complaints, adverse events and risk to provide an overview of performance and identify priorities for action to improve care and experience.	1. The content of the Quality Report has evolved and contains information on key priorities. There is now a Quality Report within the Health & Social Care Partnership (HSCP); there is also a version being tested within specialties in the Acute Services Division (ASD). 2. The Clinical Governance Steering Group (CGSG) has oversight of the Quality Report, SPSP Stakeholders and the Adverse Events/ Duty of Candour Group* minutes.Consideration should be given to the role and remit of this group(CGSG) in light of the requimernemts of the Quality of Care Approach. 3. There is now an extablished combined group* . This group is working through a plan of action. 4.Our commitment to learn will be demonstrated in a number of ways:e.g . Case study learning sessions to be delivered in 2019 to aid decision making and DoC implementation. SAER / LAER Learning Summaries are to be shared withtopic specific groups. 5. Further develop Datix Risk Management system. 6.Develop dashboardsand other means of accessing information. 7, Implement the new HIS Quality Framework	Medical Director	31.10.2018	1. Reporting to clinical & clinical & care governance groups and committees.l. 2. Reporting on acute adult, maternity, mental health, neonates, paediatrics and primary care to SPSP Stakeholder Group. 3. Reporting bi annually on adequacy of risk management systems and processes to Audit & Risk Committee. 4. Annual Assurance Statement. 5. HEAT target reports. 6. Portfolio of performance review data. 7. Accreditation systems. 8.Locally designed subject specific audits. 9.Requirement for DoC Annual Report 10.From Feb 2018, NHS Fife Committee Self assessment checklist 11. Compliance monitoring of policies & procedures to ensure these are up to date.	1. Internal Audit reviews and reports on controls and process; including annual clinical governance review / departmental reviews. 2. External Audit reviews. 3. HIS visits and reviews. 4. Healthcare Environment Inspectorate (HEI) visits and reports. 5. Health Protection Scotland (HPS) support. 6. Health & Safety Executive 7. Scottish Patient Safety Programme (SPSP) visits and reviews. 8. Scottish Govt DoC Annual Report	1.Risk management KPIs to be developed. 2.Improvements as recommended in Internal Audit Clinical Governance Strategy and Assurance Report B15-17 + B18-18 3.Compliance with DoC legislation	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	Enhanced controls and continuing improvements to the systems and processes for monitoring,reporting and learning are being put in place.

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
1514	Impact of the UK's withdrawal from the EU on the availability and cost of medicines and medical devices	High 20	Evelyn McPhail
43	Vascular access for haematology/Oncology	High 20	Shirley-Anne Savage
521	Capacity Planning	High 16	Valerie Hatch
529	Information Security	High 16	TBC
637	SAB HEAT TARGET	High 16	Christina Coulombe
1365	Cancer Waiting Times Access Standards	High 15	TBC
356	Clinical Pharmacy Input	High 15	Frances Elliot
1515	Impact of the UK's withdrawal from the EU on Nuclear Medicine and the ability to provide diagnostic and treatment service(s)	High 15	Jeanette Burdock

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Reason for unlinking from BAF	Current Risk Rating	Risk Owner
1366	T34 syringe drivers in the Acute Division	Closed Risk		
1297	Obsolete Equipment In Use – No Replacement Plan In Place (Graseby 3000 Series)	Closed Risk		
528	Pandemic Flu Planning	No longer a high risk	Moderate 12	Dona Milne

NHS Fife 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?)
Strategic Planning																					
	stainable			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**									The transformation programmes have been agreed and reports to the Joint Strategic Transformation Group. Organisational challenges have impacted on the meeting schedule. Meeting have been paused from February 2019 until a full review has been undertaken.			*Ongoing actions designed to mitigate the risk including:* 1. Establishment of IMPACT in 2016 - a small internal business unit which provides focussed, co-ordinated, client tailored support to accelerate delivery of NHS Fife's strategic objectives. Provides a programme management framework to ensure the programme is delivered. 2. Establishment of the Joint Strategic Transformation Group (JSTG) to drive the delivery of the H&SC Strategic Plan and the Clinical Strategy.	Nil	Review of structure of JSTG is underway with a pause on meetings going forward. The review will cover role and remit of group including governance arrangements. Leadership to strategic planning coming from the Exectuive Directors Group. Clinical Strategy workstream update has been produced to reflect progres against recommendations.	Chief Officer Health and Social Care Partnership	31.03.2018	1. Minutes of meetings record attendance, agenda and outcomes. 2. Action Plans and highlight reports from the Joint Strategic Transformation Group. 3. Action plans, minutes and reports from the SEAT Regional Planning meetings and East Region Programme

1417	Person Centred, Clinically Excellent, Exemplar Employer, Sus	15.01.2019	06.03.2019	**Key Risks** 1. Community/Mental Health redesign is the responsibility of the H&SCP/IJB which hold the operational plans, delivery measures and timescales 2. Governance of the JSTG remains with 4 committees - 2 from the IJB and 2 from NHS. This may impact on effectiveness of scrutiny. 3. Regional Planning. There is a challenge in alignment of strategic plans of partner boards with those of the Regional lead. 4. Development and recommendations of the East Region Health and Social Care Delivery Plan may impact on the focus and priority of local service redesign and the pace of its delivery.	4 - Likely - Strong possibility this could occur	4 - Major	16	High	4 - Likely - Strong possibility this could occur	4 - Major	16	High	The workplans is at varying stages of development with some programmes more advanced than others. Reporting of progress of transformation programmes has improved with written updates to JSTG for two of the programmes. Papers to IJB produced about the other two programmes.	Medical Director	Clinical Governance	Chair	3. 3 of the 4 key strategic priorities are being taken forward by the H&SCP/IJB. The remaining priority is being taken forward by Acute services and progress shared through regular highlight reports. Programme Boards provide oversight and strategic guidance to the programme. Collaborative oversight is provided by the JSTG. 4. NHS Fife is a member of SEAT with executive attendance at Regional Planning meetings. Progress is being made in some areas. 5. NHS Fife is a member of the East Region Programme Board established to develop the East Region Health and Social Care Delivery Plan and is represented by directors on all workstreams. 6. Establishment of the Executive Board to provide strategic and operational oversight of the health boards services including the transformation programmes. 7. The Service Planning Reviews have taken place for 2019/20 -21/22 which will inform actions to deliver Clinical Strategy and prioiritise transformation programmes.		1. The NHS Fife CEO chairs the Acute Services workstream of the East Region Health and Social Care Delivery Plan 2. Chief Executive, Chief Operating Officer and Associate Director of Planning participate in Regional planning via SEAT and appropriate sub/working groups.	Chief Operating Officer (COO) Acute	Ongoing. First plan to be submitted 31/03/2018	Board. 4.Performance Assessment Framework is in place and assures committees on acute services division performance and winter planning monitoring.

Linked Operational Risk(s)

Risk ID	Risk Title
	Nil currently identified

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Reason for unlinking from BAF
	NIL APPLICABLE	

			Target Score				
Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Likelihood (Target)	Consequence (Target)	Rating (Target)	Level (Target)	Rationale for Target Score
1. Internal Audit Report on Strategic Planning (no. B10/17) 2. SEAT Annual Report 2016 3.Governance committee oversight of performance assurance framework	Nil at present	Current challenges associated with delivery of our strategic objectives include the focus on the 4 strategic priorities (Site Optimisation, Community Redesign, Mental Health Redesign and Medicines Efficiencies), the interdependencies of workplans (NHS Fife/H&SCP/ Region) in terms of the whole					Once governance and monitoring is in place and transformation programmes are being realised, the risk level should reduce.

		system oversight of operational plans, delivery measures and timescales. Site Optimisation Programme is progressing on track with phase 1 complete. This programme is being reviewed following changes in leadership. A full review of the JSTG is due with the group paused until this is complete.	3 - Possible - May occur occasionally - reasonable chan	4 - Major	12	Moderate	

Current Risk Rating	Risk Owner

Current Risk Rating	Risk Owner

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?)
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Linked Operational Risk(s)

Risk ID	Risk Title
	Nil currently identified

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Reason for unlinking from BAF
	NIL APPLICABLE	

			Target Score				
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		system oversight of operational plans, delivery measures and timescales. Site Optimisation Programme is progressing on track with phase 1 complete. This programme is being reviewed following changes in leadership. A full review of the JSTG is due with the group paused until this is complete.	3 - Possible - May occur occasionally - reasonable chan	4 - Major	12	Moderate

Current Risk Rating	Risk Owner

Current Risk Rating	Risk Owner

Audit & Risk Committee

DATE OF MEETING:	16 May 2019
TITLE OF REPORT:	Performance & Accountability Review Framework
EXECUTIVE LEAD:	Carol Potter, Director of Finance & Performance
REPORTING OFFICER:	Carol Potter, Director of Finance & Performance

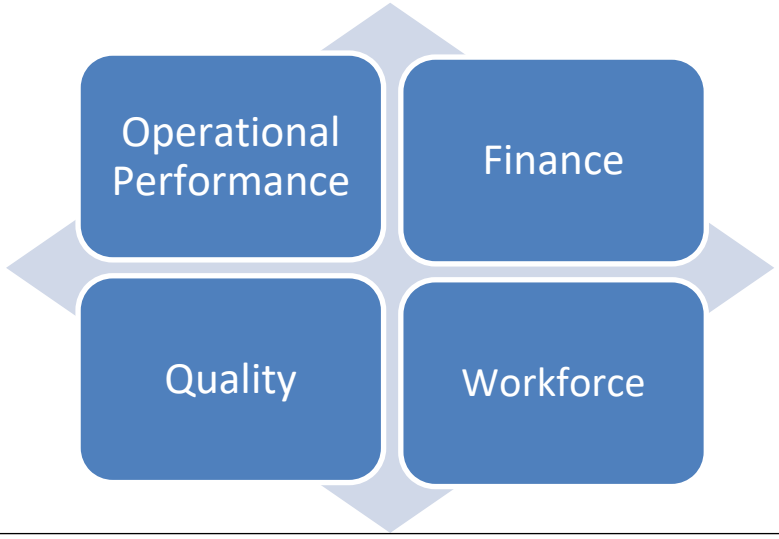
Purpose of the Report (delete as appropriate)

	For Discussion	For Assurance

SBAR REPORT

Situation

NHS Fife is committed to supporting the people of Fife to live long and healthy lives. The strategic and operational management of the organisation must be aligned to this vision, with a robust governance framework in place to provide assurance to the Board of the systems and processes and culture to deliver this vision. It is essential therefore, that there is effective scrutiny across all quadrants of governance.



Background

The implementation of a Performance & Accountability Review Framework across NHS Fife seeks to provide a structured, transparent and systematic approach to ensure delivery of standards and targets across the four quadrants of governance, with an effective reporting and assurance mechanism from 'service to Board'.

At Board level the Integrated Performance Report provides an overarching view of the key performance, quality, workforce and financial metrics, however there is an opportunity to enhance the approach at an operational level with individual management teams and services, and to ensure greater connectivity between operational management and Committee / Board level assurance mechanisms.

Historically there was a performance review process within the Acute Services Division, led by the Chief Operating Officer, but this lacked any overt relationship with those corporate Directors with professional, system wide responsibility; the Executive Directors Group; and wider stakeholders. Within the health services delegated to the Health & Social Care Partnership and corporate areas, there has been no formal performance review process to date.

Assessment

Establishing a formal Performance & Accountability Review Framework seeks to ensure the Board, Executive Directors Group, management teams and individual staff are able to:

- Assess performance against clear targets and goals
- Inform strategic and operational decision making using robust data
- Undertake exception reporting
- Predict future performance and forecast outturn
- Identify and monitor key actions
- Establish effective review structures including intervention as necessary and appropriate
- Focus resources and improvement efforts in key areas
- Identify any systematic problems across NHS Fife
- Evaluate the impact of new developments or initiatives
- Prioritise key improvements in line with the Clinical Strategy

The **overarching purpose of the Performance & Accountability Review Framework**, therefore is to:

- Ensure effective systems and processes are in place to provide assurance to the NHS Board and stakeholders that services are performing to the highest statutory and regulatory standards
- Develop the business intelligence capability of NHS Fife and thus inform service delivery, improvement activity; productivity and efficiency; sustainability; and deliver transformation
- Support delivery of strategic objectives as set out in the Clinical Strategy and the Annual Operational Plan
- Provide assurance on best value in the use of all resources

Implementation of the Performance & Accountability Review Framework will support the risk management process and ongoing review of the Board Assurance Framework (BAF).

Critically, the Performance & Accountability Review Framework seeks to ensure that those individuals holding delegated responsibility for operational performance, workforce, quality & safety and financial resources, as agreed through the Board's Scheme of Delegation, are held accountable through robust and effective reporting and assurance mechanisms. It will form a key pillar in support of the Board's overall system of corporate governance.

A number of key principles will underpin the Performance & Accountability Review Framework:

- **Creating a performance culture through improvement** – the framework is intended to support a culture of continuous improvement, delivered for the benefit of patients. It is not intended as a punitive or negative process. It will require clear objectives at all levels of the organisation supported by existing individual PDP/appraisal processes. The aim is to instil a rigorous performance and accountability culture with a clear understanding of individual responsibility.

- **Transparency** – the metrics and evidence used to assess performance will be clearly set out for all services, adapted to reflect clinical and non clinical services.

- **Delivery focus** – the approach will be integrated, action focused, and seek to improve performance.

- **Proportionality** – the arrangements eg frequency of meetings will be adapted to suit the requirements of different services, to ensure management actions and interventions are proportional to the potential performance risk

- **Balance** – all parties involved in the performance and accountability review meetings will seek to deliver a balance between challenge and support

The Performance & Accountability Review meetings will be chaired by the Chief Executive or Director of Finance & Performance, supported by the Medical Director, Director of Nursing, and Director of Workforce.

The Chief Operating Officer has confirmed that a parallel process will be in place within the Acute Services Division; whereby the Chief Operating Officer will chair Directorate Performance & Accountability Review meetings, supported by the Deputy Chief Operating Officer, Deputy Director of Finance, Associate Medical Director, Associate Director of Nursing and Senior HR Manager. Clarification is awaited on the model to be adopted within the Health & Social Care Partnership, and whether a parallel process is planned.

For meetings with the Finance, Human Resources and Estates & Facilities Directorates, the Chief Operating Officer and Director of Health & Social Care will also be invited to attend, to allow feedback and challenge on services provided to their respective areas.

The purpose of the 'corporate' roles at the meetings will be to question, understand, request information and to escalate matters as required, and onwards as required through the Board's governance structures. Attendees from services will be expected to provide written data on performance in advance of the meetings. During the meetings, the services will be expected to present a summary of key performance metrics, explain any variances, and highlight planned actions, with a focus on areas of exception, both positive and negative.

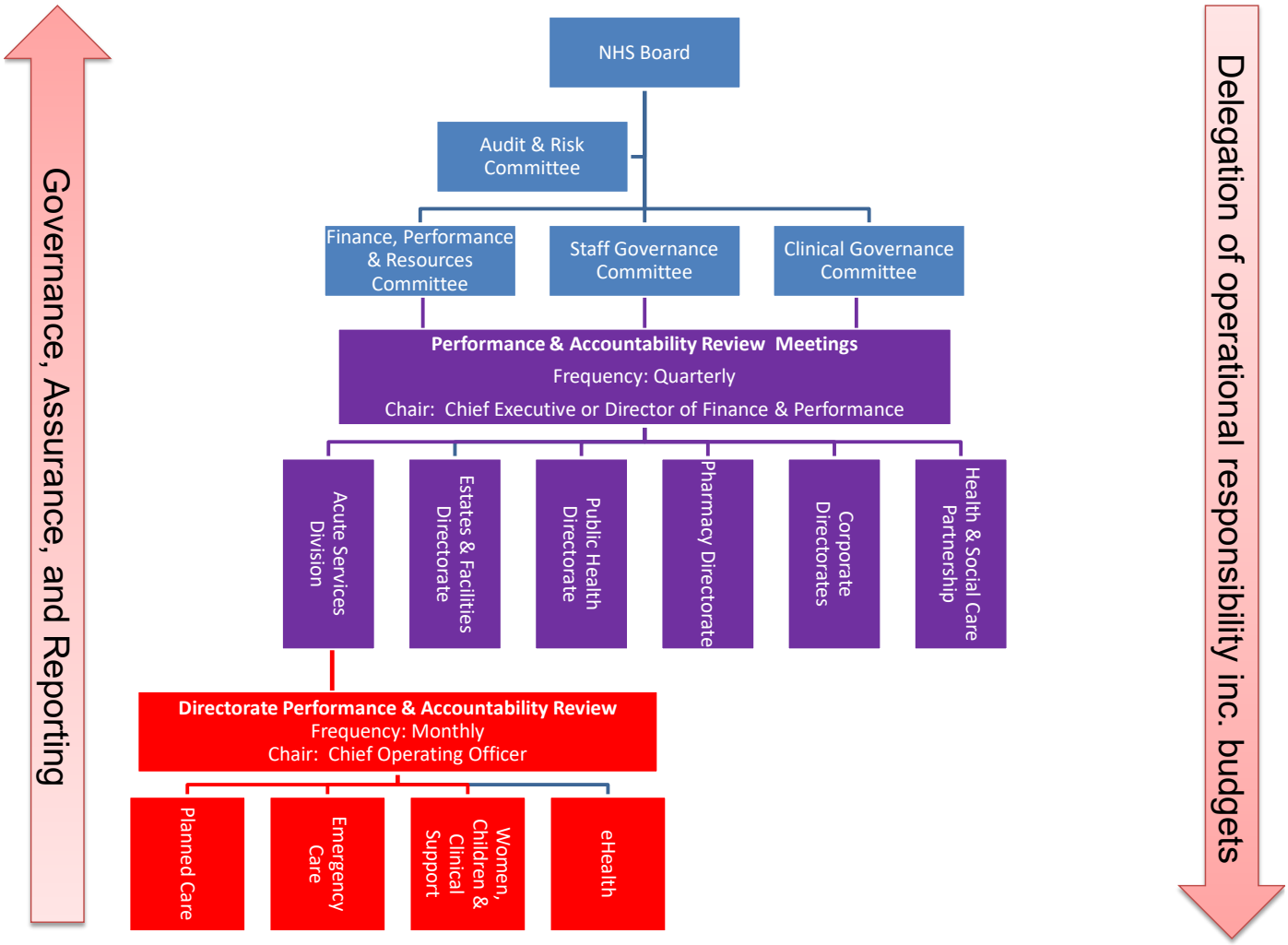
Appendix 1 provides a matrix of the **proposed meetings structure**, highlighting the attendees with a corporate focus and those with a service focus, as well as frequency of meetings.

Appendix 2 provides a summary of the anticipated **performance metrics** for each service, to be reported on at each meeting. It is recognised that the previous performance review process within the Acute Services Division was supported by a detailed performance data pack. A detailed review of this will be undertaken through the Performance & Information teams on behalf of the Director of Finance & Performance and Chief Operating Officer and will implement any agreed changes in advance of the first review meetings for 2019/20. The Performance and Information teams will also be required to work with other Executive Directors and / or senior managers to support the development of performance data packs for all other areas, based on relevant performance metrics, ensuring there is clear ownership by individual Directors for the production of these packs for their respective areas.

As the Performance & Accountability Review Framework is embedded during 2019/20, a **formal oversight escalation model** will be established, as set out in **Appendix 3**. Outcome reporting from the Performance & Accountability Reviews will seek to provide a concise and streamlined summary of key issues and actions, with a clear escalation route to link operational services and discussion at Committee level, in support of the Integrated Performance Report. This will be undertaken in the form of the brief SBAR approach, as already adopted by each Governance Committee for reporting of issues for escalation to the NHS Board.

Where possible, the scheduling and frequency of meetings will be aligned to enable reporting to the Governance Committees. A **proposed timetable** is attached at **Appendix 4**.

The diagram below provides a visual overview of the process.



Recommendation

Members of the Board's standing governance Committees are asked to:

- **Note** the Performance & Accountability Framework to be implemented for 2019/20, in support of enhanced assurance on all aspects of performance.

Objectives: (must be completed)	
Healthcare Standard(s):	All
HB Strategic Objectives:	All
Further Information:	
Evidence Base:	NA
Glossary of Terms:	NA
Parties / Committees consulted prior to EDG:	Chief Executive EDG
Impact: (must be completed)	
Financial / Value For Money	Statutory requirement to break even
Risk / Legal:	There are no specific implications from the issues in this paper as it provides an overview of the planning approach
Quality / Patient Care:	
Workforce:	

Appendix 1
Performance & Accountability Review Framework - Meetings Structure

Directorate / Division	Frequency	Corporate Attendees	Service Attendees
Acute Division	Quarterly[1]	Chief Executive (Chair) Director of Finance & Performance (Vice Chair) Medical Director Director of Nursing Director of Workforce	Chief Operating Officer Deputy Chief Operating Officer General Managers Associate Director of Nursing Associate Medical Director Clinical Directors Heads of Nursing
Estates & Facilities	Quarterly	Chief Executive (Chair) Director of Finance & Performance (Vice Chair) Medical Director Director of Nursing Director of Workforce Chief Operating Officer Director of Health & Social Care	Director of Estates & Facilities Head of Estates Head of Facilities PPP Contract Manager
Public Health	Quarterly	Chief Executive (Chair) Director of Finance & Performance (Vice Chair) Medical Director Director of Nursing Director of Workforce	Director of Public Health Deputy Director of Public Health
Pharmacy	Quarterly	Chief Executive (Chair) Director of Finance & Performance (Vice Chair) Medical Director Director of Nursing Director of Workforce Chief Operating Officer Director of Health & Social Care	Director of Medicines Chief Pharmacists Chief Finance Officer

[1] This approach is predicated on a supporting sub-structure where the Chief Operating Officer establishes a monthly performance and accountability framework at a Directorate level, accompanied by the Deputy Director of Finance, Associate Medical Director, Associate Director of Nursing and Senior HR Manager, meeting with each Directorate including the GMs, Service Managers, Clinical Directors, Heads of Nursing and Finance Business Partners. A similar sub-meeting would be required with eHealth. The Chief Operating Officer has confirmed this model is being implemented from May 2019.

Directorate / Division	Frequency	Corporate Attendees	Service Attendees
Corporate: Finance	Quarterly	Chief Executive (Chair) Medical Director Director of Nursing Director of Workforce (Vice Chair) Chief Operating Officer Director of Health & Social Care	Director of Finance & Performance Deputy Director of Finance Assistant Director of Finance Finance Manager Head of Procurement Head of Corporate Governance Project Director
Corporate: Human Resources	Quarterly	Chief Executive (Chair) Director of Finance & Performance (Vice Chair) Medical Director Director of Nursing	Director of Workforce Senior HR Manager Head of Human Resources Head of Staff Governance
Corporate: Nursing	Quarterly	Chief Executive (Chair) Director of Finance & Performance (Vice Chair) Medical Director Director of Workforce	Director of Nursing Associate Directors of Nursing Head of AHPs Patient Relations Manager Risk Manager
Corporate: Medical	Quarterly	Chief Executive (Chair) Director of Finance & Performance (Chair) Director of Nursing Director of Workforce	Medical Director Director of Medical Education Primary Care Manager Business Manager
Health & Social Care Partnership	Quarterly[2]	Chief Executive (Chair) Director of Finance & Performance (Vice Chair) Medical Director Director of Nursing Director of Workforce Director of Public Health	Director of Health & Social Care Divisional General Managers Associate Director of Nursing Associate Medical Director Chief Finance Officer

[2] This approach is predicated on a supporting sub-structure where the Director of Health & Social establishes a monthly performance and accountability framework at a Divisional level, accompanied by the Chief Finance Officer, Associate Medical Director and Associate Director of Nursing, meeting with each Division including the GMs, Service Managers, Clinical Directors, Heads of Nursing and Finance Business Partners. Confirmation is awaited from the Director of Health & Social Care on this matter.

Appendix 2
Performance & Accountability Review Framework - Performance Metrics

Governance Quadrant	Acute Directorates	Estates & Facilities	Public Health	Corporate Directorates	Health & Social Care	Pharmacy
Operational Performance	• Outpatients • ED attendances • ED 4 hour • Medical ward admissions & discharges • 18 week RTT • Cancer • ECAS • AU1 • Stroke • Frailty • Others TBC	TBC	TBC	TBC	• CAMHS • Psychological therapies • Delayed Discharges • TBC	TBC
Finance	• Run rate • Efficiency • Forecast outturn • Cost pressures	• Run rate • Efficiency • Forecast outturn • Cost pressures	• Run rate • Efficiency • Forecast outturn • Cost pressures	• Run rate • Efficiency • Forecast outturn • Cost pressures	• Run rate • Efficiency • Forecast outturn • Cost pressures	• Run rate • Efficiency • Forecast outturn • Cost pressures
Quality	• Adverse Events • SAERs • Incidents • Patient Falls • Tissue Viability • Medication Incidents • SABs Incidents • Cardiac Arrest Incidents • Patient Safety • Patient track • Complaints • Patient Feedback	TBC	TBC	TBC	• Adverse Events • SAERs • Incidents • Patient Falls • Tissue Viability • Medication Incidents • SABs Incidents • Cardiac Arrest Incidents • Patient Safety • Complaints • Patient Feedback • TBC	TBC

Governance Quadrant	Acute Directorates	Estates & Facilities	Public Health	Corporate Directorates	Health & Social Care	Pharmacy
	• Others TBC					
Workforce	• Nurse, bank, agency & overtime • Medical agency & overtime • Vacancies • Absence management • Mandatory training • Skin surveillance	• Vacancies • Absence management • Mandatory training	• Vacancies • Absence management • Mandatory training	• Vacancies • Absence management • Mandatory training	• Nurse, bank, agency & overtime • Medical agency & overtime • Vacancies • Absence management • Mandatory training • Skin surveillance	• Vacancies • Absence management • Mandatory training
Other				• FOI responses		

Appendix 3
Performance & Accountability Review - Oversight Model

Level	Description	Characteristics	Support	Additional Financial Controls	Accountability
1	**Service with maximum autonomy** No potential support need identified across the four governance quadrants – lowest level of oversight and expectation that the directorate/service will support colleagues in other oversight categories	Minor issues in one quadrant of governance	**Universal** support eg tools, guidance, benchmark information made available for directorates		Quarterly accountability review led by Director of Finance & Performance
2	**Service offered targeted support** Potential support needed in one or more of the four governance quadrants, but formal action is not needed	Minor or moderate concern in one or more quadrant of governance	**Universal** support (as for level 1) **Targeted** support as agreed with the directorate to address issues and help move the directorate/service to level 1; either offered to directorate (and accepted voluntarily) or requested by directorate		Quarterly accountability review led by Chief Executive
3	**Service receiving mandated support for significant concerns**	Moderate risks in two quadrants of governance, or significant risk in one quadrant	**Universal** support (as for level 1) **Targeted** support as agreed with the directorate (as for level 2) **Mandated** support as determined by the Performance and Accountability Review process to address specific issues to help move the service to level 2 or 1; compliance required	Reduced authorisation limits	Monthly accountability review led by Chief Executive with written monthly report to EDG
4	**Special measures** Directorate / service has very serious or complex issues which are impacting on the Board's overall performance. The extent of the issues or the response to the issue may impact outside the directorate.	Significant risk in 2 or 3 quadrants	**Universal** support (as for level 1) **Targeted** support as agreed with the directorate (as for level 2) **Mandated** support as determined by the Performance and Accountability Review process to help minimise the time the directorate / service is in level 4; compliance required	Reduced authorisation limites	Monthly accountability review led by Chief Executive with written monthly report to Board Governance Committees

Appendix 1
Performance & Accountability Review Framework - Meetings Timetable[3]

Directorate / Division	Review 1	Review 2	Review 3	Review 4
Performance reports issued	w/c 3 & 10 June	w/c 2 & 9 September	w/c 2 & 9 December	w/c 2 & 9 March
Acute Division	w/c 10 & 17 June 2019	w/c 9 & 16 September 2019	w/c 9 & 16 December 2019	w/c 9 & 16 March 2020
Estates & Facilities				
Public Health				
Pharmacy				
Corporate: Finance				
Corporate: Human Resources				
Corporate: Nursing				
Corporate: Medical				
Health & Social Care Partnership				
Escalation reports issued to CEO	w/c 24 June	w/c 23 September	w/c 23 December	w/c 23 March
Escalation to Committees	July	November	January	April

[3] Specific dates to be confirmed during each week
Frequency of meetings would flex accordingly as required under the Oversight Model set out in Appendix 3

Technical bulletin 2019/1

Technical developments and emerging risks from January to March 2019

AUDIT SCOTLAND

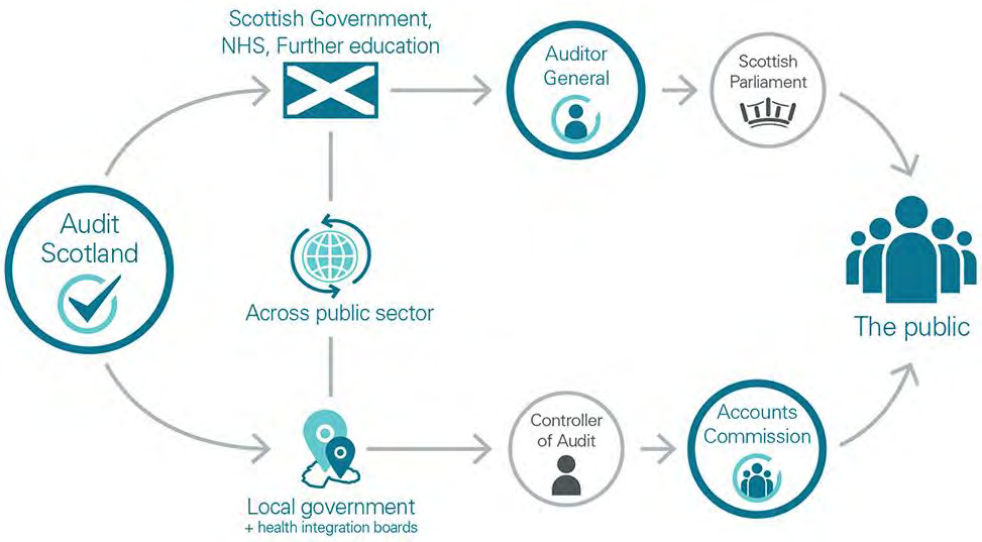
Prepared for appointed auditors and audited bodies in all sectors

15 March 2019

Who we are

The Auditor General, the Accounts Commission and Audit Scotland work together to deliver public audit in Scotland:

- The Auditor General is an independent crown appointment, made on the recommendation of the Scottish Parliament, to audit the Scottish Government, NHS and other bodies and report to Parliament on their financial health and performance.
- The Accounts Commission is an independent public body appointed by Scottish ministers to hold local government to account. The Controller of Audit is an independent post established by statute, with powers to report directly to the Commission on the audit of local government.
- Audit Scotland is governed by a board, consisting of the Auditor General, the chair of the Accounts Commission, a non-executive board chair, and two non-executive members appointed by the Scottish Commission for Public Audit, a commission of the Scottish Parliament.



About us

Our vision is to be a world-class audit organisation that improves the use of public money.

Through our work for the Auditor General and the Accounts Commission, we provide independent assurance to the people of Scotland that public money is spent properly and provides value. We aim to achieve this by:

- carrying out relevant and timely audits of the way the public sector manages and spends money
- reporting our findings and conclusions in public
- identifying risks, making clear and relevant recommendations.

Contents

Introduction

Purpose

1. The purpose of technical bulletins from Audit Scotland's Professional Support is to provide auditors appointed by the Auditor General and Accounts Commission with:

- information on the main technical developments in each sector and on professional matters during the quarter
- guidance on any emerging risks identified in the quarter.

2. The information on technical developments is aimed at highlighting the key points that Professional Support considers appointed auditors require to be aware of. It may still be necessary for auditors to read the source material if greater detail is required. These can be accessed by using the hyperlinks, where provided. They are also available to appointed auditors from the *Technical reference library* maintained by Professional Support on ishare and the Extranet. Auditor actions are highlighted in red.

3. Technical bulletins are also published on the Audit Scotland website and therefore are available to audited bodies and other stakeholders.

Technical bulletins provide information on developments and guidance on emerging risks

Highlights summary

4. Six of the main items in this technical bulletin that are particularly highlighted are summarised in the following table:

Professional Support has provided guidance on guaranteed minimum pension [see paragraph 12]	Professional Support has provided an update on the emerging risk on loans fund repayments [see paragraph 26]	The Scottish Government has issued revised statutory guidance on accounting for equal pay [see paragraph 39]
The Scottish Government has issued the 2018/19 NHS board accounts manual [see paragraph 112]	The Scottish Government has published a blueprint for good governance in health boards [see paragraph 116]	The Financial Reporting Council has issued revisions to ISA (UK) 540 on auditing accounting estimates [see paragraph 134]

Feedback

5. The presentation and format of this technical bulletin has been refreshed. Professional Support encourages and would welcome feedback on the changes or any other aspect of this bulletin.

Feedback on this technical bulletin is welcome

Contact point

6. The main contact point for this technical bulletin is Paul O'Brien, Senior Manager (Professional Support) – pobrien@audit-scotland.gov.uk.

Section 1
Cross-sector

Auditing developments

Contacting Professional Support

7. Auditors are encouraged to contact Professional Support to seek advice or a second opinion on a technical matter (e.g. an interpretation or application of statutory guidance, legislation, the accounting code/manual). The best way to make contact is to use one of the following email addresses depending on the relevant sector:

- TechnicalQueries-LocalGovernment@audit-scotland.gov.uk
- TechnicalQueries-CentralGovernment@audit-scotland.gov.uk
- TechnicalQueries-Health@audit-scotland.gov.uk
- TechnicalQueries-FurtherEducation@audit-scotland.gov.uk.

Auditor action
Auditors should use the relevant email address when contacting Professional Support with a technical enquiry

Accounting developments

Property, plant and equipment

New manual for valuers

8. The Royal Institute of Chartered Surveyors has issued a UK supplement to the RICS valuation – global standards 2017. The supplement reflects valuation standards and other authoritative requirements that are specific to the UK, and provides additional application guidance.

9. The supplement took effect from 14 January 2019 and applies to all valuations where the valuation date is on or after that day. It therefore applies to 2018/19.

The supplement applies to valuations with a valuation date on or after 14 January 2019

10. Part 2 of the supplement sets out professional and valuation standards. Part 3 sets out a number of advisory UK valuation practice guidance applications (UK VPGA), including the following:

- UK VPGA 4 covers the valuation of local authority assets for accounting purposes.
- UK VPGA 5 covers central government.
- UK VPGA 9 covers relationships with auditors.

11. Auditors should note that the supplement no longer requires a full valuation by an internal valuer to be subject to review by an external valuer.

Retirement benefits

Guaranteed minimum pension

12. Professional Support is aware of issues related to the *Guaranteed minimum pension* (GMP). Where a public sector pension scheme was 'contracted out'

of the additional state pension arrangements (before those arrangements ended in April 2016), the scheme was required to provide members with a GMP for service between 6 April 1978 and 5 April 1997. The GMP is broadly equivalent to the amount the members would have received had they not been contracted out.

As an interim solution, pension schemes fund GMP annual increases

13. Funding the annual increase in GMP was previously split between the Department for Work and Pensions and each pension scheme. However, the introduction of the new *Single state pension* in April 2016 brought uncertainty over the ongoing indexation of the GMP amount. This led to an interim solution being announced by the UK Government for members reaching statutory pension age between 6 April 2016 and 5 December 2018, which involves the pension schemes funding all the increase.

14. The UK Government's preferred permanent solution is to convert GMP to a scheme benefit. However, there a number of complications including:

- the need to reconcile data held by HM Revenue and Customs with that held by pension schemes
- ongoing court cases in respect of ensuring equal payments on a gender basis.

Preferred permanent solution is to convert GMP to benefit

15. The Government has therefore extended the interim solution to 5 April 2021. Actuaries and other stakeholders are currently in discussion over how best to address these matters. However, Professional Support understands that:

- actuaries will reflect the Government's preferred long-term solution of converting GMP to scheme benefit at the next round of valuations in 2020. This will lead to an increase in liabilities as a result of the scheme paying full GMP increases for all members with a statutory pension age after 2016
- the Chartered Institute of Public Finance and Accountancy (CIPFA) is preparing guidance on the treatment in the 2018/19 financial statements (e.g. disclosure of a contingent liability).

16. Professional Support will advise auditors when there are further developments.

Contact point

17. The contact point for this section of the technical bulletin is Paul O'Brien, Senior Manager (Professional Support) - or pobrien@audit-scotland.gov.uk.

Section 2
Local government sector

Financial statements developments

New guidance on streamlining

18. CIPFA has issued guidance on streamlining local government financial statements and year end processes. The aim of the publication is to strike a better balance between compliance with accounting standards and providing clearer, simpler and more transparent information.

19. The guidance provides practical assistance through a combination of general guidance, case studies and worked examples. It considers matters such as materiality, accounting policies and presentation.

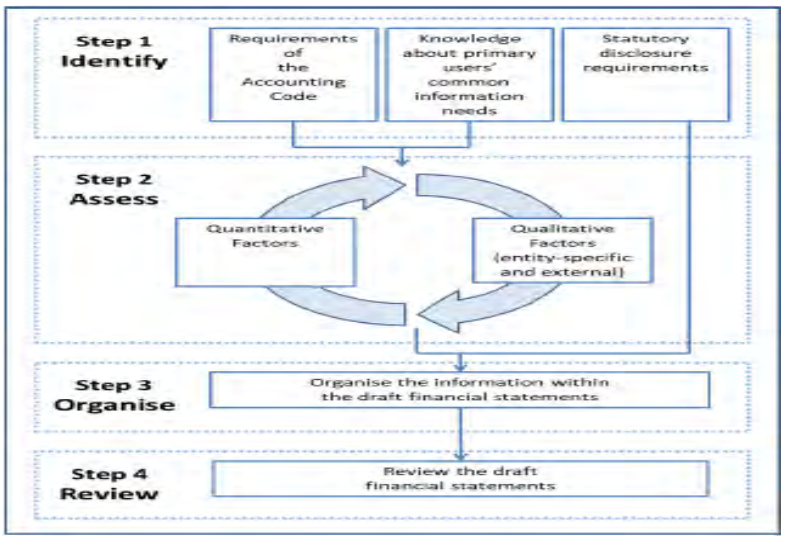
Materiality

20. Some key points in the guidance in respect of materiality are:

- An understanding of materiality is crucial to effective streamlining, particularly the recognition that materiality is often concerned with what should be left out as much as it is about what should be included.
- Consideration of materiality has to be based on a clear view of who the users of the financial statements are, the sort of decisions that they might take, and the information they would need to support these decisions.
- Information should not be included that would detract from the key messages.
- Materiality does not depend solely on the magnitude of an item, but also on the context that it might provide for other disclosures.

Use materiality to avoid key messages of the financial statements being obscured

21. The guidance sets out a four-step approach to materiality in the following diagram:



The four-step approach to materiality is based on the International Accounting Standards Board's Materiality practice statement adapted for local government circumstances

Accounting policies

22. In respect of determining the significance of accounting policies, the guidance advises that:

- Local government bodies need to assess significance for their local circumstances, based on who their primary users are deemed to be and the information that will be of most help to them
- accounting policies are not required for transactions and balances which are not material
- decisions should be made about whether policies are best presented in a single consolidated note or in each of the notes on the particular transactions or balances that they relate to.

Review accounting policies so that only important and relevant information is included

Presentation and layout

23. One of the most important aspects in respect of streamlining presentation and layout is deciding who the main users are and what key information they need. For local government financial statements, the primary users are service recipients and resource providers (including council tax payers). They also include elected representatives insofar as they act on behalf of service recipients and resource providers.

24. Bodies tend to follow the layout and ordering in the example financial statements in the guidance notes to the *Code of practice on local authority accounting in the UK* (the accounting code) but other options might include:

- separating the notes into relevant sections
- including some or all of the accounting policies and judgements in the disclosure notes they relate to
- combining disclosure requirements into a single note where possible.

Consider presentation and layout to help users focus on key messages and navigate through the statements

25. Options for improving the presentation of the disclosures include:

- using tables instead of narrative disclosures
- ensuring that disclosure notes do not include more information than the accounting code requires unless this has been identified as a key information need
- omitting lines in tables when not required (e.g. for nil disclosures)
- providing an index to disclosure notes
- including additional lines in the financial statements instead of separate disclosure notes.

Loans fund repayments update

26. Technical bulletin 2018/4 (paragraph 19) highlighted an emerging risk in respect of the repayment of loans fund advances made before 1 April 2016 (pre-2016 advances). Audit Scotland has subsequently issued a position statement to the CIPFA Directors of Finance Section, CoSLA, and the Scottish Government. The main points set out in the statement are summarised in the following paragraphs.

27. The Local Authority (Capital Finance and Accounting)(Scotland) Regulations 2016 came into force on 1 April 2016 and replaced the provisions in the *Local*

The 2016 regulations apply to advances made from 1 April 2016

Government (Scotland) Act 1975 in respect of the loans fund with a prudent approach. In Audit Scotland's view, the regulations have no retrospective application and apply only to loans fund advances made on or after 1 April 2016.

28. Statutory guidance with finance circular 7/2016 sets out proper accounting practices for administering a loans fund and:

- provides options for the repayment of loans fund advances made from 1 April 2016 under the new prudent approach
- reflecting the legislative position, requires all pre-2016 advances to continue to be repaid as if the 1975 Act had not been repealed (the statutory method).

Statutory guidance requires advances made before 1 April 2016 to be repaid under the statutory method

29. A small number of councils adopted one of the options under the new prudent approach for repaying pre-2016 advances in 2017/18, i.e. they did not charge the general fund with repayment of those advances in accordance with the statutory method. Audit Scotland understands that further councils are similarly planning on adopting a prudent option for repaying pre-2016 advances in 2018/19.

30. The Cabinet Secretary for Finance has announced an intention to amend the regulations to allow councils to adopt the new prudent approach for pre-2016 advances.

31. Councils are required to observe proper accounting practices applicable to the year for which their financial statements are prepared. For 2018/19, applicable proper accounting practices are those in force at 31 March 2019. Any non-compliance with proper accounting practices represents a misstatement in the financial statements.

32. The following table summarises Audit Scotland's view of the impact on proper accounting practices in 2018/19 depending on when the planned amendment to the regulations is made, and consequently whether a council adopting the new prudent approach in 2018/19 would result in a misstatement in the financial statements for that year:

Timing of amendment	Impact on 2018/19	Misstatement	Audit Scotland's current understanding
On or before 31 March 2019	Yes	No	Not possible in practice
After 31 March 2019 but before authorised for issue date – retrospective effect	Yes	No	Not possible in practice
After 31 March 2019 but before authorised for issue date – no retrospective effect	No	Yes	Most likely position
After authorised for issue date	No	Yes	Not expected to be the case

33. It is expected therefore that the amendment to the regulations will not impact on proper accounting practices applicable to 2018/19. It follows that, in Audit Scotland's view, any council not charging their general fund with the repayment of pre-April 2016 advances in accordance with the statutory method in 2018/19 would have a misstatement in their financial statements. The nature of the misstatement would be the adoption of an illegal

Planned amendments to the 2016 regulations are not expected to apply in 2018/19

accounting policy resulting in a misstated general fund balance at 31 March 2019.

34. Misstatements can be material by size or nature. It is understood that the amounts involved are significant and, because it relates to illegality, Audit Scotland would expect any misstatement to be judged as material by its nature even if below the monetary amount set for materiality by auditors. This is consistent with relevant auditing standards.

35. The accounting code requires the correction of material prior period errors retrospectively in the first set of financial statements after their discovery. In Audit Scotland's view, the councils which did not repay pre-2016 advances in accordance with the statutory method in 2017/18 will therefore have to correct that misstatement in the 2018/19 financial statements.

36. Under auditing standards, auditors are required to qualify their opinion if the financial statements contain a material uncorrected misstatement. While the final judgement rests with each individual appointed auditor, Audit Scotland anticipates that auditors will qualify their opinion on the 2018/19 financial statements if:

- any council does not charge the general fund in 2018/19 with the repayment of pre-2016 advances in accordance with the statutory method
- any of the relevant councils do not correct in 2018/19 the misstatement in the 2017/18 financial statements.

37. The wording accompanying the qualified opinion would explain the context and reason.

38. The Directors of Finance Section has recently responded to the position statement indicating that they have a different interpretation of the regulations. Dialogue on this matter therefore continues, and further updates will be provided in due course.

Equal pay provision – new statutory guidance

39. The Scottish Government has issued revised statutory guidance on accounting for equal pay in finance circular 1/2019. The statutory guidance extends the statutory mitigation previously permitted by finance circular 4/2015 to:

The statutory mitigation for equal pay provisions has been extended

- enable a council to delay the impact on the general fund of recognising a provision for equal pay claims until payment is actually made
- allow capital receipts to be used to fund the settlement of the deferred payments.

40. .A deferred charge for an equal pay provision held as a statutory adjustment at 31 March 2018 under finance circular 4/2015 may continue to be held until the equal pay back pay payment is made or the provision is otherwise reduced. In addition, any increase in equal pay provision in 2018/19 and 2019/20 may also be deferred.

41. The accounting for the statutory adjustment has been simplified with effect from 2018/19. Instead of using a separate equal pay provision statutory adjustment account, the deferred charge for the equal pay provision is to be held as part of the employee statutory adjustment account. The value held in the former account at 31 March 2018 should be transferred to the latter account.

Accounting for the statutory mitigation has been simplified

42. As part of the disclosure for the employee statutory adjustment account, a council is required to analyse the amount held in that account for equal pay and the amount held for untaken annual leave.

43. Capital receipts currently set aside for settling deferred equal pay payments may continue to be held until payment is made. Capital receipts received in 2018/19 and 2019/20 may be set aside to fund equal pay payments.

44. The accounting for this use of capital receipts has also been simplified. Capital receipts previously held in the equal pay statutory adjustment account will now be held in the capital grants unapplied account (which is to be renamed the capital grants and receipts unapplied account). A retrospective restatement is required so that the balance on the capital grants and receipts unapplied account as at 31 March 2018 is restated to include the capital receipts and renamed at that date. A council is required to identify, separately, the amount held in that account for capital grants and the amount of capital receipts held for equal pay.

Auditor action
Auditors should confirm that the revised statutory guidance is followed in 2018/19

45. Only those receipts set aside at the time of disposal and held in the capital grants and receipts unapplied account may be used. The amount of capital receipts held in the capital grants and receipts unapplied account cannot exceed the amount necessary to fund the deferred charge for equal pay held in the employee statutory adjustment account. Any excess of capital receipts requires to be transferred to the capital fund.

Financial instruments – draft guidance on earmarking general fund

46. The Local Authority (Scotland) Accounts Advisory Committee (LASAAC) has issued draft guidance on earmarking an element of the general fund in respect of increases in the fair value of financial assets. Under the accounting code's adoption of *IFRS 9 Financial instruments*, increases in the fair value of financial assets classified as fair value through profit and loss are recognised in the general fund. The draft guidance proposes that an element of the resulting general fund balance should be earmarked to the extent it is not readily convertible to cash.

Draft guidance proposes that an element of the general fund be earmarked to the extent it is not readily convertible to cash

47. Gains in the fair value of a financial asset are considered to be 'readily convertible to cash' if all of the following criteria apply:

- A value can be determined at which a transaction could occur to convert the change in fair value into cash.
- In determining the value, information that market participants would consider in setting a price is observable (which is closely aligned with levels 1 and 2 in the IFRS 13 fair value hierarchy).
- There are no circumstances that prevent the immediate conversion to cash of the change in fair value.

48. Even where an increase in fair value is considered readily convertible to cash, bodies would be required to judge whether it is prudent to use the increase to fund services where the fair value of the asset is considered to be volatile.

Draft guidance on internal transactions

49. LASAAC has issued draft guidance on accounting for internal transactions. The guidance is intended to assist in implementing changes to the accounting code for 2018/19 which prohibit the inclusion of income and expenditure on a trading basis between service segments in the comprehensive income and expenditure statement (CIES).

50. As a consequence of the change to the accounting code, previous LASAAC guidance on accounting for insurance which recommended internal premiums is withdrawn.

Previous guidance on insurance funds has been withdrawn

51. The draft guidance clarifies that the changes in the accounting code relate only to treatment in the CIES. This does not preclude bodies from recording, for management and control purposes, internal transactions during the year. Adjustments which reconcile a body's segment management arrangements to the required presentation in the CIES should be made in the expenditure and funding analysis. This would include, for example, the elimination of any internal insurance premiums.

52. The apportionment of external costs between segments, as the re-allocation of underlying expenditure, in the CIES continues to be allowed.

Pay awards

53. Pay awards for non-teaching local government staff have recently been agreed, and are summarised (along with the latest offer for teachers) in the following table:

Year	Increase for non-teaching staff	Increase for teaching staff
2018/19	3.5% (for those earning up to £80,000) Flat rate of £1600 (for those earning above that amount)	3%
2019/20	3%	7%
2020/21	3%	3%

Auditor action
Auditor should confirm that pay increases are properly reflected in the 2018/19 financial statements

54. It is expected that the increases for non-teaching staff with effect from 1 April 2018 will be included in March 2019 salaries. Where that is not possible, the effect of the increase will require to be accrued in the 2018/19 financial statements. Accruals will also be required for teachers based on the latest offer.

55. All increases will require to be communicated to actuaries for inclusion in pension liabilities at 31 March 2019.

Investment in subsidiaries

56. Professional Support has been asked for a view as to whether paragraph 9.1.2.61 of the accounting code allows a council to measure an investment in its subsidiary at cost if the council does not prepare group financial statements (on the grounds of materiality).

Auditor action
Auditors should confirm that investments in subsidiaries are measured as financial assets if group financial statements are not prepared

57. Paragraph 9.1.2.61 states that, within a council's single entity financial statements, investments in subsidiaries (and associates and interests in joint ventures) should be accounted for either:

- at cost; or
- as a financial asset.

58. IAS 27 is clear that single-entity financial statements (referred to in IAS 27 as 'separate financial statements') are those statements in addition to group financial statements. It follows that the option to measure an investment in a

subsidiary at cost only applies if group financial statements are also prepared.

Revised guidance on health and social care integration

59. LASAAC has issued revised mandatory accounting guidance on health and social care integration for 2018/19. The changes are summarised in the following paragraphs.

Treatment of over and underspends

60. The guidance confirms that the accounting treatment of an over or under spend by an integration joint board (IJB) should be in accordance with its integration scheme. In summary, the integration scheme may provide that:

- an underspend is retained by one or more partners, and the funding contribution for the year is reduced
- an overspend is borne by one or more partners, and the funding contribution for the year is increased
- an underspend or overspend does not result in any adjustment to the funding contribution for the year.

61. Appendix C has been added to the guidance to summarise the scenarios that may arise and how these should be treated. The following table provides a summary by contrasting the impact on certain elements of an IJB's accounts depending on whether or not the funding contribution for the year is adjusted to reflect under or overspends:

Area	Funding adjustment	No funding adjustment
Does commissioning expenditure reflect the true cost of providing integrated services?	Yes	No
Is there transparency regarding the funding change in the financial statements?	No	N/A
Is an explanation of cost pressures provided in the financial statements?	No	No
What is the impact on the period for preparing the annual accounts?	Extended	None

62. The guidance recommends that IJBs consider whether the following information should be included in the management commentary:

- The initially agreed funding from each partner.
- Changes in the budgeted funding contributions.
- The final budget for the use of, or contribution to, reserves compared to that originally planned.
- An analysis of variances between the outturn and the final budget.

The guidance recommends information on under/overspends to be included in the management commentary

- An analysis of any variances which have been retained by the funding partners.

63. Where an IJB retains an underspend for the financial year, it should recognise a debtor rather than a cash balance. The debtor represents the amount of funding contribution retained by each partner that has not yet been used by the IJB. The practical effect is that accounting entries that would normally involve cash (e.g. debit cash, credit income) should instead involve the debtor (e.g. debit debtor, credit income).

Reserves

64. An underspend (i.e. income exceeding expenditure) would lead to a balance on the general fund which is matched by a debtor.

Negative reserves should be avoided

Direct reserve accounting is prohibited

65. Where an accumulated deficit on the general fund (i.e. a negative reserve) arises, the guidance requires an IJB to make every effort to remedy the funding situation in year to prevent this position arising. Where this is not possible, the management commentary should include a clear explanation of the causes of the position, the implications for current and future service delivery, and financial recovery plans.

66. With reference to the use of reserves to fund expenditure, the guidance reminds IJBs that direct reserve accounting (i.e. the direct charging of expenditure to the general fund in the movement in reserves statement) is prohibited. All operational income and expenditure must be recognised in the surplus or deficit on the provision of services.

Hosted services

67. The guidance clarifies that where an IJB manages services for another IJB, they should assess which one is acting as principal based on the practices undertaken during the financial year. The IJBs should liaise to ensure consistency of treatment.

68. Where the IJB determines it is acting as agent:

- the relevant expenditure, and related funding, should be excluded from the CIES
- information on the principal and agent relationship should be disclosed.

Set aside arrangements

69. The guidance requires the annual accounts to provide a clear explanation of the progress towards full implementation of the required arrangements for calculating the appropriate amounts of hospital set asides.

Remuneration report - pay band disclosures

70. Where there are no staff members other than those disclosed as a 'relevant person' in the remuneration report, the guidance advises that the provision of a specific table for pay band information may be unnecessary.

71. In that event, a note should be provided to the effect that "Pay band information is not separately provided as all staff pay information has been disclosed in the information above".

Pension funds – 2018/19 example accounts and checklist

72. CIPFA has issued a revised publication which illustrates the financial statements of pension funds within the local government pension scheme for 2018/19.

73. The publication provides an example set of accounts that meet the minimum requirements of the 2018/19 accounting code. However, it is clear that the example accounts should not be treated as either a definitive interpretation of the accounting code or as a template (because it may not contain all the disclosures that might be appropriate for individual pension funds).

74. The main change for 2018/19 results from the adoption by the accounting code of *IFRS 9 Financial instruments*. However, this is likely to have a limited impact for pension funds because most assets and liabilities are already classified as fair value through profit and loss.

75. Examples of assets which pension funds may need to consider in the context of the new expected credit loss impairment model are lease rentals receivable from directly held investment property and contributions from admitted bodies not covered by Crown or third-party guarantees.

76. The publication also includes a disclosure checklist that identifies the accounting code's requirements in relation to pension funds.

Grant claims developments

Housing benefits

2018/19 subsidy claims

77. The Department for Work and Pensions (DWP) has issued a letter and guidance notes on completing the 2018/19 housing benefit (HB) subsidy claim. The letter contains details of the amounts paid for 2018/19 in respect of administration subsidy and interim benefit subsidy received. The deadlines are:

- 30 April 2019 for councils to submit the pre-certified claim to the DWP and external auditors
- 30 November 2019 for the certified claim to be submitted to the DWP.

HBCOUNT has been replaced by HBAP

78. The DWP has also issued module 2 of the Housing benefit assurance process (HBAP) approach to the certification of HB subsidy claims for 2018/19. HBAP replaces the previous HBCOUNT.

79. Module 2 contains a checklist to help auditors ensure that the council's system is using the correct benefit parameters to calculate benefit entitlement and for the council to claim the correct amount of subsidy.

Other circulars

80. The DWP has issued:

- circular S2/2019 to provide details of HB administration subsidy for 2019/20
- circular A1/2019 to advise of changes to claims for claimants receiving severe disablement premium
- circular A3/2019 to advise of changes to HB for mixed age couples (i.e. where only one partner is over pension credit qualifying age)
- circular A8/2018 and circular A2/2019 to advise of the benefits rates from April 2019.

Contact points

81. The contact points for this section of the technical bulletin are:

- Paul O'Brien, Senior Manager (Professional Support) - pobrien@audit-scotland.gov.uk
- Anne Cairns, Manager (Professional Support) – acairns@audit-scotland.gov.uk (grant claims items only).

Section 3
Central government sector

Auditing developments

Technical guidance notes

Audit of 2018/19 annual report and accounts

82. Professional Support has published Audit of 2018/19 annual report and accounts (central government) - technical guidance note 2019/1(CG) to provide guidance to appointed external auditors on performing the audit of the 2018/19 annual report and accounts of central government bodies.

83. The technical guidance note comprises a number of modules. The modules, along with a brief summary of the contents, are set out in the following table:

Module	Subject area
Overview	Auditors' overall responsibilities for the annual report and accounts; summary of overall financial reporting requirements; auditing standards; presentation of body-only financial statements; accounting policies, estimates, and prior year errors, events after the reporting period
1 Property, plant and equipment	Each module highlights the risks of misstatement in each financial statement area, explains the financial reporting requirements applying to that area, and sets out actions for each risk that auditors should undertake to assess whether the board has met those requirements.
2 Provisions, creditors and accruals	
3 Financial assets	
4 Group financial statements	
5 Leases and similar arrangements	
6 Grants and other income	
7 Other financial statement areas	As for modules 1 to 6 but this module includes a number of financial statement areas including investment properties, related parties etc
8 Regularity of expenditure and income	This module provides guidance on auditor's responsibilities for the regularity of expenditure and income, and the risks of irregularities. It also sets out test procedures for auditors to carry out.
9 Non-financial statements	This module covers the remuneration and staff report; performance report, governance statement and other non-financial statements. It explains auditors' responsibilities, sets out the different audit opinions required, highlights the main risks of misstatement, and sets out test procedures that auditors should undertake to assess whether the body has met those requirements.
10 Charitable NDPBs	This module applies the other modules to a charitable NDPB's statement of accounts and provides supplementary guidance.

84. Following extensive consultation with all auditors, the technical guidance note represents an agreed position on a range of complex technical issues and is a key document as auditors perform the audit of central government 2018/19 annual report and accounts.

85. For the purposes of the Audit Scotland website, all the modules have been combined into one document. The individual modules are also available from the relevant subject pages on the central government site of the *Technical reference library* on ishare and the Extranet.

Auditor action
Auditors should use the technical guidance note when planning and performing the audit of 2018/19 annual report and accounts

2018/19 GBS account information

86. Professional Support will obtain information on account balances at 31 March 2019 for central government bodies from the Government Banking Service (GBS) and distribute them to relevant auditors. The GBS has confirmed that the arrangements for obtaining 2018/19 account balances are unchanged.

Annual report and accounts developments

Revised 2018/19 FReM

87. HM Treasury has issued a revised version of the 2018/19 Government financial reporting manual (the FReM).

88. In addition to the changes from 2017/18 in the original version explained in technical bulletin 2018/1 (at paragraph 88, i.e. the adoption of *IFRS 9 Financial instruments* and *IFRS 15 Revenue from contracts with customers*), this revised version also includes changes to reflect the impact of the general data protection regulations and trade union facility time disclosure requirements on the remuneration and staff report.

Auditor action
Auditors should refer to this revised version of the FReM when auditing the 2018/19 annual report and accounts

2019/20 FReM

89. Treasury has issued the 2019/20 FReM. The only change from 2018/19 is to allow for the early adoption of *IFRS 16 Leases* when certain criteria are met.

Financial statements developments

2018/19 disclosure checklists

90. The National Audit Office (NAO) has issued the 2018/19 FReM Disclosure guide which is designed to ensure that bodies covered by the FReM have prepared their 2018/19 financial statements in the appropriate form and have complied with all disclosure requirements.

91. The guide is cross-referenced to the 2018/19 FReM, individual financial reporting standards, and the *Companies Act 2006*. Auditors will need to generate a tailored checklist by selecting the criteria that are material to their audited body.

92. While the guide is designed primarily for the NAO's internal use, auditors in Scotland may also find it helpful. When checking that the FReM's disclosure requirements have been met, auditors should:

- consider requesting that the body completes the NAO's 2018/19 disclosure guide for the financial statements
- investigate the reasons for any non-compliance that the guide highlights

Auditor action
Auditors should consider requesting that bodies complete this checklist

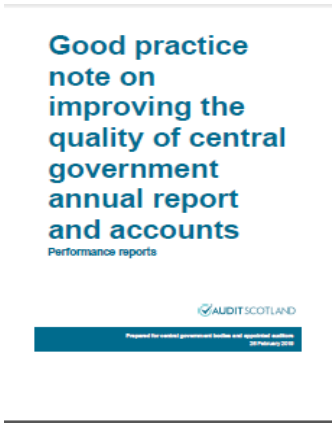
- assess whether the body's responses in the checklist are consistent with auditor's knowledge.

Non financial statements developments

New good practice note on performance reports

93. Professional Support has published a good practice note to share the findings from a review of the performance reports in the 2017/18 annual report and accounts of central government bodies. Some issues for bodies to consider highlighted in the good practice note are set out in the following table:

Auditor action
Auditors should confirm that bodies have considered this good practice note

	• Stand back and consider whether the report tells a fair, balanced and understandable story • Avoid using a checklist approach which can lead to duplication and a disjointed narrative • Provide a balanced account of performance using the performance measures that the board judge to be the most effective in assessing performance • Be sufficiently specific so that users can understand why risks are important, and describe the actions to mitigate the key risks • Avoid using jargon, or explain it where it cannot be avoided

94. Bodies are encouraged to use the findings in this good practice note to assess and enhance their own 2018/19 performance reports.

Guidance on 2018/19 remuneration and staff report

Auditor action
Auditors should refer to this guidance when auditing the remuneration and staff report in the 2018/19 annual report and accounts

95. The Cabinet Office has issued EPN 571 2018/19 Disclosure of salary, pension and compensation information to provide guidance on the preparation of the pay pension and compensation disclosures in the remuneration and staff report for 2018/19. Example disclosures are provided at Annex 13C.

96. There are no significant changes to the remuneration disclosures set out from 2018/19. However, this guidance does not reflect the application of the FReM's requirements to Scottish bodies and therefore auditors should refer to module 9 of technical guidance note 2019/1(CG).

Wider scope developments

Financial management

97. The Scottish Government Finance directorate has published an amendment to the Scottish Public Finance Manual. Finance guidance note 2019/01 provides an update to the internal control checklist in the certificates of assurance section.

Contact point

98. The main contact point for this section of the technical bulletin is Neil Cameron, Manager (Professional Support) – ncameron@audit-scotland.gov.uk.

Section 4
Health sector

Auditing developments

Technical guidance notes

Audit of 2018/19 annual report and accounts

99. Audit Scotland's Professional Support has published Audit of 2018/19 annual report and accounts (health boards) - technical guidance note 2019/2(H) to provide guidance to all appointed external auditors on performing the audit of the 2018/19 annual report and accounts of health boards.

100. The technical guidance note highlights risks of misstatement in the financial statements, performance report and accountability report, and sets out actions for auditors to address each risk.

101. In response to feedback, a new approach has been adopted this year. Instead of replicating the risks that are common to central government bodies, this technical guidance note provides only supplementary guidance on the risks of misstatements that are specific to health boards. It will therefore have to be read in conjunction with technical guidance note 2019/1(CG).

102. Paragraph 54 of the technical guidance note states that capital grants should be charged against the non-core capital resource limit. This was based on a previous version of the accounts manual. Auditors should note that the final version of the accounts manual has been revised to remove that reference (see paragraph 113 on the accounts manual). Capital grants should be charged against the non-core revenue resource limit.

Auditor action
Auditors should use this technical guidance note when performing the audit of the 2018/19 annual report and accounts

2018/19 model independent auditor's reports

103. Professional Support has published 2018/19 independent auditor's report (health boards)-Technical guidance note 2019/3(H) to provide auditors with the model independent auditor's reports which should be used for the 2018/19 annual report and accounts. The technical guidance note also provides application guidance on their use.

104. In the interests of consistency, auditors are required to use the relevant model report in appendices 1 to 2 of the technical guidance note as a condition of their audit appointment. The only exception to using the wording in each model is to tailor the terminology to reflect local circumstances.

105. The changes to the model independent auditor's reports for 2018/19 are summarised in the following table:

	• Additional wording has been added to reflect the requirements in ISA (UK) 700 requires for public interest entities • A reference has been added to highlight that risks of material misstatement are reported in the annual audit report • A similar reference has been added to highlight that conclusions on wider scope responsibilities are reported in the annual audit report • The 'Bannerman' paragraph has been moved from the beginning of the model reports to the end

106. Any proposed modifications to any audit opinion or conclusion, or the inclusion of 'emphasis of matter' or 'other matter' paragraphs, should be discussed with Professional Support in advance of finalising the report.

107. Auditors should use this technical guidance note when reporting on 2018/19 audits. They should complete for each report the checklist at Appendix 3 which provides a list of the key auditor actions.

108. The technical guidance note also provides an assurance statement for the consolidation schedules at Appendix 4. Auditors should complete the auditor action checklist at Appendix 5.

Auditor action
Auditors should use this technical guidance note when reporting the audit of the 2018/19 annual report and accounts and complete the relevant checklists

Review of central work on CNORIS

109. Professional Support will be undertaking a review of the work carried out by the NHS Central Legal Office (CLO) relating to the *Clinical negligence and other risks indemnity scheme* (CNORIS). The objective of the review is to establish the extent to which the information prepared using the work of the CLO, as a management expert under *ISA (UK) 500 Audit evidence*, can be used as audit evidence.

110. Professional Support will also evaluate the appropriateness of the methodology adopted by the Scottish Government to establish the total national liability for CNORIS. The review will focus on the estimation of the liability as at 31 March 2019 with a view to assessing the reliability of the methodology used for 2018/19.

111. Professional Support will then provide auditors with the outcome of the reviews to:

- inform auditors' evaluation of the relevance and reliability of the information prepared by the CLO as audit evidence
- provide assurance on the methodology used in the preparation of the CNORIS figures as at 31 March 2019 which are provided to boards.

Annual report and accounts overall developments

2018/19 accounts manual

112. The Scottish Government has issued the *2018/19 NHS board manual for annual report and accounts* to complement the guidance contained in the 2018/19 FReM.

113. The main changes included in the accounts manual compared with 2017/18 are summarised the following table:

Auditor action
Auditors should refer to the accounts manual when auditing the 2018/19 annual report and accounts

Area	Change
Notes 1, 10 and 27	These notes reflect the adoption by the FReM of *IFRS 9 Financial instruments*.
Notes 3 and 4	Guidance on other operating expenses has been expanded to reflect the FReM requirement that individually material items are to be separately disclosed in the financial statements.
Note 6	References to the carbon reduction commitment scheme have been updated to reflect that the compliance phase ends in October 2019 and that excess allowances held at 31 March 2019 must be written off.
Note 13	Guidance has been added to require boards to use the Scottish life expectancy tables when calculating the provision for early pension.
Remuneration and staff report	The requirements in the FReM in respect of trade union facility time and the general data protection regulations have been reflected.
Governance statement	The amendment highlights that governance statement should reflect the group, including the endowment funds, and clarify that the governance statement should not be made publicly available before the accounts are laid in Parliament.
Parliamentary accountability report	An example disclosure has been included for fees and charges.
Summary of resource outturn	The reference to capital grants being charged to the non-core capital resource limit has been removed.

Financial statements developments

Property, plant and equipment

2018/19 capital accounting manual

114. The Scottish Government has issued the *2018/19 NHS capital accounting manual* (CAM) to interpret the accounting guidance contained in the 2018/19 FReM on capital accounting issues in the health sector.

115. There are no significant changes from the 2017/18 CAM.

Auditor action
Auditors should refer to the CAM when auditing property, plant and equipment in 2018/19

Non-financial statements developments

Governance statements

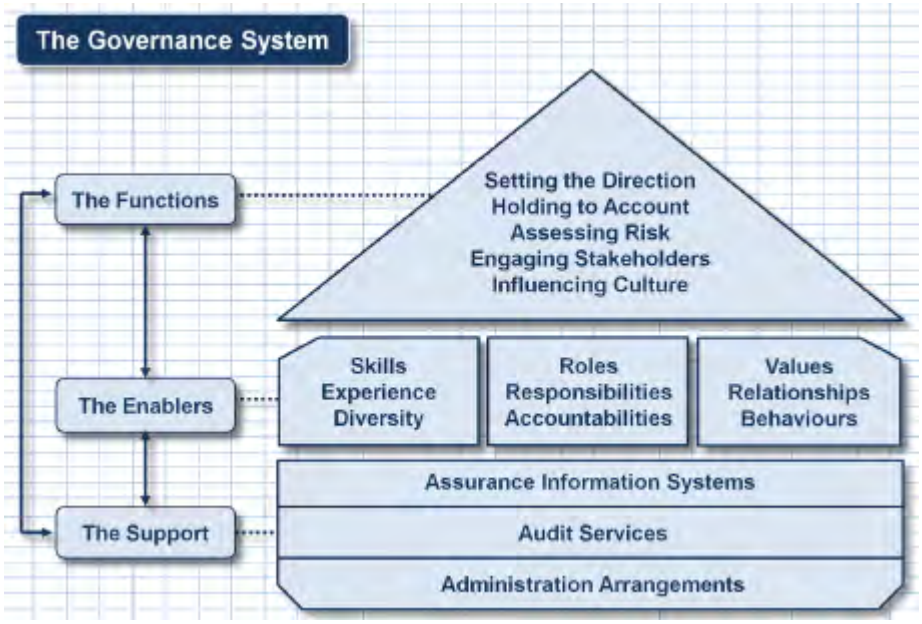
Blueprint for good governance

116. The Scottish Government has published A blueprint for good governance to ensure that all boards assess and develop their corporate governance systems.

117. Corporate governance in this context is concerned with what the board members do and should be distinguished from the day-to-day operational management.

118. The corporate governance blueprint describes a three-tiered model that defines the functions of a governance system, the enablers and the support required to effectively deliver those functions. It is illustrated in the following diagram:

Auditor action
Auditors should refer to this document when considering 2018/19 governance statements



119. The blueprint sets out the importance of a consistent and systematic approach to assessing current governance arrangements. Boards are required to annually self-assess their performance using a tool developed to measure the delivery of the functions, enablers and support. The self-assessment should be validated by a tri-annual independent review of the corporate governance system.

Wider scope

Financial management

Guidance on 2019/20 operational plans

120. The Scottish Government has issued guidance to assist boards prepare their operational plans for 2019/20. The plans should set out how boards intend to deliver expected levels of performance for delivering Scottish Government priorities on: waiting times; health and social care integration; mental health; and healthcare associated infections.

Boards will be required to break even over each three-year period from 2019/20

121. Annex 1 to the document provides guidance on the new three-year financial planning and performance cycle which will operate from 2019/20. Boards will be required to break even over the three year planning period. Within this requirement, boards will have flexibility to report under or overspends of up to 1% of their core revenue resource limit.

122. Where boards cannot break even over the three-year period they will remain part of the NHS board performance escalation framework.

123. Guidance on the presentation of the summary of resource outturn to reflect this requirement will be provided in the accounts manual for 2019/20 and examples have also been provided in the guidance.

Contact point

124. The main contact point for this section of the technical bulletin is Neil Cameron, Manager (Professional Support) – ncameron@audit-scotland.gov.uk.

Section 5
Professional matters

Auditing developments

Review of Financial Reporting Council

125. A report has been issued by Sir John Kingman following a review of the Financial Reporting Council (FRC) carried out on behalf of the Department for Business, Energy, and Industrial Strategy (BEIS). Following criticism of the FRC (for example that it responds too slowly and is excessively close to the firms it regulates), the objective of the review was to ensure that the FRC's structures, culture, processes and powers are fit for purpose.

The review recommendation that the FRC be replaced with a new regulator has been accepted by the Government.

126. The report recommends that the FRC be replaced with an independent statutory regulator, accountable to Parliament, with a new mandate, clarity of mission, leadership and powers. The BEIS has agreed to take forward this recommendation and has issued its own consultation paper.

127. The new regulator is to be called the Audit, Reporting and Governance Authority, and will have an over-arching duty to promote the interests of consumers, rather than producers, of financial information. It will also have duties requiring it to:

- be forward-looking
- promote competition in the market for audit services, and monitor and report on developments in that market
- promote brevity, comprehensibility and usefulness in corporate reporting
- regulate and be responsible for the registration of the audit profession.

No concerns over auditing standards

128. The review did not identify major concerns in relation to auditing standards, and did not make any recommendations in this area. However, it recommended that the new regulator should work towards a position where individual audit quality inspection reports, including gradings, are published in full. As an interim step, it recommended that the audit quality reports should be published on an anonymised basis. The Government and FRC will be taking forward these recommendations.

Proposal to publish audit quality reports to be progressed

129. The review also recommended that the independent auditor's report should include 'graduated' audit findings in respect of key audit matters. For example, judgements describing an estimate as cautious, balanced or optimistic. The BEIS will consult on proposals in due course.

130. The report covered the arrangements for local audit in England. Following the abolition of the Audit Commission, the review found that the framework is fragmented and expressed serious concerns that the arrangements are prioritising a reduction in cost of audit over audit quality. The report recommends bringing together in one place all the relevant responsibilities, so a single regulatory body can take an overview.

131. The BEIS has indicated that it will be reviewing the effectiveness of the current arrangements once they have bedded in and will reflect on these recommendations as part of that review.

132. The report also considered audits carried out by the NAO under the Companies Act as the FRC monitors the quality of these audits carried out by the NAO. However, the FRC reports the results of these reviews privately to the NAO, and does not interact with the audit committee chair. The report recommends that the new regulator's individual audit quality reviews gradings and findings in relation to the NAO should be shared with the relevant audit committee and Parliament, and should be published.

133. When requested by the Controller and Auditor General (C&AG), the FRC also reviews selected non-Companies Act audits, reporting privately to the C&AG the results of this work. The report recommends that all financial audits in scope of the NAO should be brought within the audit quality monitoring scope of the new regulator, and not only at the discretion of the C&AG.

Revised auditing standard on estimates

134. The FRC has issued a revised ISA (UK) 540 Auditing accounting estimates and related disclosures. The revised standard is effective for periods beginning after 15 December 2019, but early adoption is encouraged.

135. The revisions support an enhanced focus by auditors on management estimates and disclosures arising from changes in international financial reporting standards (IFRS), particularly the move to accounting for financial assets on an expected loss basis and revenue recognition from contracts.

The standard supports an enhanced focus on estimates and disclosures - early adoption is encouraged

136. Key revisions to ISA (UK) 540 are set out in the following table:

Revision	Further information
Enhanced requirements for risk assessment procedures and the auditor's work effort in responding to the assessed risks of material misstatement.	These include, in addition to addressing risks related to estimation uncertainty, specific attention to other risk factors in making accounting estimates such as complexity and subjectivity.
Enhanced work requirement in respect of developing an auditor's point estimate or range.	If the auditor develops a range of estimates, the auditor is specifically required to determine that the range includes only amounts that are supported by sufficient appropriate audit evidence
Audit procedures to address whether estimates and disclosures are reasonable.	This involves amending the objective and the requirements to the effect that audit procedures address whether both the accounting estimates and the related disclosures are 'reasonable' in the context of the applicable financial reporting framework (the previous standard addressed whether disclosures were 'adequate').
Enhancements to reinforce the application of professional scepticism	These include: • using wording to drive questioning or challenging management where appropriate • more focus on identifying indicators of possible management bias • requiring further audit procedures to be designed and performed in a manner that is not biased toward obtaining audit evidence that may be corroborative or towards excluding audit evidence that may be contradictory • an enhanced retrospective review and an overall evaluation based on procedures performed.
Emphasising the importance of the need to consider internal control.	There are improved linkages to ISAs (UK) 315 and 330.

Revision	Further information
Communicating certain matters to those charged with governance	A new requirement to remind auditors of their responsibilities to communicate certain matters to those charged with governance and to consider the matters to communicate regarding accounting estimates

Update on reviewing auditing standards

137. The FRC has issued a position paper on its review of auditing and ethical standards. The paper sets out how the FRC intends to respond to the feedback from the recent consultation (referred to in technical bulletin 2018/4 at paragraph 66), including a planned timetable to make revisions to the standards.

138. The proposed revisions are intended to make audit more responsive to the needs and legitimate public expectations of users and require enhanced work effort to strengthen quality and consistency. The intention is to follow the position paper with a consultation in July 2019 on the revised text of a number of standards including:

- ISA (UK) 240 so that it is even clearer as to the auditor's responsibilities in respect of fraud, given recent reported confusion in this respect. The FRC will also consider whether the scope of the auditor's responsibilities in this respect should be extended.
- ISA (UK) 250 with view to integrating sections A and B, and better meeting user expectations, including extending the current scope of ISA (UK) 250B to all regulated entities.
- ISA (UK) 701 to expand the obligation to report in a way that provides a qualitative assessment of the auditor's judgment on key audit matters (i.e. graduated reporting).
- ISA (UK) 720 to strengthen the work effort required of the auditor in achieving the intended outcomes of the standard, and address weaknesses identified in the recent thematic review (see paragraph 66 of technical bulletin 2018/4). The FRC will also consider the current status of 'other information' and the assurance required over it.

Proposed revisions to standards from 2020/21 will be consulted on over the summer

139. Proposed revisions to ISA (UK) 570 have already been issued (see following item). There will also be proposed revisions to the ethical standard to support auditor independence and remove conflicts of interest.

140. It is proposed that the effective date of the revisions will be for audits of financial periods commencing on or after 15 December 2019.

Proposed changes to ISA (UK) 570

141. The FRC has issued an exposure draft of proposed changes to ISA (UK) 570 in respect of going concern. Given the fundamental importance of going concern in a set of financial statements, the FRC believes it is in the public interest to propose revisions to this standard to drive necessary improvements in audit quality.

142. This consultation is based on the current statutory and accounting framework, and does not propose changes beyond that framework. A summary of the main proposed changes is set out in the following table:

Area	Proposed change
Linking the ISA to other ISAs	Links from ISA (UK) 570 to important principles in other ISAs are to be enhanced to: • better demonstrate how they are applied in respect of going concern • provide an improved basis for the evaluation of management's assessment of the body's ability to continue as a going concern.
Strengthening the objectives	The objectives of the ISA are to be revised to require the auditor to obtain sufficient appropriate audit evidence about whether a material uncertainty related to going concern exists.
Enhancing risk assessment procedures	Clearer links are to be drawn between the auditor's responsibilities in respect of going concern and the auditor's understanding of the body and its environment, the applicable financial reporting framework, and the body's system of internal control.
Evaluating management's assessment	The auditor's work effort in relation to the evaluation of management's assessment to be more robust including a more rigorous challenge of the method, information and assumptions.
Professional scepticism and management bias	Additional requirements and application material are to be added designed to enhance the auditor's application of professional scepticism and consideration of the potential for management bias. This includes a definition of management bias being added (i.e. a lack of neutrality by management in the preparation of information).
Enhanced auditor reporting	Where the going concern basis of accounting is appropriate, a new requirement for the auditor's report has been added to include: • an explanation of how the auditor evaluated management's assessment of the body's ability to continue as a going concern and where relevant, key observations arising with respect to that evaluation • a conclusion that management's use of the going concern basis of accounting is appropriate • where no material uncertainty has been identified, a statement that the auditor has not identified a material uncertainty related to going concern.
Strengthening communication with those charge with governance	A new requirement is to be added to place more emphasis on communications with those charged with governance in situations where management is unwilling to make or extend its assessment when requested to do so by the auditor.
Communicating with regulators	A new requirement is to be added for the auditor to consider whether there are any requirements beyond the ISAs which would require the auditor to report to a regulator.

143. Comments should be sent to AAT@frc.org.uk by Friday 14 June.

Report into commercial audit market

144. The Competition and Markets Authority (CMA) has issued a report on the market for the provision of statutory audit in the UK commercial sector. The report follows a review (referred to in technical bulletin 2018/4 – paragraph 68) which considered whether the audit market is working as well as it should.

145. The review comes amid growing concerns about statutory audits, in particular following the collapse of Carillion and the criticism of those charged with governance, as well as recent poor results from the FRC's reviews of audit quality.

A well-functioning market would produce high quality audits

146. The CMA report asserts that a well-functioning market would produce high-quality audits. Competition must be focused on quality, and there must be sufficient choice of viable competitors. The review identified the following main reasons why the CMA believes that audit quality is falling short:

- companies choose their own auditor and, for example, may seek 'cultural fit' over 'challenging scrutiny' and attach too much weight to price
- choice is a prerequisite of effective competition but is too limited, with 97% of the audits of the biggest companies undertaken by the Big Four accountancy firms (i.e. PWC, EY, KPMG and Deloitte), and barriers facing mid-tier firms
- auditor's focus on quality may be diluted by 75% of revenue of the Big Four coming from non-audit services such as consulting, which provides a weak incentive to challenge

147. To address these concerns, the CMA is proposing a package of reforms to create incentives for better audit quality as set out in the following table:

Concern	Proposed reform
Auditor independence - Auditors must be properly incentivised to deliver sceptical audits. This requires auditors to be independent and willing to challenge company management. Companies selecting and paying their own auditors is an impediment to high quality audits. One way to achieve this would be to transfer responsibility for the audit selection processes, and audit engagement monitoring, from companies to an independent body. However, most stakeholders are opposed to this reform as they are concerned it would disenfranchise shareholders. In addition, a blanket generic removal of shareholders' rights to appoint the auditor would be inconsistent with the current EU legislative framework.	**Regulatory scrutiny of audit committees** - Audit committees should be subject to specific regulatory requirements and obligations. The CMA's current view is that this regulation should include: • A requirement that audit committees report directly to the regulator before, during and after a tender selection process. The regulator would also have the ability to include an observer on all or a sample of audit committees. • A requirement that audit committees report directly to the regulator throughout the audit engagement. • The ability for the regulator to issue public reprimands or direct statements to shareholders.
Barriers to mid-tier firms auditing large companies - There are concerns about the capability of mid-tier firms to carry out the most complex audits. However, the CMA found that the firms were frequently ruled out of tenders on the basis of lack of experience; but they would only be able to build that experience by gaining a more substantial foothold in the market. Mid-tier firms consequently appear reluctant to bid for the largest audits due to the cost of tendering relative to the likelihood of winning.	**Mandatory joint audit** - A joint audit would require two firms to sign off on the accounts of their audit client. Responsibility for the audit opinion, and audit liability, would rest with both auditors. The CMA's preferred way of achieving this would be by mandating that at least one of the audit pair is a mid-tier firm. This would give mid-tier firms access to the largest clients, allowing them to develop their experience and credibility. **Market share cap** - An alternative approach, but less favoured by the CMA, is imposing a market share cap on the Big Four.

Concern	Proposed reform
Conflicts between audit and non-audit services - The CMA do not believe that the rules that limit the effect of conflicts caused by combined audit / non-audit structures are sufficient to focus attention on high quality audit because: (a) Profit pooling means that audit partners directly benefit from the commercial success of the non-audit part of the business (b) The significant revenue derived from non-audit services means that governance and investment decisions are heavily driven by non-audit considerations. (c) There are underlying cultural concerns of the same firm providing audit and non-audit services.	**Operational split between audit and non-audit parts of the firm** - An operational split with separate profit pools and governance arrangements for audit and non-audit. The CMA want to test whether an operational split could be designed in a way that would make it almost as effective as structural separation. If that is not the case, full structural separation (prohibiting audit firms from providing non-audit services) will be revisited
Under-performance - The report highlights the importance of a regulatory regime that makes visible the differences in audit quality between firms and then holds firms to account for any underperformance.	**External peer review** - The regulator would determine which companies were subject to a peer review as an additional, independent quality check. External peer reviews could be funded by a levy on audit fees. A peer review firm, unconnected to the auditor, would be appointed by the regulator. In contrast with the regulator's audit quality reviews, the peer review would occur prior to the signing-off of the accounts.

Independent review into audit standards

148. A review led by Donald Bryden (the Bryden Review) has been launched by the UK Government into audit standards. Building on the Kingman and CMA reviews, this review will now consider audits as a product and what the standards and requirements should be for audits in the future. Specifically, it will consider:

The review will consider audit standards and requirements for the future

- how far audit can and should evolve to meet the needs of investors and other stakeholders
- how auditors verify information
- how to manage any residual gap between what audit can and should deliver
- the public's expectations from audit.

149. The new review will also test the current model and ask whether it can be made more effective as well as looking at how audit should be developed to better serve the public interest in the future, taking account of changing business models and new technology.

Accounting developments

Financial reporting framework after EU withdrawal

150. The International Accounting Standards and European Public Limited-Liability Company (Amendment etc.) (EU Exit) Regulations 2019 have been laid to set out how new or amended IFRS issued by International Accounting

Standards Board (IASB) will be adopted for use in the UK after 29 March (or later date if the UK's exit is delayed). The provisions are summarised in the following table:

Start of financial year	Financial reporting framework
On or before 29 March	EU-adopted IFRS
After 29 March	UK-adopted IFRS

2018/19 financial statements will continue to be prepared under EU-adapted IFRS

151. This means that public sector financial statements for 2018/19 will be prepared under EU-adopted IFRS, but the basis of preparation will move to UK-adopted IFRS from 2019/20.

152. On 30 March 2019, EU-adopted IFRS and UK-adopted IFRS will remain the same. However, the regulations will give the UK Government power to endorse and adopt new or amended IFRS from that date. A separate instrument will delegate the adoption function in practice to a UK endorsement body. New or amended IFRS that are still in the process of being endorsed in the EU will be assessed for adoption in the UK by this body.

Contact point

153. The contact point for this section of the technical bulletin is Paul O'Brien, Senior Manager (Professional Support) - pobrien@audit-scotland.gov.uk.

Section 6
Fraud and irregularities

Auditor action
Auditors should consider whether weaknesses in internal control which facilitated each fraud may exist in their bodies and take the appropriate action

154. This chapter contains a summary of fraud cases and other irregularities facilitated by weaknesses in internal control at audited bodies that have recently been reported by auditors to Professional Support.

Expenditure

Change of bank details

155. Third parties defrauded a total of over £30,000 from three public bodies by infiltrating email accounts and re-directing payments intended for legitimate suppliers.

Key features (case 1)

The perpetrator set up rogue email addresses containing very slight changes from the legitimate addresses for both the public sector body and one of its partners. All emails between the two parties could then be intercepted and amended by the perpetrator.

A regular payment was due to be made to the partner and confirmation of the bank details was requested by email. The perpetrator modified the bank details to a fraudulent account, and the payment was made to that account.

The fraud was identified after the partner was contacted on social media and asked to respond to a sequence of emails. It then became apparent that the email addresses and the new bank details were fraudulent.

Weakness in internal control

The fraud was possible as no phone call was made to the partner to confirm the change of bank account.

Key features (cases 2 and 3)

Emails purporting to be from two legitimate suppliers were received by the public bodies advising of a change in their bank details. In one case, the email contained a letter on headed paper to this effect. In the other case, the public sector body asked for confirmation of the 'old' bank details, and email confirmation of this was received.

The bodies amended the bank details, and two payments were then made. The fraud was identified when the suppliers queried non-receipt of their payments.

Weakness in internal control

The frauds were possible as no phone call was made to the suppliers to confirm the change of bank account.

Income

Admission ticket sales

156. Perpetrators defrauded £12,000 from an NDPB through fraudulent ticket sales.

Key features

The perpetrators purchased a number of tickets for events from overseas using stolen credit card details, and then re-sold the tickets. The fraud was not identified until when the genuine card holders queried the transactions and requested refunds. A subsequent review identified an unusual increase in refunds for disputed card transactions.

The NDPB has now moved to an enhanced card payment system. The IP addresses used for the fraudulent ticket sales have also been blocked.

Weakness in internal control

The fraud was facilitated by a card payment system which did not include secondary authentication for payments.

Fraudulent refunds

157. An environmental services employee defrauded £12,500 from a council by failing to bank income and by processing false refunds.

Key features

The employee legitimately sold refuse sacks to residents, but subsequently processed a refund and retained the cash. The individual also identified council tax and housing rent accounts that were in credit, processed a refund for the overpayment, and again retained the cash.

No issues were initially detected as the cash recorded in the ledger agreed to the cash in the till.

The fraud was identified following a review of transactions by the sales ledger team, who identified that it was unusual to expect refuse sack refunds. Further investigation identified that refunds were being processed by the same officer for council tax and housing rents payments.

Management have now introduced a daily review of all refunds processed. Council tax and housing rent account credit balances are now being identified and highlighted to customers.

Weakness in internal control

The fraud was facilitated by the absence of regular performance reviews to highlight unusual items and inadequate segregation of duties.

Failure to bank income

158. A housing officer defrauded £6,000 from a council by failing to bank income.

Key features

The officer did not record cash income on income records. The main control was to reconcile the income records to the bank statement, and therefore the missing income was not timeously detected.

The fraud was identified when a finance officer discovered that expected income was not in the relevant bank account. Following investigation, it was established that this income had not been banked and that the issue went back to 2016.

A review of the system controls is being undertaken to allow weaknesses to be identified and addressed.

Weakness in internal control

The fraud was possible due to a failure in budget monitoring processes and the income reconciliation process relying upon income details being recorded in the income records.

Failure to bank income (2)

159. A modern apprentice has defrauded £11,000 from a council's licensing department by failing to bank income.

Key features

The fraud was identified after a member of the public who had paid for a license asked for a copy of the receipt. When the transaction was investigated by a licensing officer, the money was found in the apprentice's work tray. It was then identified that cash receipts were not being recorded on any internal system nor had the corresponding money been banked. Controls have since been strengthened to address a number of weaknesses.

Weakness in internal control

The fraud was possible due to a number of basic control weaknesses including:

- inadequate segregation of duties relating to the receiving, recording and banking of income
- financial reconciliations not being carried out
- poor supervision
- receipts not being issued to customers
- cash not being banked regularly.

Client funds

Embezzlement of care home residents' funds

160. The owner of a council-funded care home defrauded £38,000 from residents.

Key features

The owner was not managing residents' funds through individual bank accounts, as required by the contract with the council, in order to hide the fraudulent transactions.

A council employee responsible for managing the contract initially identified that residents were having financial difficulty and cash flow problems. A subsequent investigation of residents' funds identified unusual bank transfers with a lack of supporting information.

The business owner was reported to the Procurator Fiscal and is awaiting trial, but has repaid the funds.

Weakness in internal control

The fraud was facilitated by inadequate contract management arrangements.

Theft

Theft of laptops

161. An unknown third party stole laptops valued at £7,000 from a school.

Key features

The equipment was stolen from a secure storage area within the school. The theft was discovered when an employee went to retrieve the equipment prior to use. The matter has been reported to the Police.

Weakness in internal control

An internal audit investigation identified physical control weaknesses including:

- key boxes not being locked
- annual asset returns not being completed
- computer equipment not being security marked.

Contact point

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