Audit & Risk Committee

Tue 19 January 2021, 10:00 - 12:00

Agenda

10:00 - 10:00
0 min

1. Apologies for Absence

10:00 - 10:00
0 min

2. Declaration of Members' Interests

10:00 - 10:00
0 min

3. Minutes of Previous Meeting held on 19 November 2020

Martin Black

Item 3 - Audit Risk Minutes 19 November 2020.pdf (7 pages)

10:00 - 10:00
0 min

4. Action List

Martin Black

Item 4 A&R Action List 1921.pdf (1 pages)

10:00 - 10:00
0 min

5. Matters Arising

Martin Black

10:00 - 10:00
0 min

6. TRAINING SESSION

6.1. Counter Fraud Training Session for Members (Gordon Young, Head of Counter Fraud Service, in attendance)

Gordon Young

10:00 - 10:00
0 min

7. ANNUAL REPORT PATIENT EXEMPTION CHECKING (PECS) 2019/20

Margo Mcgurk

Item 7 - NHSF ARC Patient exemption Checking (PECS) Annual Report 201920mm.pdf (3 pages)
Item 7 - NHSF ARC Patient exemption Checking (PECS) Appendix (Recoveries & Write Offs by reason) 201.pdf (1 pages)
Item 7 - NHSF ARC Patient exemption Checking (PECS) Appendix (Write Offs by Category) 2019-20.pdf (1 pages)
Item 7 - NHSF ARC Patient exemption Checking (PECS) Appendix (Write Offs by Reasons) 2019-20.pdf (1 pages)

10:00 - 10:00
0 min

8. GOVERNANCE - INTERNAL AUDIT

8.1. Internal Audit Progress Report

Shona Slayford

- Item 8.1 - Progress Cover Paper SBAR v7 FINAL.pdf (4 pages)
- Item 8.1 - NHSF Jan 2021 Progress Report v8 FINAL.pdf (11 pages)

8.2. Interim Evaluation of Internal Control Framework

Tony Gaskin

8.3. Internal Audit - Follow-Up Report Recommendations

Shona Slayford

- Item 8.3 - Jan 2021 Audit Follow Up Report v7 FINAL.pdf (36 pages)

8.4. Internal Audit Framework

Tony Gaskin

- Item 8.4 - Internal audit framework cover paper FINAL.pdf (4 pages)
- Item 8.4 -Appendix 1 Audit charter Final.pdf (7 pages)
- Item 8.4 - 2 Spec Final.pdf (23 pages)

10:00 - 10:00
0 min

9. GOVERNANCE - EXTERNAL AUDIT

9.1. Audit Scotland Annual Audit Plan

Patricia Fraser

10:00 - 10:00
0 min

10. RISK

10.1. Board Assurance Framework

Helen Buchanan

- Item 10.1 - SBAR Update on Board Assurance Framework to NHS Audit & Risk Committee 190121 V1.0.pdf (5 pages)
- Item 10.1 - Appendix 1, NHS Fife BAF Financial Sustainability - F,P& RC 101120.pdf (2 pages)
- Item 10.1 - Appendix 2, NHS Fife BAF Environmental Sustainability – F,P& RC 101120.pdf (1 pages)
- Item 10.1 - Appendix 3, NHS Fife BAF Workforce Sustainability - SGC 291020.pdf (2 pages)
- Item 10.1 - Appendix 4, NHS Fife BAF Quality & Safety - CGC 041120.pdf (1 pages)
- Item 10.1 - Appendix 5, NHS Fife BAF Strategic Planning - CGC 041120 & F,P&R 101120.pdf (1 pages)
- Item 10.1 - Appendix 6. NHS Fife Board Assurance Framework (BAF) - Integration Joint Board.pdf (1 pages)
- Item 10.1 - Appendix 7, NHS Fife BAF e Health Delivering Digital and Information Governance & Security - CGC 041120.pdf (2 pages)

10.2. Risk Management Key Performance Indicators

Helen Buchanan

- Item 10.2 - Risk Management Key Performance Indicator Report to NHS Fife Audit and Risk Committee on 190121 V 1.0.pdf (3 pages)
- Item 10.2 - Appendix 1, Risk Management Key Performance Indicators (KPIs) Summary V 1.0.pdf (6 pages)

10.3. Corporate Risk Register Update

Helen Buchanan

10:00 - 10:00
0 min

11. OTHER

11.1. Issues for escalation to NHS Board

Martin Black

10:00 - 10:00
0 min

12. Any Other Competent Business

10:00 - 10:00
0 min

13. Date of Next Meeting - Thursday 18 March at 10am within the Boardroom, Staff Club, Victoria Hospital. (TBC)

MINUTE OF THE AUDIT & RISK COMMITTEE MEETING HELD ON 19 NOVEMBER 2020 AT 2PM VIA MS TEAMS

Present:

Mr M Black, Chair
Ms S Braiden, Non-Executive Member
Ms J Owens, Non-Executive Member
Ms K Miller, Non-Executive Member

In Attendance:

Mrs C Potter, Chief Executive
Ms P Fraser, Audit Scotland
Mrs M McGurk, Director of Finance
Ms A Clyne, Audit Scotland
Mr T Gaskin, Chief Internal Auditor
Mr A Mitchell, Thomson Cooper Accountants
Mr B Hudson, Regional Audit Manager
Mrs R Robertson, Assistant Director of Finance
Dr G MacIntosh, Head of Corporate Governance & Board Secretary
Mrs C Leitch, Financial Planning, Projects and Costing Accountant
Ms F McLeary, minutes
Ms O Notman, NHS Lothian

1. Welcome / Apologies for Absence

The Chair welcomed Trish Fraser and Alison Clyne, from Audit Scotland, and Alan Mitchell, from Thomson Cooper Accountants, who were attending the meeting to speak to various agenda items.

Apologies were received from Cllr David Graham and Helen Buchanan.

2. Declaration of Members' Interests

There were no declarations of interest made by members.

3. Minute of the last Meeting held on 17 September 2020

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

4. MATTERS ARISING

There were no matters arising.

5. PATIENTS' PRIVATE FUNDS – ANNUAL ACCOUNTS 2019/20

Mrs McGurk highlighted the importance of ensuring that NHS Fife has effective management reporting and control arrangements to support funds that they hold on behalf of patients. She invited Alan Mitchell, from Thomson Cooper Accountants, to take the Committee through work they have done and to give his opinion on the year-end financial statements.

Mr Mitchell presented the audit completion memorandum to the Audit & Risk Committee, which highlighted the key audit risk areas. These were the security of the patients' private funds, the assets that NHS Fife hold and the compliance with the financial operating procedures that are put in place for the receipt and payments of the funds. He reported that the audit was carried out in June 2020, and this was followed up with selected ward visits in September. The audit completion memorandum reports that there were no significant issues identified during the audit.

There were a number of minor items listed where there was non-compliance with the financial operating procedures. However, none of these were significant and will be addressed by management.

Overall, the Committee were invited to note that there were no significant issues or weaknesses identified. Mr Mitchell was happy to report that there were no restrictions in the scope of the audit and, on that basis, a clean audit report was given in respect of these accounts.

In response to a question raised by Mr Black around follow-up of the minor issues of non-compliance found in the audit, Mrs McGurk agreed to look into these and would report back to a future meeting of the Audit and Risk Committee.

Action: MM

The Audit & Risk Committee:

- **reviewed** the Patients' Private Funds Accounts; and
- **recommended** that the accounts are approved by the NHS Board.

6. ENDOWMENT FUND ANNUAL ACCOUNTS & REPORT 2019/20

Mrs McGurk reported that the Endowment Sub-Committee has reviewed the Annual Accounts of the Fife Health Board Endowment Fund on 2 October 2020 and recommended approval to the Board of Trustees, who formally approved the accounts on 28 October 2020. These accounts have been submitted to the Audit and Risk Committee for noting as part of the governance process.

The Audit & Risk Committee **noted** the approval of the Endowment Fund Accounts by the Board of Trustees at their last meeting in October 2020.

7. SERVICE AUDITOR REPORTS ON THIRD PARTY SERVICES

Mrs McGurk reminded the Committee that each year audits are undertaken on behalf of NHS Fife by auditors appointed by NHS National Services Scotland (NSS) and NHS Ayrshire & Arran, for services on behalf of all NHS Scotland Boards. There are three

reports that form part of the overall assurance to support this Committee's consideration of the annual accounts.

Two out of the three audits this year received qualified opinions. The scrutiny around the findings of these reports and the assessment of management responses have been considered in full at either the NSS Audit & Risk Committee or at the same Committee within NHS Ayrshire & Arran.

NSS Practitioner Payments and CFS Service Audit
This full report has been prepared by KPMG, as Independent Service Auditors for NSS. The auditors have provided a qualified opinion, having identified weaknesses that prevented them from being satisfied that three of five control objectives set out in the report had been evidenced.

NSS IT Services
The auditors provided a qualified opinion, having identified weaknesses that prevented them from being satisfied that three of six control objectives set out in the report had been evidenced. This included a lack of documentation and evidence to corroborate that the necessary checks have been performed.

There was quite a detailed assessment completed by NSS, supported by the NSS external auditor, to understand what level of assurance NHS Fife and the other boards could take from these reports. This information has been outlined in the summary provided.

The NSS Director of Finance has advised that there were no findings related to payment transaction processing, and their external auditor has determined that there is no need for further testing. The Committee can take assurance that there is no impact upon the Board's financial statements.

It is important to note that NSS do have a piece of work to do to ensure that the necessary improvements in the control environment are progressed and evidenced, and a detailed management response has been provided for each finding. An improvement plan has been established and this will be monitored by the NSS Audit & Risk Committee. Mrs McGurk suggested that an update should be provided to the NHS Fife Audit & Risk Committee in March 2021, to give assurance that the plan is progressing. It was agreed that this request should be made by the Director of Finance for the March meeting.

Action: MM

NHS Ayrshire & Arran Financial Ledger Services
The auditors provided an unqualified opinion and reported no critical or significant risk findings.

The Committee discussed the three reports. In response to a question raised by Ms Miller around the qualified opinions and whether these were in consequence of new auditors in place, Mrs McGurk advised that these were new issues that had been picked up. She advised that the NSS Audit & Risk Committee have put significant pressure and challenge on the management team of NSS to make sure these actions are addressed and to progress the necessary improvement plan.

The Audit & Risk Committee **noted** the reports and audit opinions of the independent service auditors in 2019/20 for each of the services hosted by NSS and by NHS Ayrshire & Arran on behalf of NHS Fife.

8. INTERNAL AUDIT ANNUAL REPORT 2019/20

Mr Gaskin highlighted that this report had been to the previous Audit and Risk Committee in September, in draft form, and had now been finalised, with a completed action plan, management responses and appropriate timescales.

He reported that there had been one minor change since that the last meeting, and this was in reference to the planned audit of remobilisation activities. This has been impacted by the current pandemic and the impact on services restarting. Internal Audit is however having discussions with the Director of Finance and Chief Executive around the lessons learned from the initial remobilisation period, welcoming the fact that NHS Fife is presently revising its strategic planning and resource allocation approach.

In response to a question raised by Ms Braiden around assurances relating to Information Governance, Mr Gaskin advised that this was a complex area. He has held discussions with the Medical Director around where the improvements are needed on reporting through the governance structure, particularly to the Clinical Governance Committee. In order to avoid a potential disclosure in the next year, it would be important that this be improved.

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

9. ANNUAL ACCOUNTS

9.1 Audit & Risk Committee Annual Statement of Assurance

The Audit and Risk Committee **noted** the Chair's signed approval of the Committee's final version of its Assurance Statement.

9.2 Draft Annual Accounts for the Year Ended 31 March 2020

Rose Robertson, Caroline Leitch and Olga Notman were thanked for attending this meeting, principally for this agenda item. Mrs McGurk drew attention to the cover paper, particularly to Section 2.1, and reminded the Committee that there were three statutory financial targets that have to be met every year. She reported that NHS Fife had met these targets for 2019/20.

She highlighted that the application of IFRS16, to introduce leases onto the balance sheet, had been further deferred for one year and will now be effective from financial year 2021/22. As a consequence of the Covid-19 pandemic, the valuation of property in 2019/20 was impacted to the extent that most valuers have caveated their valuation statements. As at the valuation date, they considered that they could attach less

weight to previous market evidence for comparison purposes, to inform opinions of value. Given the unknown future impact that Covid-19 might have on the real estate market, they have recommended that valuation of property is kept under frequent review.

The Director of Finance noted that, in accordance with IAS 28 Investments in Associates and Joint Arrangements, the primary financial statements have been amended for the additional disclosures required to reflect the interest of Integration Joint Boards. None of these changes impact on the financial statements.

The key areas of focus were discussed. Section 2.1.6 reports that Audit Scotland intend to issue an unqualified opinion on the accounts with inclusion of the Emphasis of Matter to draw attention to the material uncertainty declared by NHS Fife's valuer as above. Mrs McGurk reiterated that it was highlighted to the Audit & Risk Committee at its September meeting that there were significant challenges this year in delivering the annual accounts, due to capacity issues within the Finance team. A support team was established to help with the process, and this was welcomed by Audit Scotland.

Net expenditure for the year (p.35) shows a £54m (7%) increase on 2018/19, with an increase in pay costs of £38m and increase in other health care expenditure (excluding contributions to IJB) of £18m being the main drivers of this increase. Section 2.1.12 provided more detail on the £38m pay costs. £16m was due to a 6% increase in superannuation contribution. The remaining £22m is largely due to the Agenda for Change pay award agreed in July 2018.

Section 2.2.15 related to the consolidated statement of the financial position and shows an overall increase in the value of net assets. There was a net increase in the value of Property, Plant and Equipment.

In response to questions raised by Ms Braiden around Finance capacity issues and the recurring failure to meet saving targets within Acute Services, Mrs McGurk advised that departure of key staff during 2020 led to issues in completing the annual accounts. At the point of these departures, the pandemic also hit, which impacted on the ability to recruit to address the gap. She was pleased to report that a new post for a Head of Finance and Procurement has been advertised and interviews will be held in December.

In relation to the recurring savings question, Mrs McGurk advised that she had been working with the Chief Executive and the Executive Directors' Group and had held a full session to look at the Strategic Planning and Resource Allocation process. This is a formal assessment that will be done on an annual basis and will inform a medium-term financial, organisational and workforce plan for NHS Fife. This will look at the areas that will need to be addressed through a new approach. The next step will be briefing the NHS Board and the Finance, Performance & Resources Committee. Mrs Potter added that the Deloitte report on Acute Services produced last year made a number of recommendations, some of which were being taken forward and some of which were being challenged. The impact of Covid on this work has however been significant.

In relation to a question raised by Mr Black around the potential effects of EU exit, Mrs McGurk advised that an EU Exit Group had been re-established and is being chaired by the Director of Estates & Facilities, who will work with the Scottish Government and NSS particularly around the issues of the supply chain.

9.3 Annual Audit ISA260 Report for the Board of NHS Fife and Auditor General for Scotland / draft Letter of Representation (ISA560)

Ms Fraser advised that the ISA250 report includes a summary of significant findings from the audit for Committee members to consider, prior to approving the accounts for signing. This includes a letter of representation that provides the draft audit opinion on the accounts. A copy of the letter of representation requires to be signed and returned to Audit Scotland.

The letter confirms to members of the Committee that the audit work undertaken is now substantially complete and, following final checks on the accounts, it is anticipated that Audit Scotland will be issuing the audit certificate and opinion next week after the NHS Fife Board meeting. She was hoping to issue the annual audit report in advance of the meeting next week.

She referred to papers and noted that there are two significant findings for members to consider: the first matter is the uncertainty over valuations obtained for the non-current assets. She has included an 'emphasis of matters' paragraph in our audit certificate to draw attention to it. This is not however a qualification or modification.

The second issue is around the calculation of the annual holiday pay accrual. This has been raised on previous occasions and is raised on the basis that the calculation varies each year. She reported that this year the estimate is fair and reasonable, but she would recommend that a review of the calculation process be put in place going forward.

Appendix 1 set out Audit Scotland proposed audit opinion for the annual accounts. Ms Fraser was pleased to report that there are no qualifications or modifications to be brought to attention of the Committee. Appendix 2 showed the draft letter of representation. This is a standard letter providing Audit Scotland with assurances in relation to various aspects of the accounts.

In response to a question raised by Ms Braiden around holiday pay accrual, Ms Fraser advised that more work was needed in this area. It would be helpful to have a system brought in for calculating the accrual, which would be consistently applied each year. Mrs McGurk agreed that NHS Fife would review the process. She added, for the Committee's awareness, that the holiday pay accrual is likely to be a significant issue in the Annual Accounts for 2020/21 and, because of deferred leave, that the holiday pay accrual is likely to be higher again in 2020/21. The Corporate Finance Network who support the NHS Board Directors of Finance group is considering this issue.

9.4 Annual Assurance Statement to the NHS Board

The Audit & Risk Committee approved the Annual Assurance Statement to the NHS Board as it stood, without the addition of any areas to be escalated from the internal or external annual reports.

The Audit & Risk Committee;

- **reviewed** the draft Annual Accounts for the year ended 31 March 2020, endorsing the content of the Corporate Governance Report and the Governance Statement from the Chief Executive;
- **considered** the content and assurances to be taken from the External Auditor's Annual Audit ISA 260;
- **recommended** that the Board adopt the Annual Accounts for the year ended 31 March 2020;
- **recommended** that the Board authorise the designated signatories (Chief Executive and Director of Finance) to sign the Accounts on behalf of the Board, where indicated in the document;
- **approved** the proposed arrangements for resolution of minor matters in relation t the accounts, and up to the date of submission to the Scottish Government Health and Social Care Directorate; and
- **noted** that the accounts are not placed in the public domain until they are laid in Parliament.

10. ISSUES FOR ESCALATION TO NHS BOARD

There were no issues of escalation to be highlighted from the current meeting.

11. ANY OTHER BUSINESS

Mr Black thanked the Finance Team especially for all their hard work and effort in producing the annual accounts against a challenging background.

Date of Next Meeting: 19 January 2021 at 10am within The Boardroom, Staff Club, Victoria Hospital (location TBC)

ACTION LIST FROM AUDIT & RISK COMMITTEE – 2020-21

	Title	Action	Lead	Outcome
1	Internal Audit reporting 19/20 – Follow Up Report	Consult with EDG around the validated information and evidence of completion of audit actions, and dates of dates of the outstanding actions, which were considerably out-of-date and still remained open with limited evidence of progress. Further work was also required on the follow-up process, to ensure this was timely and robust.	MM	EDG now consider the progress on internal audit actions quarterly. Directors have been reminded of the need to ensure good progress is made in clearing outstanding issues.
2	Patients' Private Funds – Annual Accounts 2019/20	There were a number of minor items listed where there was non-compliance with the financial operating procedures. However, none of these were significant and will be addressed by management.	MM	
3	Service Auditor Reports on Third Party Services	Mrs McGurk suggested that an update should be provided to the NHS Fife Audit & Risk Committee in March 2021, to give assurance that the plan is progressing. It was agreed that this request should be made by the Director of Finance for the March 2021 meeting.	MM	

Completed Updated

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**19 January 2021**
Title:	**Annual Report – Patient Exemption Checking (PECS) 2019/20**
Responsible Executive:	**Margo McGurk, Director of Finance**
Report Author:	**Margo McGurk, Director of Finance**

1 Purpose

The purpose of this report is to advise the Committee on the work of Counter Fraud Services (CFS) during 2019/20 in checking the propriety of exemptions claimed by patients for charges for ophthalmic and dental work. The report also identifies the amounts recovered and those written off. The paper is being presented to the Committee later than originally planned due to changes to the Committee workplan during the COVID 19 pandemic.

This is presented to the Committee for:
- Assurance

This report relates to a:
- Government policy/directive

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

2 Report summary

2.1 Situation

This report is submitted in fulfilment of the requirement above.

2.2 Background

Patients resident in Scotland and other UK residents visiting Scotland are entitled to certain NHS items and services free of charge if they are:

- are aged 16, 17 or 18 and in full time education
- receive certain benefits
- are on a low income
- are pregnant or have given birth in the last 12 months
- have an entitlement card

- have a medical exemption certificate
- need to travel to hospital for NHS treatment

Overseas visitors are subject to the National Health Service (Charges to Overseas Visitors) (Scotland) Amendment Regulations 2006.

CFS has a dedicated team responsible for checking claims for exemption from charges exemption claims. Claim details are checked against relevant agencies, i.e. Department for Work and Pensions (DWP) and if the exemption cannot be confirmed, the patients will be contacted and requested to provide proof of their entitlement. If it is identified that patients have no entitlement to exemption from charges, the CFS team will request payment for the service provided. If the patient withholds payment, a Penalty Charge Notice will be issued and enforced.

Unfortunately, a very small minority of patients intentionally seek to defraud the health service. Any suspected fraudulent claims are investigated and analysed by CFS.
The majority of these investigations are triggered by patients not providing evidence when obtaining services or treatment. In addition, a sample of claims where evidence has been provided is also checked.

2.3 Assessment

CFS has issued its annual report on PECS for 2019/20 (see Appendix 1). The report sets out the recoveries and write offs by service for NHS Fife and NHS Scotland.

The amount recovered by CFS on behalf of NHS Fife for 2019/20 was £43,344 (2018/19 - £44,180). This represented 4.6% (2018/19 – 5.0%) of the Scotland total.

The value of the write offs increased from £27,402 last year to £52,194 this year, which represented 5.0% (2018/19 – 6.1%) of the Scotland total. The increase was the result of a national exercise targeted at improving compliance which also resulted in a higher level of write-offs.

2.3.1 Quality/ Patient Care

No direct impact.

2.3.2 Workforce

No direct impact.

2.3.3 Financial

Relates to the sound use of public money. Details are set out in the Assessment and in the Appendices.

2.3.4 Risk Assessment/Management

The PECS Team implemented a prioritised and re-focussed approach to the risk of diversion of public money through fraud and error during the year and now operate a process which is considered to be proportionate.

2.3.5 Equality and Diversity, including health inequalities

Protects public money so that it may be prioritised in accordance with health strategy.

2.3.6 Other impacts

Contributes to the positive reputation of the service.

2.3.7 Communication, involvement, engagement and consultation

The Principal Statistician at NSS has been consulted in the preparation of this report.

2.3.8 Route to the Meeting

As above.

2.4 Recommendations

The Committee is asked to ***discuss*** this report and to note it.

2 List of appendices

The following appendices which relate to this report may be accessed here:

- Appendix 1 Summary of Patient Recoveries and Write-offs
- Appendix 2 Report of Cases Written Off by Exemption Category
- Appendix 3 Report of Cases Written Off by Reason

NHS SCOTLAND COUNTER FRAUD SERVICES

NHS FIFE

SUMMARY OF PATIENT RECOVERIES AND WRITE OFFS - 1 APRIL 2019 TO 31 MARCH 2020

The tables in this section provide a summary of the number and value of recoveries by service (Table 1) and the number and the value of proposed write offs (Table 2) resulting from patient exemption checking.

Table 1 - Amount of patient recoveries in respect of period 1 April 2019 to 31 March 2020

	NHS FIFE		SCOTLAND	
Service	**Number of Cases**	**Value**	**Number of Cases**	**Value**
Dental	409	£38,182.75	8,507	£865,380.49
Ophthalmic	145	£11,820.10	2,547	£217,989.77
Total	**554**	**£50,002.85**	**11,054**	**£1,083,370.26**
Less Debt recovery costs*	N/A	£6,659.29	N/A	£144,281.23
Total value of monies to be transferred to Health Board	N/A	**£43,343.56**	N/A	**£939,089.03**

* Total debt recovery costs have been split between each Board on a pro-rata basis.

Table 2 - Proposed write-offs in respect of period 1 April 2019 to 31 March 2020

	NHS FIFE		SCOTLAND	
Service	**Number of Cases**	**Value**	**Number of Cases**	**Value**
Dental	360	£43,557.82	6,996	£901,744.14
Ophthalmic	141	£8,635.90	2,297	£147,488.89
Total	**501**	**£52,193.72**	**9,293**	**£1,049,233.03**

A more detailed breakdown of the write offs, by Exemption Category and Write off Reason, is attached for your information. The report showing the number of GP17(PR) forms which were not submitted is no longer required. The process has been streamlined and there are no incidences of forms not being available when requested.

If you have any queries or need any further information, please telephone Derek Smith (Patient Claims Manager) on 01506 705204.

NHS SCOTLAND COUNTER FRAUD SERVICES

PATIENT EXEMPTION CHECKING
1 April 2019 to 31 March 2020

REPORT OF CASES WRITTEN OFF - by exemption category

NHS FIFE

DENTAL

	NHS FIFE		SCOTLAND	
Exemption category	**Number of Cases Written Off**	**Amount Written Off**	**Number of Cases Written Off**	**Amount Written Off**
Age 18 in full-time education	6	£343.52	168	£10,354.80
Income Related Employment Support Allowance	57	£7,760.10	1,024	£144,651.38
Income Support	32	£4,539.60	667	£84,374.42
Income-based Job Seekers Allowance	57	£8,231.56	1,225	£164,523.56
Pension Credit Guarantee Credit	3	£497.84	85	£10,255.47
Tax Credit	205	£22,185.20	3,827	£487,584.51
Total	**360**	**£43,557.82**	**6,996**	**£901,744.14**

OPHTHALMIC

	NHS FIFE		SCOTLAND	
Exemption category	**Number of Cases Written Off**	**Amount Written Off**	**Number of Cases Written Off**	**Amount Written Off**
Age 16-18 in full-time education	3	£177.90	30	£1,831.90
Income Related Employment Support Allowance	20	£1,536.30	322	£24,138.50
Income Support	5	£300.90	163	£11,158.56
Income-based Job Seekers Allowance	6	£379.30	97	£6,443.96
Pension Credit Guarantee Credit	4	£408.40	152	£13,010.52
Tax Credit	103	£5,833.10	1,533	£90,905.45
Total	**141**	**£8,635.90**	**2,297**	**£147,488.89**

NHS SCOTLAND COUNTER FRAUD SERVICES

PATIENT EXEMPTION CHECKING
1 April 2019 to 31 March 2020

REPORT OF CASES WRITTEN OFF - by reason

NHS FIFE

DENTAL

	NHS FIFE		SCOTLAND	
Write Off Reason	**Number of Cases Written Off**	**Amount Written Off**	**Number of Cases Written Off**	**Amount Written Off**
Agency Confirmed	0	£0.00	1	£132.32
Duplicate Claim	0	£0.00	1	£112.88
EDI Declaration Not Available	0	£0.00	3	£593.40
Elderly	1	£11.40		
Health Problems	2	£125.72	59	£6,868.68
No Trace of Patient	7	£631.12	382	£41,788.12
Patient Deceased	3	£332.68	172	£19,492.80
Policy	61	£6,546.64	1,551	£164,614.56
Potential Contractor Fraud	9	£405.88	127	£9,510.84
Terminally Ill	2	£113.08	29	£3,316.28
Unrecoverable	5	£389.28	47	£5,462.55
W/O by Debt Managers	270	£35,002.02	4,601	£646,876.67
Total	**360**	**£43,557.82**	**6,996**	**£901,744.14**

OPHTHALMIC

	NHS FIFE		SCOTLAND	
Write Off Reason	**Number of Cases Written Off**	**Amount Written Off**	**Number of Cases Written Off**	**Amount Written Off**
Duplicate Claim	0	£0.00	1	£67.50
Elderly	0	£0.00	34	£2,870.50
Health Problems	1	£98.40	31	£2,511.30
No Trace of Patient	3	£165.90	115	£6,439.50
Patient Deceased	7	£511.20	169	£13,923.20
Policy	22	£1,227.70	457	£27,402.40
Potential Contractor Fraud	1	£146.20	27	£1,840.00
Terminally Ill	0	£0.00	10	£761.90
Unrecoverable	2	£137.50	21	£1,308.70
W/O by Debt Managers	105	£6,349.00	1,432	£90,363.89
Total	**141**	**£8,635.90**	**2,297**	**£147,488.89**

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**19 January 2021**
Title:	**Internal Audit Progress Report**
Responsible Executive/Non-Executive:	**M McGurk, Director of Finance**
Report Author:	**B Hudson – Regional Audit Manager**

1 Purpose

This is presented to the Audit and Risk Committee for:

- Assurance
- Discussion

This report relates to a:

- Local policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This paper provides the Audit and Risk Committee with comprehensive assurance on the progress of the 2020/21 Internal Audit Plan and the completion of the two remaining reviews from the 2019/20 Internal Audit Plan.

2.2 Background

The Internal Audit year runs from May to April. The Internal Audit team has delivered the two remaining reviews from 2019/20 plan and continues to work on the 2020/21 plan under the supervision of the Chief Internal Auditor. Audit work completed allows the Chief Internal Auditor to provide the necessary assurances prior to the signing of the 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.

2.3 Assessment

Each audit report includes an action plan that contains prioritised actions, associated lead officers and timescales. Progress on implementation of agreed actions is monitored through the Audit Follow-up System, which is maintained and reported to the Audit and Risk Committee by Internal Audit.

We are updating our time recording server and due to an issue experienced last week, we are unable to provide detailed time input of days delivered for inclusion in this progress report.

Appendix A shows:

- Final Internal Audit Reports Issued Since the last Audit and Risk Committee
- Internal Audit Reports issued in draft at the time of submission of papers for the Audit and Risk Committee
- Internal Audit Work in Progress and Planned
- Changes to the 2020/21 Internal Audit Plan
- Summary of Internal Audit Findings in Final Internal Audit Reports issued since the last Audit and Risk Committee
- Internal Audit Performance against Service Specification Key Performance Indicators.

Impact of and response to COVID-19

As with many aspects of NHS Fife's operations, COVID-19 has impacted on Internal Audit. Most notably the focus on COVID-19 priorities has impacted on client staff availability, the timely provision of required information, as well as, on audits where fieldwork would ordinarily require on-site presence. However, we have adapted and developed workarounds where restrictions have made an on-site presence inappropriate.

NHS Boards will remain on an emergency footing until at least 31 March 2021 and will be required to focus on achieving key Scottish Government Health Protection priorities including Urgent Care, Test and Protect, the Flu vaccination programme and the rollout of the COVID-19 vaccine, in the context of Winter planning and Brexit.

We have reported the need to revise Strategy, Corporate Objectives and Strategic Risks in the light of COVID-19 and we will continue to monitor the Strategic Risk Register throughout 2020/21 to ensure our audit plan is covering the right areas and advise the Board of any areas which may need revision. We will revisit and amend the operational plan during this financial year.

A key audit will be **B16/21 – Sustainable Services** which will evaluate the principles and methodology used to inform the NHS Fife Remobilisation plan and its links to strategy, sustainability and service redesign. Our 2019/20 Annual Report noted that NHS Fife had started a process to identify, develop and expand positive service change from management of COVID-19 and highlighted the requirement to update the Board's strategies, objectives and risks as well as the opportunity to drive improvement and increase sustainability, efficiency, service user experience and staff wellbeing. This audit will assess the extent to which Board processes are designed to meet these challenges in the context of the themes and recommendations from the Annual Report. We will highlight for consideration by the Audit and Risk Committee and discussion with

the Board and relevant stakeholders, any risks and consequences associated with principles which cannot be delivered at this time.

The first phase of this review will be reported to the January 2021 Audit and Risk Committee, within the Internal Control Evaluation, which will, amongst other areas, consider NHS Fife's progress to the August 2020 Audit Scotland guidance document 'COVID-19 Guide for Audit and Risk Committees'. The second phase of the sustainability audit will assess the extent to which the agreed approach is being implemented successfully, the effectiveness of the approach taken and the monitoring arrangements to identify and mitigate risks to its success. The timing of this phase will be dependent upon the Board's own progress.

Advice and input

In addition to formal audit reviews which result in a report to the Audit and Risk Committee, Internal Audit have also provided advice and assistance to officers and Board members on a range of areas including:

- Assurance mapping and risk advice, in particular Digital and Information risks
- Joint production of governance, assurance and risk principles for use by the Board
- Consideration of how best to provide assurances required under the Scottish Public Finance Manual
- Advice provided to the process maps for agency nurses and authorisation of invoices, etc.
- Initial review of NHS Fife's proposed approach to strategic planning and resource allocation.

Improvement Activities

As noted above, understandably, the pressures of COVID-19 have impacted on the availability of senior management which in turn allowed us some time to reflect on our working practices, both to build on action taken in response to previous External Quality Reviews and to adapt to a post-COVID19 environment. This work included:

- Revision of the internal audit reporting protocol and flowchart
- Update to the FTF report template
- Revision and updating of the Audit Follow Up Protocol
- Development of a revised client quality questionnaire
- Ongoing development of the FTF website
- Update and enhancement of the FTF Intelligence Library
- Review of internal documentation and processes including analytical review and performance review, again to ensure we add value wherever possible.

2.3.1 Quality/ Patient Care

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

2.3.2 Workforce

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

2.3.3 Financial

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

2.3.4 Risk Assessment/Management

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

2.3.5 Equality and Diversity, including health inequalities

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

2.3.6 Other impacts

N/A

2.3.7 Communication, involvement, engagement and consultation

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

2.3.8 Route to the Meeting

This paper has been produced by the Regional Audit Manager, reviewed by the Chief Internal Auditor and considered by the Executive Directors Group on 7 January 2021.

2.4 Recommendation

The Audit and Risk Committee is asked to:

- **DISCUSS** and note the progress on the delivery of the Internal Audit Plans.
- **APPROVE** the changes to the 2020/21 Internal Audit Plan set out in Appendix A

3 List of appendices

The following appendices are included with this report:

- Appendix A – Internal Audit Progress Report

Internal Audit Progress Report

Introduction

This report presents the progress of internal audit activity up to 23 December 2020.

Internal Audit Activity

NHS Fife Completed Audit Work

The following audit products, with the audit opinion shown, have been issued since the last Audit and Risk Committee meeting on 13 July 2020. Each review completed has been categorised within one of the five strands of corporate governance. A summary of each report is included for information within the 'Summary of Audit findings' section.

Audit 2020/21	Opinion on Assurance	Recommendations	Draft issued	Finalised
Corporate Governance				
B06/21 – Annual Internal Audit Report	N/A	One 'Fundamental' Six 'Significant' Two 'Merits Attention'	September 2020	10 November 2020
B07/21 – Governance Statement	N/A	N/A	N/A	Reported as part of B06/21
B08/21 – Internal Control Evaluation (ICE)	N/A		Presentation of the themes from the report to January 2021 meeting with final report to be presented in full to the March 20201 Audit and Risk Committee meeting.	
B09/21 – Audit Follow Up	N/A	N/A	N/A	Report provided to each Audit and Risk Committee
B14/21 – Sharps Management	Moderate Assurance	One 'significant' Two 'Merits Attention'	20 November 2020	22 December 2020

B16/21 – Remobilisation Planning[1]	N/A	N/A	N/A	Relevant findings have been included within B08/21 - ICE
Financial Governance				
B25/21 – Property Transaction Monitoring	All transactions were classified 'as properly conducted'	Three 'Merit Attention'	26 August 2020	3 September 2020

[1] B16/21 – The first phase of this review will be reported to the January 2021 Audit and Risk Committee, within B08/21 Internal Control Evaluation and evaluates the adequacy of the design & methodology of the NHS Fife Remobilisation Plan. The second phase of the sustainability audit will assess the extent to which the agreed approach is being implemented successfully, the effectiveness of the approach taken and the monitoring arrangements to identify and mitigate risks to its success. The timing of this phase will be dependent upon the Board's own progress.

Audit 2019/20	Opinion on Assurance	Recommendations	Draft issued	Finalised
Corporate Governance				
B17/20 – Organisational Performance Management	Moderate Assurance	Six 'Merits Attention'	21 July 2020	22 October 2020
Financial Governance				
B25/20 - Capital Management – Orthopaedic Project	Moderate Assurance	Two 'Merits Attention'	30 September 2020	10 December 2020

NHS Fife Work in Progress and Planned:

Audit 2020/21		Status	Target Audit Committee
B11/21	Attendance at meetings/ Ad-hoc Advice provided by Chief Internal Auditor, Audit Manager and Principal Auditors	Fieldwork	Yearend report to May 2021 meeting
B12/21	Assurance Mapping [2]	Fieldwork	Yearend report to May 2021 meeting
B13/21	Risk Management	Planning	May 2021
B15/21	NHS Resilience	Planning	May 2021
B17/21	Remobilisation Review [3]	Planning	TBC
B18/21	Health and Social Care Integration	Fieldwork	Yearend report to May 2021 meeting
B19/21	Patient Safety Programme	Planning	May 2021
B20/21	Adverse Event Management	Fieldwork	March 2021
B21/21	Medical Equipment and Devices	Planning	March 2021
B22/21	Workforce Review [4]	Planning	TBC
B26/21	Financial Process Compliance	Fieldwork	March 2021
B27/21	Patients Funds	Planning	May 2021
B28/21	Information Assurance and Security	Fieldwork	May 2021

[2] B12/21 - Meetings have been held with the General Manager – Digital and Information and the Risk Manager and the BAF is being updated to reflect these discussions including an update to the wording of the BAF risk. More broadly, the methodology has been agreed and consideration is being given to how best to incorporate other known assurance requirements.

[3] B17/21 - The second phase of the audit, commencing later on in the financial year, will assess the extent to which the agreed approach is being implemented successfully, monitored appropriately and to which identified risks to its success have been identified and mitigated. The undertaking of this work may be impacted by Covid and the emergency status Health Boards are currently placed under.

[4] B22/21 – This review was carried forward from 2019/20 with the risks as follows (agreed by Previous Director of Finance and previous Director of Workforce):

- that we incur additional costs or fail to meet targets because the lengthy approval process creates unnecessary delays
- Without control managers might make inappropriate recruitment decisions and not meet budgets.

Discussions will take place with the new Directors to consider the detail of this review.

Proposed Changes to the Internal Audit Plan 2020/21

When the Internal Audit Plan for 2020/21 was approved at the July meeting of the Audit and Risk Committee, Internal Audit were clear that the audit plan would need to be a fluid document that reacts to known changes in the risk environment.

NHS Fife has recently introduced a new approach for Strategic Planning and Resource Allocation. The Chief Internal Auditor has provided the Director of Finance with initial comments on the proposal, guidance and associated documentation. To allow for this process to progress and embed itself within NHS Fife, there are two audits within the Financial Governance section of the Internal Audit Plan which we propose to remove, subject to **APPROVAL** by the Audit and Risk Committee:

- B23/21 – Savings Programme
- B24/21 – Financial Planning

Internal Audit will undertake a high level review of these areas as part of our Internal Control Evaluation (ICE) and the Internal Audit Annual Report for 2020/21 as well as providing an opinion on the adequacy and in the future, the effectiveness of this new strategic process.

As with many aspects of NHS Fife's operations, COVID-19 has impacted on Internal Audit. Most notably the focus on COVID-19 priorities has impacted on client staff availability and the timely provision of required information, as well as on any audits where on-site presence is restricted.

Internal Audit have been requested to undertake a Digital and Information review of its ITIL processes (best practice in IT Service Management) to confirm whether the best practice in operation pre-Covid continues to be followed. Following the Information Governance and eHealth areas of concern raised by Internal audit in the recent Annual Report for 2019/20, this review would add value as a key piece of work which would address a currently unarticulated but very serious risk to NHS Fife. The Audit and Risk Committee is asked to **APPROVE** this change to the audit plan.

Other reviews may arise as risk changes over the remaining part of the 2020/21 financial year, and these, if applicable, will require approval at future Audit and Risk Committee meetings.

Summary of Audit Findings

This section provides a summary of the findings of internal audit reviews concluded since the previous Audit and Risk Committee meeting of July 2020 where a progress report was considered.

1. B06/21 Internal Audit Annual Report / B07/21 Governance Statement

This was considered at the September 2020 Audit and Risk Committee meeting, and formally approved at the November 2020 meeting.

2. B08/21 Internal Control Evaluation (ICE)

See Agenda Item 8.2 – presentation of key themes to the January meeting, with full report to be presented to the March 2021 Audit and Risk Committee.

3. B09/21 Audit Follow Up (AFU)

See Agenda Item 8.3 – full report.

4. B14/21 Sharps Management

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

Link to strategic / operational risk – Quality and Safety and Environmental Sustainability

Executive Summary & Agreed Management Action:

Our review sought to confirm that the issues and actions raised by the Health and Safety Executive (HSE), in improvement notices raised following their assessment of compliance with the Health & Safety (Sharp Instruments in Healthcare) Regulations 2013, had been addressed by NHS Fife in areas beyond Maternity where HSE conducted their assessment in November 2017.

The report concluded that the level of assurance was moderate meaning that controls are applied frequently but with evidence of non-compliance. One 'Significant' and two 'Merits Attention' recommendations were included in the action plan of the report.

We confirmed that the NHS Fife Safe Use of Medical Sharps: Management and Use Policy (SUMS 01) is in line with the Health & Safety (Sharp Instruments in Healthcare) Regulations 2013 and that it includes processes which address the issues and actions, regarding sharps management and training, highlighted by HSE following their inspection in November 2017 aside from a small number of issues.

A questionnaire exercise was conducted as part of this review focussing on 6 wards/departments assessed as high risk. 183 responses were received from the various staff groups included and these indicated that, although there had been no formal approach to roll-out, many of the controls, needed to

address issues and actions reported by HSE in their improvement notices, have been implemented. Assurances for other clinical wards/departments will be required to ensure the issues raised by the HSE report are being mitigated.

We also recommended that the issues raised by any HSE report are recorded as a risk and monitored until they are addressed across NHS Fife.

5. *B16/21 Remobilisation Planning*

Findings have been included within B08/21 ICE. See Agenda Item 8.2

6. *B25/21 Property Transaction Monitoring*

This report was presented to the September 2020 Audit and Risk Committee meeting

7. *B17/20 Organisational Performance Management*

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

Link to strategic / operational risk – Workforce Sustainability, Financial Sustainability and Quality and Safety

Executive Summary & Agreed Management Action:

- The strategic objectives 2019-20, along with a paper aligning the strategic objectives to the Executive Team, were agreed by Fife NHS Board in May 2019
- The Performance & Accountability Review Framework (P&ARF) was appropriately consulted on and properly approved through Fife NHS Board's governance processes
- There have been challenges in holding the scheduled P&ARF meetings on a quarterly basis. The meetings planned for December 2019 were cancelled due to other priorities. The meetings planned for March and June 2020 were cancelled due to other higher priorities, mainly the COVID-19 pandemic, which has changed the context in which NHS Fife is operating. This has impacted the delivery of the P&ARF since September 2019 and therefore the approach will need to be reviewed to remain relevant and flexible. Completion of TURAS/Senior Management appraisals is described as underpinning the successful implementation of the revised P&ARF process, with delegation of responsibility for achievement of strategic objectives highlighted as being a key part of that. From a limited sample of four Executive Directors' objectives, we evidenced links for the corporate objectives and KPIs to Executive Directors appraisal/TURAS objectives. However, we noted that for two Directors, the link was not overt and we recommend that NHS Fife should confirm within the P&ARF that all corporate objectives are appropriately mapped to a responsible Director within the appraisal/TURAS system
- As the P&ARF evolves and the revised Risk Management Framework is implemented across the organisation, it could be further enhanced by

including risk management to ensure that associated risks are considered, and where they have been affected by improved or decreased performance, the impact on the risk score should be recorded in line with the Risk Management Framework

- The process uses Action Trackers to record outstanding actions for completion at subsequent P&ARF meetings. Our review of the action trackers for the September 2019 meetings found that they are not being used effectively with one department not including the deadline date for the actions, and another not having assigned individuals for completion of the tasks.

8. *B25/20 - Capital Management – Orthopaedic Project*

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

Link to strategic / operational risk – Strategic Planning

Executive Summary & Agreed Management Action:

1. Our review of the Fife Elective Orthopaedic Project concludes that:
    - There are appropriate and adequate governance arrangements in place as follows:
        - gateway reviews of key milestones of the project with oversight by the Scottish Government Social Health Directorate Capital Investment Group
        - a Project Board for the Fife Elective Orthopaedic Centre Project (FEOCP) with members from diverse areas of expertise and experience including a Non Executive Director
        - an approval process of key milestones of the project through the NHS Fife Standing Committees, including the Finance, Performance and Resources and Clinical Governance Committees and the NHS Fife Board. The Fife Elective Orthopaedic Project Board reports to the NHS Fife Capital Investment Group and thereafter to the Executive Directors Group (EDG).
    - Reporting arrangements are in place for the monitoring of progress, quality and financial commitments of the project. We evidenced regular reporting to the Finance Performance and Resources Committee, Clinical Governance Committee and the NHS Fife Board
    - The Scottish Capital Investment Manual (SCIM) methodology has been used for the project which is based on best practice from across the UK and globally and mandated through NHS CEL 19 (2009) Scottish Capital Investment Manual for NHSScotland. SCIM is required for all infrastructure and investment programmes and projects by NHS Scotland bodies and therefore is an appropriate methodology for this project
    - The Initial Agreement and the Outline Business Case documents are aligned to the '*Summary of Stages'* within the SCIM methodology
    - The update paper to the May 2020 Board meeting highlighted that the project has successfully remained in line with the timeline per the agreed programme, which in our opinion, is a significant achievement with the challenging circumstances associated with the current climate of

the COVID 19 pandemic. However, the latest position highlighted to the September 2020 meeting of the Finance Performance and Resources Committee highlighted that the project is currently showing 2 weeks behind on the main programme due to having to adapt ways of working during the COVID 19 pandemic.

We identified the following areas for improvement:

- . We noted that the key milestones of the project were properly considered & discussed within Project Board reports to the Fife Capital Investment Group and then to the Executive Directors Group but formal approval of support for the documents to progress to the next level of governance was not recorded within the minutes
- In line with the SCIM risk management process, the FEOCP has an autonomous risk register in place. The Project Director advised that it is updated on a monthly basis and is provided to every Project Board meeting. We noted that the FEOCP risk register includes identified risks, risk rating, mitigating actions and risk owner. However there is further scope to improve its effectiveness by including the action date, closed out date and any comments that would provide additional information or allow appropriate escalation of the risk.

Key Performance Indicators 2019/20

Performance against service specification as at 22 December 2020:

	Planning	Target	19 January 2020
1	Audit assignment plans for planned audits issued to the responsible Director at least 2 weeks before commencement of audit	75%	67%
2	Draft reports issued by target date	75%	60%
3	Responses received from client within timescale defined in reporting protocol	75%	75%
4	Final reports presented to target Audit Committee	75%	75%
5	Number of days delivered against plan	100% at	System Issue

		year-end	– not provided
6	Number of audits delivered to planned number of days (within 10%)	75%	

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**19 January 2021**
Title:	**Audit follow up position at 18 December 2020**
Responsible Executive:	**Margo McGurk, Director of Finance**
Report Author:	**Barry Hudson, Regional Audit Manager**

1. Purpose

This is presented to the Audit & Risk Committee for:

- Assurance
- Discussion

This report relates to the:

- Audit Follow up Protocol

This aligns to the following NHSScotland quality ambition:

- Effective

2 Report summary

2.1 Situation

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

2.2 Background

As reported to the 16 May 2019 Audit and Risk Committee, Internal Audit agreed to take responsibility for NHS Fife Audit Follow Up and an exercise was undertaken to identify outstanding actions. Notifications were raised and sent to relevant responding officers for all recommendations for which we were unable to identify that actions had been completed/implemented for final reports issued in 2017/18 and 2018/19. These items continue to be followed up and reported to the Audit and Risk Committee. If any further delays are experienced, we will continue to highlight the consequences in terms of risk and control to the Audit and Risk Committee in full.

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

A revised Audit Follow Up Protocol, as part of the Internal Audit Framework, will be presented to this January 2021 Audit and Risk Committee for approval. External Audit recommendations will continue to be followed up through NHS Fife Finance Directorate and Internal Audit will continue to review progress against external audit recommendations where relevant to internal audit fieldwork.

As part of the new arrangements Internal Audit will validate the evidence supplied by responding officers for actions they are declaring as completed to confirm that their actions address the recommendations made.

2.3 Assessment

The appendices to this report detailed in paragraph 4 below show the status of all internal audit recommendations as at 18 December 2020, with comparable figures from the last AFU report which went to July 2020.

	July 2020	**December 2020**
Total Recommendations from 2017/18, 2018/19 and 2019/20	177	191
Total Completed	74	102
Number validated responses from total completed	61	92
Remaining Recommendations:		
Extended with revised dates	53	40
Outstanding	16	15
Not yet due	19	7
Superseded	15	27

Responding officers have reported a number of delays in progressing actions due to prioritisation of COVID-19 duties. Where COVID-19 has impacted on progress, this is highlighted in appendix 3 to this report. While Internal Audit acknowledges that NHS Fife are currently dealing with a second wave of COVID-19 cases and that there are valid reasons for these delays, we would expect that as the vaccination process progresses and as staff return to their substantive duties, there will be further clear evidence of progress. Despite the impact of COVID-19 on NHS Fife, improvements have been made by the organisation and responding officers in reducing the number of actions outstanding from prior year audit reports.

A large number of the outstanding actions were prior to Internal Audit taking over the administration for Audit Follow Up.

The Responsible Director for the remaining 3 extended actions from 2017/18 has now left NHS Fife and we have now identified responsible officers who are currently working towards completion of these actions.

Where we have issues around progress for outstanding recommendations, in particular, where no response is received from the responsible officer, we will liaise with the Director of Finance and the Board Secretary to escalate.

A further 5 recommendations from 2018/19 were escalated to the Director of Finance, with new responsible officers identified to take forward.

2.1.1 Quality/ Patient Care

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

2.1.2 Workforce

There are no workforce implications arising from this report.

2.1.3 Financial

There are no direct financial implications arising from this report.

2.1.4 Risk Assessment/Management

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

2.1.5 Equality and Diversity, including health inequalities

An impact assessment has not been completed because it is not applicable for this report.

2.1.6 Other impacts

Not applicable

2.1.7 Communication, involvement, engagement and consultation

The content of the report was discussed with the Chief Internal Auditor, Director of Finance and Head of Corporate services/Board Secretary, ahead of submission to the Audit and Risk Committee.

2.1.8 Route to the Meeting

Not applicable

2.4 Recommendation

The Audit and Risk Committee is asked to:-

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

3. List of appendices

The following appendices are included with this report:

Appendix A:	Status and Priority Definitions	Page 1

Report Contact

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

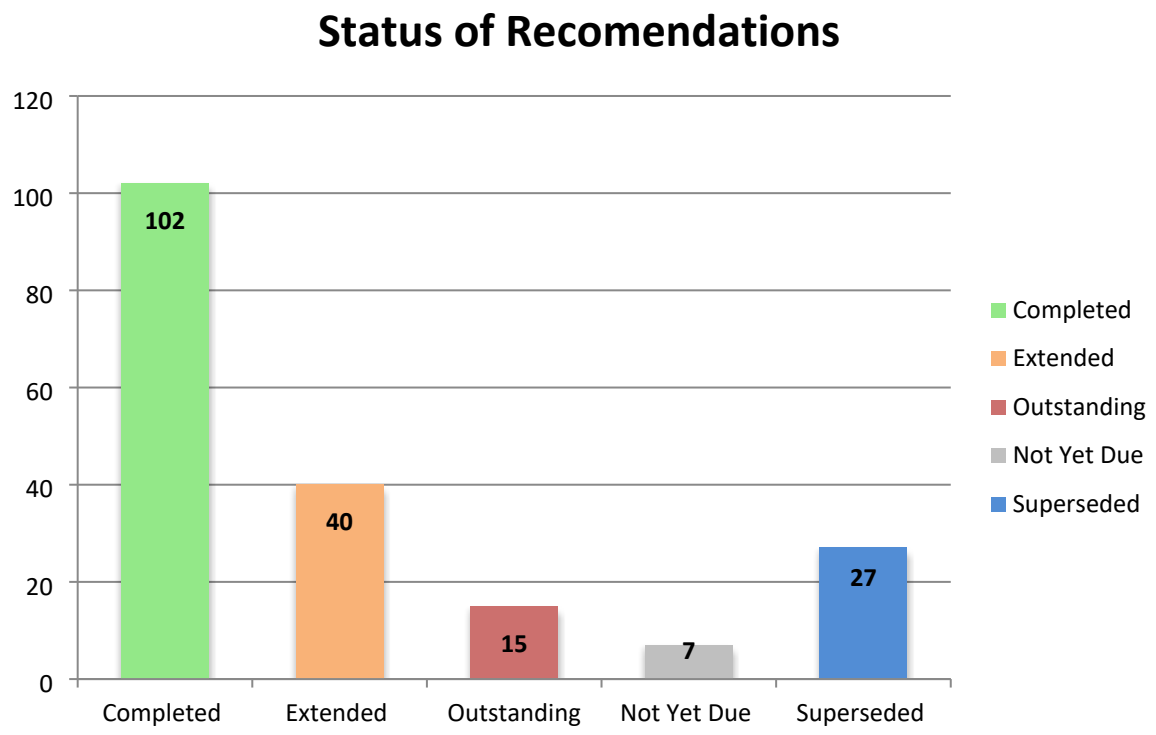
Action Status	
Term	**Definition**
Complete	Client has informed Internal Audit that the action has been implemented
Extended	Client has requested further time to implement the action (see A**ppendix D**)
Outstanding	The original, or extended, due date has passed and the client has not provided an update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

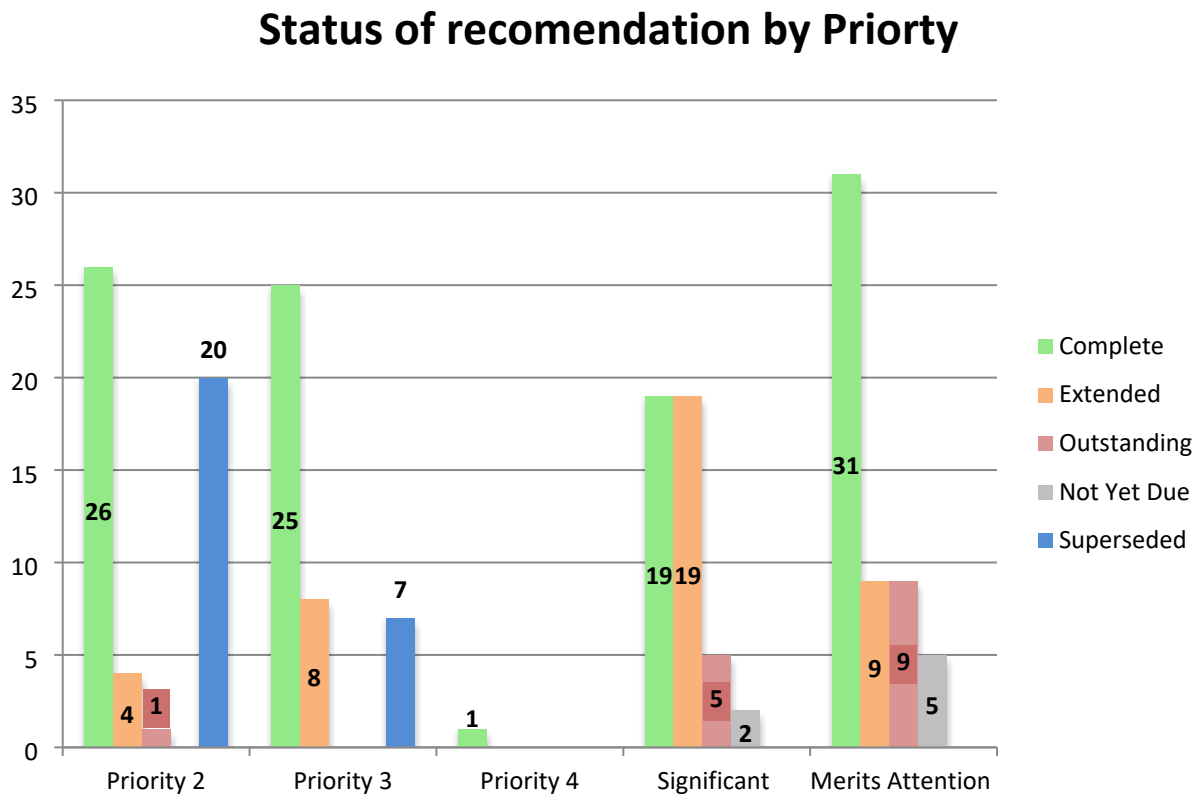
As our report format, including categorisation of audit opinion and report recommendations, changed in audit year 2018/19 the priority of the recommendations referred to in this report are quoted using two different systems. These are included in the table below:

Recommendation Priority	
Term	**Definition**
More Recent Reports	
Fundamental (F)	Non Compliance with key controls or evidence of material loss or error. Action is imperative to ensure that the objectives for the area under review are met.
Significant (S)	Weaknesses in control or design in some areas of established controls. Requires action to avoid exposure to significant risks in achieving the objectives for area under review.
Merits Attention (MA)	There are generally areas of good practice. Action may be advised to enhance control or improve operational efficiency.
Older Reports	
Priority 1	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	Relate to important issues that require the attention of senior management and may also give rise to material financial loss or error.
Priority 3	Are usually matters that can be corrected through line management action or improvements to the efficiency and effectiveness of controls.
Priority 4	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.

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

Status of Internal Audit actions at 18 December 2020





2017/18	Date of Issue	Total Recs.		Complete	Extended	Outstanding	Not Yet Due	Superseded		Not Validated
Appendix					***D***	***E***				***F***
B10/18 Transformation Programme	*Follow Up Review undertaken under B15/20*							4		-
B18/18 Clinical Governance Strategy	Dec-17	17		4	0	0	0	13		1
B19/18 Patient Safety Programme	Jan-18	2		2	0	0	0	0		-
B21B/18 Remuneration Sub-Committee	May-18	2		2	0	0	0	0		-
B24/18 Property Transaction Monitoring (PTM)	*All actions from B24/18 will be considered in B25/21 PTM*							3		-
B26/18 Brookson Locum Invoice Approval Process	Feb-18	6		3	3	0	0	0		-
B27B/18 Service Contract Expenditure	Jul-18	4		4	0	0	0	0		-
B28/18 Service Contract Income	Oct-17	2		2	0	0	0	0		1
B31A/18 Departmental Review: Podiatry	Mar-19	7		7	0	0	0	0		1
B31B/18 Departmental Review: Muirview	Nov-18	11		11	0	0	0	0		-
2017/18 Totals		**58**		**35**	**3**	**0**	**0**	**20**		**3**

2018/19	Date of Issue	Total Recs.		Complete	Extended	Outstanding	Not Yet Due	Superseded		Not Validated
Appendix					***D***	***E***				***F***
B10/19 Safety Alerts	*Follow Up Review underwayB12/20*							7		-
B11/19 Mandatory Training	Aug-19	3		0	3	0	0	0		-
B16/19 Adverse Event Management	Mar-19	1		1	0	0	0	0		-
B18/19 Medical Equipment & Devices	Mar-19	1		1	0	0	0	0		-
B22/19 Losses & Comps	Apr-19	8		3	5	0	0	0		-
B23&24/19 Savings & Financial Planning	Sep-19	2		1	1	0	0	0		-
B25/19 Financial Management	Mar-20	2		0	2	0	0	0		-
B27/19 Post Transaction Monitoring	Aug-18	2		2	0	0	0	0		-
B29/19 Service Contract Expenditure	Aug-19	4		4	0	0	0	0		-
B31& B32/19 IS Assurance & eHealth Strategic Planning	Aug-19	6		5	0	1	0	0		1
B33/19 Endowment Funds	Jun-19	4		4	0	0	0	0		-
2018/19 Totals		**40**		**21**	**11**	**1**	**0**	**7**		**1**

2019/20	Date of Issue	Total Recs.		Complete	Extended	Outstanding	Not Yet Due	Superseded		Not Validated
Appendix					***D***	***E***				***F***
B08/20 Internal Control Evaluation	Jan-20	15		6	9	0	0	0		-
B10/20 Governance Blueprint	Jun-20	1		1	0	0	0	0		-
B13/20 Risk Management Staging	Jun-20	3		0	3	0	0	0		-
B14/20 Staff & Patient Environment	Dec-19	3		0	3	0	0	0		-
B15/20 Follow-up of Transformation Programme Governance (B10/18)	Jun-20	7		1	6	0	0	0		-
B17/20 Organisational Performance Management	Oct-20	6		0	1	0	5	0		-
B19/20 Adverse Events Management	Mar-20	4		2	2	0	0	0		1
B21/20 Medicines Management	Dec-19	23		19	1	3	0	0		1
B22A/20 Review of Workforce Strategy Implementation	Jun-20	2		0	0	2	0	0		-
B22b/20 Staff Lottery Follow up	Aug – 19	3		3	0	0	0	0		-
B23a/20 Workforce Planning – Attendance Management	Jan -20	4		2	0	2	0	0		-
B26/20 Property Transaction Monitoring	July-19	1		1	0	0	0	0		-
B27/20 Financial Process Compliance	Jan-20	2		1	1	0	0	0		1
B31/20 eHealth Strategic Planning & Governance	Jun- 20	6		0	0	5	1	0		-
B32/20 NHS Scotland Waiting Times Methodology	Mar-20	13		10	0	2	1	0		-
2019/20 Totals		93		46	26	14	7	0		3
Overall Totals		**191**		**102**	**52**	**15**	**7**	**15**		**7**

	Rec Number	Priority	Brief Description	Responsible Officer	Original Due Date	Extended Due Date	Reason for Extension from Responsible Officer
B26/18 Brookson Locum Invoice Approval Process	2b	2	There are no documented procedures or FOPs detailing the formal procedures that should be followed for the different stages involved in booking locum staff through Brookson's.	Previous Deputy Director of Finance	30-Jun-18	31-Mar-21	The previous Deputy Director of Finance has now left NHS Fife and following escalation to the Director of Finance, new responsible officers have been identified to take this action forward to completion.
	4	2	Arrangements are to be made to have timesheet approval introduced as intended under the Brookson process. Efforts to be made to renegotiate timescale for invoice payments to a more realistic one.	Previous Director of Finance	30-Jun-18	31-Mar-21	The previous Director of Finance is now Chief Executive and a new responsible officer has been identified to take this action forward to completion.
	5	2	Arrangements for authorisation of invoice payment should be transferred to the clinical service employing the locums. It would seem most appropriate that this is a shared responsibility of clinical leads and service managers.	Previous Director of Finance	30-Jun-18	31-Mar-21	The previous Director of Finance is now Chief Executive and a new responsible officer has been identified to take this action forward to completion.
17/18 Sub Total	**3**						
B11/19 Mandatory Training	1	3	A central record of course updates and reviews should be maintained. This information should be provided to the SGC at least annually to provide assurance that courses are being kept up to date with any changes to legislation or working practices.	Director of Workforce/ Head of Workforce Development	31-Mar-20	01-Mar-21	The Director of Workforce will undertake a project with the following criteria: • Identify the best resource to manage this, • Consider how we best communicate it out to all training services and, • Consider how this will be facilitated on an on-going basis (and by whom).
	2	3	A policy on mandatory training requirements to be followed by staff should be introduced.	Director of Workforce	31-Mar-20	01-Mar-21	The needs are different across the organisation so writing a policy on mandatory training

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							requirements would be challenging e.g. not all core topics including in mandatory skills is applicable to all roles
	3	3	Information should be provided to the SGC to ensure that they are informed and have up to date information regarding the actions in place to ensure that NHS Fife meets its mandatory training obligations	Director of Workforce/ Head of Workforce Development	31-Mar-20	01-Mar-21	NHS Fife e are working on a more sustainable format for producing these reports more regularly in future that does not have such a big impact on time/ resources until the reporting function is available.
B22/19 Losses & Comps	1a, 3	3	Managers responsible for recording incidents should be reminded of the requirement to follow FOP16a for all cases where property is lost, damaged or written off.	Previous Assistant Director of Finance	31-Jul-19	31-Mar-21	The previous responsible officer has now left and a new responsible officer has been identified to take this action forward to completion.
	2b	3	The losses and compensation form included in FOP16a should be amended to include provision for a cross reference to the related Datix incident.	Ledger Control and Treasury Manager	31-Jul-19	31-Mar-21	FOP Update on going
	5	3	The losses and compensation form included in FOP16a should be updated to include a section regarding the prevention of recurrence of losses.	Assistant Director of Finance	31-Jul-19	31-Mar-21	The previous responsible officer has now left and a new responsible officer has been identified to take this action forward to completion.
	6	3	As per action point 1 part a	Previous Assistant Director of Finance	31-Jul-19	31-Mar-21	The previous responsible officer has now left and a new responsible officer has been identified to take this action forward to completion.
B23&24/19 Savings & Financial Planning	2	2	The process for reviewing efficiency saving opportunities should include consideration of the interdependencies in, and between, the Health Board and the IJB both in respect of additional savings opportunities to mitigate risks of adverse consequences up or down stream from where an efficiency project is being implemented.	Director of Finance	31-Mar-20	31-Mar-21	Work on this has commenced, however has been delayed due to the mobilisation of the local response to COVID 19.
B25/19 Financial	1	S	Virements between £20-50K are reported to the Chief Executive, Chief Operating Officer or Director of Health and Social Care in line with the FOP Appendix A delegated authority. We recommend that section 5 of the FOP	Deputy Director of Finance	31-Jul-20	30-Apr-21	Due to capacity issues within the Finance Directorate and the requirement for the Financial Management Team to lead on the Annual

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Management			Appendix A is reviewed and revised to include appropriate designations within the FOP for virements to ensure it clearly sets out the procedures to be followed e.g. the reporting method to be used for virements which are not fully delegated and includes the appropriate designations and authorisation levels.				Accounts process the responses to the audit recommendations remain a work in progress.
	2	M A	Recommend that approval is obtained for these virements from the relevant Executive Director or the Deputy Director of Finance. In line with Section 5 of the FOP 9.2 and 9.3, the process of approval must be actioned by use of the Vacancy Management Form. Due consideration should be given to any extant control processes in place with immediate effect to realign these budgets.	Deputy Director of Finance	31-Mar-20	30-Apr-21	Due to capacity issues within the Finance Directorate and the requirement for the Financial Management Team to lead on the Annual Accounts process the responses to the audit recommendations remain a work in progress.
18/19 Sub Total	**11**						
B08/20 Internal Control Evaluation	1	S	Work has commenced to review the integration scheme which is line with the actions outlined in the MSG report. This will be done in line with legislation, the model Integration scheme and best practice principles.	Director of Health & Social Care	31-Apr-20	28-Feb-21	As of 23 December 2020, with the exception of the finance section, the revised integration scheme for Fife is now approaching a version that is fit for circulation, Internal Audit have been asked to comment on the updated document by 13 January 2021 so that a revised version can go through the January committees.
	3	S	The recommendations made in B15/17 & B18/18 Clinical Governance Strategy and Assurance should be presented to the Clinical Governance Committee with an update on the status of actions to address them. The recommendations made in B15/17 & B18/18 Clinical Governance Strategy and Assurance should be considered and should inform the review of the Clinical & Care Governance Strategy.	Medical Director	31-Mar-20	28-Feb-21	Covid-19 Responsibilities. Indication that work will be ongoing. Extended date is for an update on these actions.
	4	S	The change in approach regarding responsibilities for considering the Activity Tracker Report outlined in the SBAR to 6 Sep 2019 CGC should be reflected in the Terms of References of the NHS Fife CGC and ASD CGC and the H&SCP's C&CGC and C&CGGs. A year-end summary of NHS Fife responses to External and Internal reports should be included in the CGC Annual Statement of Assurance and should include an indication of whether any of the matters reported will require to be	Medical Director	31-Mar-20	28-Feb-21	Covid-19 Responsibilities. Indication that work will be ongoing. Extended date is for an update on these actions.

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			included as a disclosure in the Board's Governance Statement which forms part of the annual accounts. As a development, consideration should be given to triangulating significant findings from external inspections with the issues identified by internal control systems and we recommended that, in addition to responding to the substantive points within the external report(s), NHS Fife undertake a holistic review to understand why internal systems did not identify these issues.				
	7	M A	An action plan to address the recommendation made in Audit Scotland's report on workforce Planning should be agreed by the NHS Fife SGC.	Director of H&SCP / Director of Workforce	30-Jun-20	28-Feb-21	Due to the focus on COVID we have been unable to arrange for the Chair of the GMS Implementation Group to present to the Staff Governance Committee in line with the recommendation above. This will be arranged in due course, as part of the normal business agenda of the SGC.
	10	S	Fife NHS Board should consider establishing a standing committee for Information Governance or ensure the current structure is fit for purpose to provide adequate assurance on its legislative requirements.	Director of Finance	31-Mar-20	28-Feb-21	Placed on hold during the COVID19 pandemic Work has progressed to review governance with SBAR and revised terms of reference to be submitted to the Clinical Governance Committee on reinstatement
	11	S	The risk management arrangements for information governance risks should be improved.	Director of Finance	31-Mar-20	28-Feb-21	Placed on hold during the COVID19 pandemic All risks have been reviewed and updated to follow the 'there is a risk that … because off … resulting in …" format and follow GP/R7 Risk Register and Risk Assessment policy. Discussions still to take place with the NHS Fife Risk team in relation to DATIX and policy
	12	S	The following should be considered for inclusion to reporting in the IPQR (alongside the existing reporting on compliance with the Freedom of Information (Scotland) Act 2002): i. NHS Scotland's Information Security Policy Framework (incorporating ISO27001:2013, legal requirements of the NIS Regulations and GDPR & Data Protection Act 2018 and the Public	Director of Finance	31-Mar-20	28-Feb-21	Placed on hold during the COVID19 pandemic

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			Sector Cyber Resilience Action Plan and the Cyber Assurance Framework) ii. GDPR/Data Protection Act 2018 iii. Public Sector Cyber Resilience Action Plan and the Cyber Assurance Framework				
	14	M A	The NHS Fife Information Security Policy should be reviewed as a matter of urgency.	Director of Finance	28-Feb-20	28-Feb-21	Placed on hold during the COVID19 pandemic
	15	S	Regular reporting of the implementation of the eHealth Delivery Plan to a standing committee should be initiated and this should include overtly linking the projects to relevant national and local strategies (NHS Scotland Digital Health and Care Strategy, NHS Fife Clinical Strategy and IJB Strategic Plan).	Medical Director	31-Mar-20	28-Feb-21	Covid-19 Responsibilities. Indication that work will be ongoing. Extended date is for an update on these actions.
B13/20 Risk Management Staging	1	S	Risk Management Framework is mostly still in progress and we recommend that a project plan is developed and produced with any remaining actions required, realistic key dates and milestones to enable the monitoring of the plan and ensure a timely completion.	Risk Manager	31-Jul-20	01-Feb-21	Covid 19 responsibilities
	2	S	There is further scope to enhance the strategic aspects of Risk Management within NHS Fife, within the context of the risk appetite consulted and agreed by the Board and the implementation of DL(2019) 02 Blueprint for Good Governance.	Risk Manager	31-Jul-20	01-Feb-21	Covid 19 responsibilities
	3	S	We recommend that the IJB risk management arrangements are clarified between the Fife Integration Joint Board and NHS Fife with particular reference to the treatment of residual risk and escalation process with the Fife IJB, the Health and Social Care Partnership and NHS Fife Board. We further recommend that the governance arrangements regarding risk management with the Fife IJB, and the Fife Health Care Partnership are recorded in the Risk Register and Risk Assessment policy GP/R7.	Risk Manager	31-Jul-20	01-Feb-21	Covid 19 responsibilities
B14/20 Staff & Patient	1a	M A	When available the 'Non-Compliance' report from the eESS system should be used to identify areas/departments/wards with low levels of attendance at Fire	Learning & Development	31-Mar-20	28-Feb-21	Work has not progressed with the eESS National team despite numerous attempts over the last few months. A report has been developed to identify

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Environment			Safety Training so that these areas/departments/wards can be supported to improve attendance.	Officer			compliance however, despite requesting a non-compliance report the team have yet to develop this.
	1b	M A	The report should be developed to confirm that all staff who require more specialist training (eg Responsible Persons, Fire Wardens) receive this type of training.	Estates Compliance Manager	On-going	28-Feb-21	On a more local level within NHS Fife, work will begin in 2021 to roll out the Learner functions within eESS which will give an employee and their manager access to individual learning histories in order to support local awareness of compliance. In addition to this, a Core Skills report will be issued to every manager over the next few months detailing compliance for each member of their team – this will further raise non-compliance awareness on a local level.
	2	M A	Further Standard Operating Procedures should be developed for components of the operational system for fire safety in NHS Fife and the sections for these processes should be summarised in the NHS Fife Fire Safety Procedure and cross references to the appropriate SOPs added.	Estates Compliance Manager	31-Mar-20	28-Feb-21	A memo has been developed on interim training arrangements, whilst it is not a full SOP it is still an introduction which pulls together the requirements from our Policies & Procedures. This will be used as a baseline to develop into a full SOP as time progresses. This has been shared with a group of 60 staff/managers and has been uploaded to Stafflink.
B15/20 Strategic Planning	1	S	The Risk Management process for the Transformation Programme should be revised so that it completely aligns to the NHS Fife Risk Management Framework and to include an escalation process. Mitigations should be added to the Integration Programme Risk Register along with an indication of whether these will be sufficient to reduce the risk to the target level within an acceptable timescale. The reporting of key risks included in Programme Update Reports should state the risk ratings for the risks, mitigating actions identified and an indication of whether these will be sufficient to reduce the risks to their target levels within	Associate Director	30-Sep-20	01-Feb-21	Covid 19 responsibilities

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			an acceptable timescale. BAF current risk scores should be formally reconsidered following the publication of relevant internal and external audit reports.				
	2a	S	At the time of the audit, the Integrated Transformation Board had just been formed and the request for written reports had been issued and only one meeting has met where the written reports from Transformation Programme had been presented to the Clinical Governance Committee. There have been no meetings since the start of COVID-19 so this has not been embedded across the organisations. In line with formal programme management methodology, the highlight reports including items for escalation should be adequate reporting for the Clinical Governance Committee and these will be presented to it.	Associate Director	31-Aug -20	01-Feb-21	Covid 19 responsibilities
	2b	S	Most of the Transformation work is value related rather than cash releasing efficiency savings but there are instances of this (eg the Medicines Efficiencies Transformation Programme). Work will be undertaken with the Director of Finance to reconcile the efficiency savings in the Transformation Programme to the Annual Operational Plan	Associate Director	30-Sep-20	01-Feb-21	Covid 19 responsibilities
	3a	S	The Risk Management process for the Transformation Programme should be revised so that it completely aligns to the NHS Fife Risk Management Framework and to include an escalation process.	Associate Director	30-Sep-20	01-Feb-21	Covid 19 responsibilities
	3b	S	Mitigations should be added to the Integration Programme Risk Register along with an indication of whether these will be sufficient to reduce the risk to the target level within an acceptable timescale.	Associate Director	30-Sep-20	01-Feb-21	Covid 19 responsibilities
	3c	s	The reporting of key risks included in Programme Update Reports should state the risk ratings for the risks, mitigating actions identified and an indication of whether these will be sufficient to reduce the risks to their target levels within an acceptable timescale	Associate Director	30-Sep-20	01-Feb-21	Covid 19 responsibilities

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B17/20 Organisational Performance Management	2	M A	NHS Fife should confirm, within the P&ARF, that all corporate objectives are appropriately mapped to a responsible Director within the appraisal/TURAS system.	Chief Executive	30 Oct 20 (due to impact of Covid-19, the corporate objectives will only be considered by the NHS Board in September)	28-Feb-21	This action is partly completed with the Board approving the corporate objectives on 30 September. Executive Directors are working to to update their objectives on Turas and an exercise will be required thereafter to map these across to the corporate objectives. This to be completed in parallel with the review and sign off of the Director's objectives
B19/20 Adverse Events Management	2	S	A review of actions still open for 2018 and 2019 revealed there to be 70 SAER actions and 95 LAER actions still open and overdue completion. An action plan should be drawn up to enable steps to be taken to finalise the backlog of actions currently outstanding and ensure greater effort is made to have actions completed by the respective due date.	Head of Quality & Clinical Governance	30-Jun-20	28-Feb-21	December update: Discussions about establishing processes for reporting of action status through local governance routes has begun. This is now included in the reports which are presented by Directorates to the ASD CGC. The HSCP are improving reporting which is to be extended to include the reporting of outstanding actions. Reports with data and information relating to actions are now part of KPIs which are now reviewed and monitored through the Adverse Events and Duty of Candour Group. This is a standard agenda item. Reports are now created in Datix and are accessible by Directorates.
	3	S	A review of the actions within the SAER and LAER samples selected for all stages of audit testing indicated that sufficient explanation is not being provided within DATIX on the steps taken to implement the actions. Staff should be reminded to fully note on DATIX what steps have been taken to implement actions; including what shared learning has actually taken place. Additionally, a review of the fields on DATIX for recording details of the steps taken to implement actions should be completed, so that staff can be more	Head of Quality & Clinical Governance	30-Jun-20	28-Feb-21	December update: The Adverse Events and Duty of Candour Group did not meet from March until August due to COVID-19 pandemic. The regular meeting schedule resumed in August 2020. This will be an item on the agenda to be discussed at the December 2020 meeting.

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			readily directed to note the final outcome.				
B21/20 Medicines Management	8	M A	Medicines Uplift and Delivery Form must be redesigned and this must include consideration of the issues identified by Internal Audit. Ultimately an electronic alternative solution must be explored.	Lead Pharmacy Technician	31-Mar-20	31-Jul-20	Work is ongoing.
B27/20 Financial Process Compliance	2	M A	Financial Operating Procedures to be updated.	Assistant Director of Finance	31-Jul-20	28-Feb-21	The previous responsible officer has now left and a new responsible officer has been identified to take this action forward to completion.
	10	M A	The sample selection process note should be updated and should be incorporated into Appendix 1 of the Patient Access Policy and the SOP.	Information Services Manager	30-Apr-20	28-Feb-21	The previous responsible officer has now left and a new responsible officer has been identified to take this action forward to completion.
19/20 Sub Total	**26**						
Total	**52**						

Report	Issue Date	Rec Ref.	Audit Finding & Recommendation	Responsible Officer	Original Management Response	Priority	Original Due Date	Revisions to Due Date
2018/19								
B31&32/19 IS Assurance & eHealth Strategic Planning	03-Jul-19	4	The strategic Information Governance risks to NHS Fife associated with this partnership working arrangement should be recorded on the NHS Fife Risk Management System (DATIX) and mitigations should be put in place to reduce them to a level tolerable by NHS Fife. The reason for this is that if these risks materialise they would have an adverse impact on NHS Fife being able to deliver its strategic objectives. Assurances associated with the mitigating actions should be included as expected assurances in the Terms of Reference and Workplan of the IG&SG and should be reported on in its annual assurance statement.	Information Governance and Security Manager	The risks will be recorded on the risk register together with current and planned joint mitigations. This will be informed by discussions between the NHS Fife and Fife Council Data Protection Officers which are scheduled for the end of August 2019.	2	31-Oct-19	01-May-20
18/19 Sub Total		1						
2019/20								
B21/20 Medicines Management	02-Dec-19	4a	Pharmacy Staff must be reminded: i. That a continuous temperature monitoring device must be used for the duration of the transportation time for medicines that are particularly sensitive to temperature changes ii. That a maximum/minimum thermometer must be inserted into the container when medicines are removed from a	Senior Pharmacy Technician	Pharmacy – An investigation and risk assessment will be undertaken for the transportation of medicines requiring refrigeration to determine if the wording in the SSUMPP is appropriate and if so to conclude with a proposal for how we can comply (e.g. purchase of temperature monitoring devices). Training of pharmacy, transport and clinical staff will also be reviewed and action taken to ensure that this reflects	Significant	31-Mar-20	-

Report	Issue Date	Rec Ref.	Audit Finding & Recommendation	Responsible Officer	Original Management Response	Priority	Original Due Date	Revisions to Due Date
			department fridge for transport or use outwith the department iii. To use paper/cardboard to separate medicines from cool packs for medicines requiring refrigeration.		the outcome from the investigation and risk assessment.			
		4b	Clinical Staff must be reminded to: i. Return cool boxes and cool packs to pharmacy as soon as possible with a medicines return form to allow credit of the cost of packaging for the returning department ii. Record the period of time medicines are held outwith their recommended storage temperature and record this as a DATIX incident iii. Confirm that layers of paper/cardboard have been used to separate medicines from cool packs (for medicines requiring refrigeration) iv. Insert a maximum/minimum thermometer into the container when medicines are removed from the department fridge for transport outwith the department v. Undertake a risk assessment to determine the viability of any medicines that have been removed from the fridge and not maintained at a temperature of	Senior Pharmacy Technician	The investigation and risk assessment will include the review of the responsibilities associated with the receipt of medicines requiring refrigeration in the clinical environment. The outcome will be included in a proposal to be taken to Safe and Secure Use of Medicines Group for discussion and approval. Training of pharmacy, transport and clinical staff will also be reviewed and action taken to ensure that this reflects the outcome from the investigation and risk assessment.	Significant	31-Mar-20	-

Report	Issue Date	Rec Ref.	Audit Finding & Recommendation	Responsible Officer	Original Management Response	Priority	Original Due Date	Revisions to Due Date
			between -2°C and +8°C and to discard the medicines or return them to the fridge depending on the outcome.					
		4c	Management must introduce regular spot checks to confirm that responsibilities related to preserving the cold chain are being understood and undertaken in the transportation of medicines process. Action must be taken to address any areas of non-compliance identified.	Senior Pharmacy Technician	Spot checks will be introduced as part of the Medicines Assurance Audit Programme for clinical areas and will be added to the monthly task list for Senior Stores Staff once the proposal has been approved.	Significant	31-Mar-20	-
B23a/20 Workforce Planning – Attendance Management	16-Jan-20	2	Communication to be disseminated to all Managers to raise awareness of the importance of the timeliness of the return to work discussion.	Head of Human Resources	This recommendation is supported and further communication will be disseminated to all Managers to raise awareness of the importance of the timeliness of the return to work discussion. This will also be re-iterated within all of the relevant groups involved in progressing work in respect of promoting Attendance Management within the Board.	Merits attention	31-Dec-19	30-Sep-20
B23a/20 Workforce Planning – Attendance Management	16-Jan-20	4	A governance review to be undertaken to identify any gaps or duplication with the Attendance Management groups and ensure that there is a clear framework of all the groups, their purpose (strategic or operational) and how they interrelate to ensure that themes, reporting and escalation are defined and reported.	Director of Workforce	This recommendation is accepted. Attendance management is such a significant area for improvement in terms of the health and wellbeing of the workforce and also in terms of the impact upon supplementary spend that the ability to review the current arrangements and remits is timely.	Merits attention	31-Mar-20	30-Sep-20
B31/20 eHealth Strategic Planning &	03-June-20	1	The NHS Fife Digital and Information Strategy should be updated to include: a. The need for developments to follow the Digital First	General Manager eHealth and IM&T	The NHS Fife Digital and Information Strategy will be amended to address the issues highlighted in the recommendation above. The associated	Merits attention	30-Sept-2020	

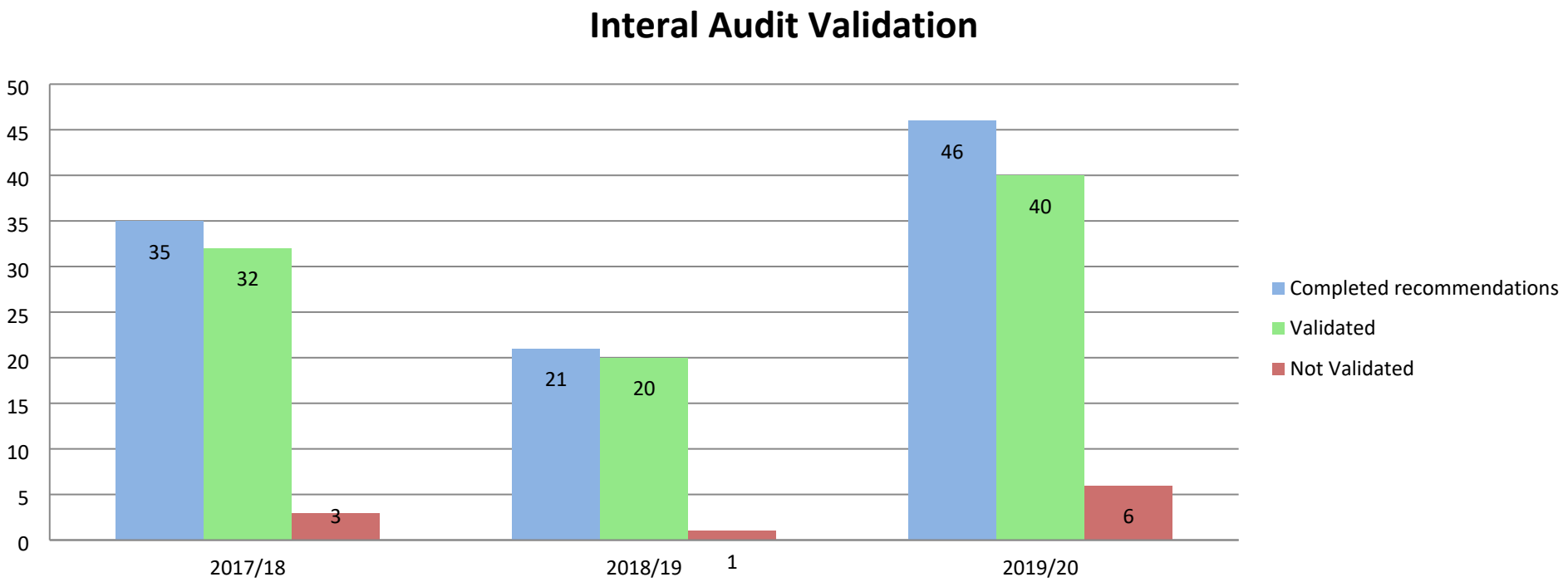
Report	Issue Date	Rec Ref.	Audit Finding & Recommendation	Responsible Officer	Original Management Response	Priority	Original Due Date	Revisions to Due Date
Governance			Service Standard as the minimum standard for development of systems (references to compliance with PRINCE 2, ITIL and ISO 27001 are included which are reflected in this Standard) b. Strengthening the training requirements to include the need for staff training on Information Governance, basic digital skills staff training and reference to the Digital Participation Charter and the Digital Champions Development Programme, which are advocated in Scotland's Digital Health and Social Care Strategy. The revised strategy should be presented to Fife NHS Board for approval. Whilst a high level of delivery plan was published as an appendix to the strategy as a baseline and it was noted that it was subject to change, the operational delivery plan should explain: c. The criteria used for project prioritisation The NHS Fife governance framework for approving business cases and monitoring strategy implementation (groups/committees and responsibilities).		Delivery Plan published will remain as a 'baseline' and the operational delivery plan will be updated and include the governance framework and prioritisation criteria. It was always the intention to submit the NHS Fife Digital and Information Strategy to Fife NHS Board for approval but recent focus on Covid 19 activities has prevented this. A request will be made for this to be added to the agenda of a future meeting of the Board.			

Report	Issue Date	Rec Ref.	Audit Finding & Recommendation	Responsible Officer	Original Management Response	Priority	Original Due Date	Revisions to Due Date
B31/20 eHealth Strategic Planning & Governance	03-June-20	2	A separate risk register should be developed to record, assess and manage the risks threatening the delivery of the NHS Fife Digital and Information Strategy. This should be subject to regular review to confirm that all risks have been identified and to update the status of mitigations and reassess the current and target risk scores. An analysis of the risks should be presented to each eHealth Board meeting including a conclusion regarding whether mitigating actions in place, and planned, will be sufficient to reduce the risk to a tolerable level in an acceptable timescale. Assurance should be provided throughout the year to a standing committee of the Board regarding the management of risks threatening the delivery/implementation of the NHS Fife Digital and Information Strategy 2019-24. Consideration should be given to revising the BAF Risk to be focussed on the Delivery/Implementation of the NHS Fife Digital and Information Strategy.	General Manager eHealth and IM&T	Whilst recognising that the BAF and linked risks require to be reviewed and potentially restated to account for the existence of the NHS Fife Digital and Information Strategy preparing a separate risk register is not required and would lead to duplication of effort. The BAF and linked risks will be reviewed and revised to reflect the risks recorded in the NHS Fife Digital and Information Strategy. The presentation of the revised BAF to the Clinical Governance and Fife NHS Board on an ongoing basis will provide assurance that these risks are being managed. This work will be informed by the current assurance mapping exercise being undertaken in conjunction with Internal Audit (B11-20) which is using the eHealth BAF as a trial of assurance mapping processes.	Significant	31-Aug-20	
B31/20 eHealth Strategic Planning & Governance	03-June-20	4	Reporting on the implementation of the Delivery Plan for the NHS Fife Digital and Information Strategy to the eHealth Board and a standing committee of the Board should be improved so that:	General Manager eHealth and IM&T	The reporting to the eHealth Board will be revised to include 'project on a page' information for larger scale projects and more summarised information for smaller projects. An executive summary report on the	Significant	30-Sept-20	

Report	Issue Date	Rec Ref.	Audit Finding & Recommendation	Responsible Officer	Original Management Response	Priority	Original Due Date	Revisions to Due Date
			it includes an executive summary clearly highlighting: Any changes to the prioritisation of projects within the plan along with reasons for the change in prioritisation Any slippage from planned delivery, the reasons for this and action being taken to address it Any projects completed along with a high level assurance regarding whether benefits anticipated at the outset of the project have been achieved and if not the reasons for this. The link between individual projects and the Transformation Programme is clearly stated.		implementation of the delivery plan associated with the NHS Fife Digital and Information Strategy will be developed and presented to a standing committee of the Board on a regular basis. This will explain changes to prioritisation, any slippage from plans and, for completed projects, whether anticipated benefits have been achieved.			
B31/20 eHealth Strategic Planning & Governance	03-June-20	5	Sections for cross reference to the NHS Fife Digital and Information Strategy and the Transformation Programme should be added to the Business Case Template as a prompt for this information to be included. Consideration should be given to utilising the SCIM template, amended to reflect size of project, when developing a specific Digital and Information business case. eHealth Board and Finance, Performance and Resources Committee members should be advised that alignment with the NHS Fife Digital and Information Strategy and the Transformation Programme are requirements for Business Cases to	General Manager eHealth and IM&T	A specific business case template will be developed for Digital and Information projects that do not require to be completed using the SCIM compliant template. This will include prompts for the required information including relevant SCIM requirements and cross references to relevant strategies and programmes (eg NHS Fife Digital and Information Strategy and the Transformation Programme). eHealth Board and Finance, Performance and Resources Committee members will be asked to approve the new template.	Merits attention	30-Sept-20	

Report	Issue Date	Rec Ref.	Audit Finding & Recommendation	Responsible Officer	Original Management Response	Priority	Original Due Date	Revisions to Due Date
			be considered for approval.					
B31/20 eHealth Strategic Planning & Governance	03-June-20	6	The impact of the acceleration of some elements of the NHS Fife Digital and Information Strategy Delivery Plan on other elements of the Delivery Plan should be specifically reported to the eHealth Board and a standing committee of the Board. This should include consideration of the transformational nature of the work undertaken and whether this would warrant acceleration in further areas of NHS Fife and the Health and Social Care Partnership based on the results experienced.	General Manager eHealth and IM&T	The acceleration of some aspects of the NHS Fife Digital and Information Strategy Delivery Plan due to Covid 19 meant that the normal requirements for Business Case approval were not undertaken (eg for the NearMe implementation). This is now being revisited so that the recurring resource requirements of these implementations and the impact on future plans can be fully understood and a Business Case presented regarding the resources required to sustain the implementations going forward. An analysis of the work that had to be deferred as a result of Covid 19 reprioritisation will also be undertaken to understand the impact this has had on risk mitigation and delivery plan prioritisation. Reacting swiftly to changes related to Covid 19 required more agile decision making and, whilst appreciating governance requirements, this speed of decision making was refreshing. A review of approval processes will therefore be undertaken to increase the speed of decision making on a business as usual basis. A paper on the above will be prepared for the eHealth Board to consider.	Merits attention	30-Sept-20	
B32/20 NHS Scotland Waiting Times	09-Mar-20	5	Finding 5 from Internal Audit Report B29/18 – NHS Scotland Waiting Times Methodology has not been addressed. This related to the impact of exceptions	Secretarial Services & Waiting Times Team	The impact on the patient journey in terms of extra time waiting will be calculated for exceptions identified and be recorded on the spreadsheet used to	Merits attention	30-Apr-20	-

Report	Issue Date	Rec Ref.	Audit Finding & Recommendation	Responsible Officer	Original Management Response	Priority	Original Due Date	Revisions to Due Date
Methodology			on the patient journey (in terms of extra time waiting) not being calculated and recorded. The NHS Scotland Waiting Times Monthly Audit Methodology requires that the impact on the patient journey should be calculated for any exceptions identified. The impact on the patient journey in terms of extra time waiting should be calculated for exceptions identified and be recorded on the spreadsheet used to collate the results so that this can be included in reporting.	Manager	collate the results so that this can be included in reporting.			
		8	Finding 8 from Internal Audit Report B29/18 – NHS Scotland Waiting Times Methodology has not been addressed. This related to referring to the main contact(s) for resolving issues identified from the monthly audit in the Patient Access Policy. Appendix 1 of the Patient Access Policy should be updated to include details of the main contact(s) for resolving issues identified from the monthly audit.	Secretarial Services & Waiting Times Team Manager	Appendix 1 of the Patient Access Policy will be updated to include details of the main contact for resolving issues identified from the monthly audit.	Merits attention	30-Apr-20	-
19/20 Sub Total		14						
Total		15						



Definitions	
Complete	Evidence has been received from the Client that action has been implemented
Validated	Internal Audit has confirmed management responses, by considering evidence, to assure the Audit and Risk Committee that recommendations reported as complete have been appropriately completed and, where possible, that action has been effective
Not Validated	Further evidence is required to assure the Audit and Risk Committee that recommendations reported as complete have been appropriately completed and, where possible, that action has been effective

Audit Year/Report	Rec. Ref.	Finding & Recommendation	Priority	Responsible Officer & Action by Date	Follow-up Response	Internal Audit Opinion on Further Evidence Required to Allow Action to be Recorded as Complete *[This further evidence will be requested from the Responsible Officers through the Follow-up Process]*
2017/18						
B18/18 – Clinical Governance Strategy	13	**Finding** There is no specific reporting currently to assure Fife NHS Board and the IJB that the C&CGS is being implemented as intended, although the delivery of the CGC and C&CGC workplans, does provide tangential assurance that the C&CGS is being implemented. The QSGG is supposed to be the group with responsibility for ensuring implementation of the C&CGS. **Recommendation** The QSGG workplan should include specific consideration of the implementation of the C&CGS to be used as the basis of assurance to both the CGC and C&CGC.	2	Chief Executive 31-Mar-2018	The Quality Safety Governance Group name was changed to Clinical Governance Oversight Group and since July 2019 is now known as NHS Fife Clinical Governance Oversight Group. A review of the group's terms of reference and workplan was undertaken during 2018-2019. (see Terms of Reference and Workplan)	Neither the Workplan nor the Terms of Reference of the Clinical Governance Oversight Group contain any responsibilities related to the Clinical & Care Governance Strategy and providing assurance regarding this to the Clinical Governance Committee and the Clinical and Care Governance Committee. This means that the finding in our report remains unaddressed as neither the Clinical Governance Committee nor the Clinical and Care Governance Committee have been provided with assurance regarding the implementation of the Clinical and Care Governance Strategy. As part of the review and revision of the Clinical and Care Governance Strategy assurance should be provided to the CGC and C&CGC regarding its implementation to date and how they will be provided with this assurance on a regular basis going forward.
B28/18 Service Contract Income	2	**Finding** As no agreement documentation could be located for the Crown Office Procurator Fiscal contract, we were unable to confirm that arrangements are in place to review charges on an annual basis. **Recommendation** It should be ensured that once the contract is located or a new one is prepared, that arrangements are in	3	Head of Management Accounting & Performance 31-Oct-2018	Due to the time that has passed we are unable to provide evidence for this action point. However going forward a register of Service Contract Income will be created to monitor the renewal and termination of such contracts.	A copy of the register of Service Contract Income referred to in the follow-up response is required to evidence completion.

Audit Year/Report	Rec. Ref.	Finding & Recommendation	Priority	Responsible Officer & Action by Date	Follow-up Response	Internal Audit Opinion on Further Evidence Required to Allow Action to be Recorded as Complete [*This further evidence will be requested from the Responsible Officers through the Follow-up Process*]
		place to review charges on an annual basis and it should be confirmed that this exercise is being completed.				
B31A/18 Podiatry Service Departmental Review	3	**Finding** The annual report for the podiatry service was presented to the August 2018 meeting of the Fife-wide Clinical and Care Governance Group. The report listed the key objectives for the podiatry service but did not include metrics to inform the group of progress to departments achieving these. **Recommendation** Reporting on podiatry service performance to the Fife-wide Clinical and Care Governance Group should include information regarding the progress being made to departments achieving their key objectives. This should include setting targets for each of the objectives.	3	Podiatry Professional Head of Service 30-Apr-2019	Performance target data for key objectives will be reported to the Divisional General Manager on a quarterly basis. Information reported relates to MSK waiting times targets, service DNA levels and wound caseloads. Work is ongoing to improve data collection from the electronic patient management system to inform this submission.	The evidence supplied relates to reporting to the Divisional General Manager rather than the Annual Podiatry Report being presented to the Fife-Wide Clinical and Care Governance Group. which is what the recommendation relates to. A copy of the latest Podiatry Annual Report presented to the Fife-Wide Clinical and Care Governance Group including reporting of performance towards achieving the key objectives for the Podiatry service is required to evidence completion of this action.
2017/18 Sub Total	**3**					
2018/19						
B31&32/19 Information Governance and eHealth	2	**Finding** Under the NIS Regulations, Healthcare is identified as an essential service therefore NHS Fife will be subject to audits commissioned by the competent authority for healthcare in Scotland (The Scottish Government). It is therefore	2	IT Operations Manager 31-Jan-2020	Item 5.9 - Information Security Policy Framework NIS Assessment with RAG Status v0.11 Fife, was submitted to the Information Governance & Security Group. This document will be updated	Although Reporting on NHS Fife's status against Status NHS Scotland's Information Security Policy Framework and Network Information Systems Regulations was reported to the IG&SG on 16 Jan 20 there has not been any reporting of this to the NHS Fife Clinical Governance Committee. The action is therefore only partly complete. Evidence needed to confirm that the action is fully complete is

Audit Year/Report	Rec. Ref.	Finding & Recommendation	Priority	Responsible Officer & Action by Date	Follow-up Response	Internal Audit Opinion on Further Evidence Required to Allow Action to be Recorded as Complete [*This further evidence will be requested from the Responsible Officers through the Follow-up Process*]
		important that NHS Fife has the required controls in place prior to the audit and that assurance on this is provided to Fife NHS Board. The competent authority published a revised Information Security Policy Framework (ISPF) in March 2019 which integrates the controls of ISO27001:2013 alongside the legal compliance requirements of NIS:2018 and GDPR:2018 and addresses the features of the Public Sector Action Plan and Cyber Essentials which Boards need to comply with. **Recommendation** Regular assurance reports should be provided to the IG&SG and CGC regarding NHS Fife's status against the controls included in the revised ISPF.			for each quarterly meeting, the FTF Auditor was provided a copy of this document.	reporting to the NHS Fife Clinical Governance Committee regarding NHS Fife's status against the controls included in NHS Scotland's Information Security Policy Framework and Network Information Systems Regulations. This could be achieved by presenting the recently published Competent Authority audit report on this subject together with the action plan to address areas of non-compliance.
2018/19 Sub Total	**1**					
2019/20						
B19/20 Adverse Event Management	1	**Finding** Responsibility for completing actions arising from SAERs and LAERs lies with service management and, although there previously was, there is currently no regular reporting to relevant committees on the SAER and LAER actions implemented and those still outstanding. This prevents follow-up of overdue actions and because there is no	MA	Head of Quality and Clinical Governance 30-Jun-2020	The audit report was discussed on 27 February 2020 with focus on overdue actions and the need for operational oversight and management of these actions. A report was provided to HSCP on 29/04/20 and ASD on 14/05/20 which included the status of all actions associated with SAER or LAER 2017- to date	The follow-up response does not include reporting to standing committees (ie NHS Fife Clinical Governance Committee and HSCP Clinical and Care Governance Committee). In order to record this action as completed evidence regarding the reporting of KPIs, for completing actions arising from SAERs and LAERs, to the NHS Fife Clinical Governance Committee and the HSCP Clinical and Care Governance Committee is required.

Audit Year/Report	Rec. Ref.	Finding & Recommendation	Priority	Responsible Officer & Action by Date	Follow-up Response	Internal Audit Opinion on Further Evidence Required to Allow Action to be Recorded as Complete [*This further evidence will be requested from the Responsible Officers through the Follow-up Process*]
		reporting on such, it prevents the standing committees from fully discharging their responsibilities as outlined in GP/I9 – Adverse Events Policy to ensure action plans have been completed and contribute to organisational learning by sharing and adopting key learning points. Arrangements are now being progressed to re-introduce meaningful KPIs to strengthen governance and give additional assurance on risk management activity. This includes reporting on the percentage of SAER and LAER actions completed by target date. The intention is to report this to the EDG, NHS Fife Adverse Events & Duty of Candour Group and the NHS Fife Clinical Governance Group on a bi-monthly basis. We were advised that DATIX is not currently configured to send out reminders to staff/management, advising of actions which are overdue completion. Outstanding actions now appear on the user front page of Datix in the 'To Do list' and work is underway to introduce a standardised functionality within 'My Reports' in Datix to enable the services to run off their own reports. These actions should enable easier identification of outstanding and overdue actions.			of report. A "My Report" has been configured which identifies overdue actions for divisions and directorates to use. Discussions are yet to take place in reference to reporting of status of actions through local governance committee and groups.	

Audit Year/Report	Rec. Ref.	Finding & Recommendation	Priority	Responsible Officer & Action by Date	Follow-up Response	Internal Audit Opinion on Further Evidence Required to Allow Action to be Recorded as Complete [*This further evidence will be requested from the Responsible Officers through the Follow-up Process*]
		Recommendation As part of the intended KPIs and additional standardised reporting templates, consideration should be given to including the number of actions overdue completion, so that the committees and groups receiving such reports have full details on the numbers still to be finalised and so that management action can be taken as necessary to minimise and prevent any back log arising. Once the KPIs and standardised reporting templates are introduced, the revised reporting arrangements functioning centrally and within the services should be reported to the NHS Fife Adverse Events & Duty of Candour Group for approval. The reporting arrangements introduced should be sufficient to enable the standing committees to ensure actions contained within action plans are being implemented as outlined in GP/I9.				
B21/20 Medicines Management	3b	**Finding** The system in place for Medicines Uplift and Delivery Forms is that the top white copy of the form is completed and sent with the medicines with a blue carbon copy retained by the Pharmacy Store. The white copy is expected to be completed by the receiving hospital, indicating that the medicines have been	S	Pharmacy Technician 30-Nov-2019	Memos to Transport and Clinical Teams reminding them to return the completed Medicines Uplift and Delivery Form to pharmacy.	The follow-up response only partly addresses the recommendation. In order to record this action as complete evidence is required of communication to Pharmacy staff reminding them to chase white copies of the Medicines Uplift and Delivery Forms when these have not been returned within a reasonable time.

Audit Year/Report	Rec. Ref.	Finding & Recommendation	Priority	Responsible Officer & Action by Date	Follow-up Response	Internal Audit Opinion on Further Evidence Required to Allow Action to be Recorded as Complete [*This further evidence will be requested from the Responsible Officers through the Follow-up Process*]
		received, and then returned to the Pharmacy Store. We found that the white copy had not been received from the community hospital by the Pharmacy Store for a significant proportion of the Medicines Uplift and Delivery Forms filed in the Pharmacy Store (blue copies are retained for these). **Recommendation** Pharmacy staff must request the white copies of the Medicines Uplift and Delivery Forms back from wards when these have not been returned within a reasonable time.				
B21/20 Medicines Management	6a&b	**Finding** SECURITY/HEALTH AND SAFETY Issues identified from Questionnaires: • In relation to section 5.1.7 of the SSUMPP, four of the Taxi Drivers indicated that the communication of health and safety risks and the need for special storage conditions when medicine requiring this is passed over for delivery was 'not applicable' when section 5.1.7 of the SSUMPP demands that these risks be communicated by pharmacy staff to those transporting medicines • In relation to section 5.1.7 of the SSUMPP, 11% of clinical staff indicated that the health and safety risks and the	Merits Attention	Lead Pharmacy Technician 31-Mar-2020	At SSUMPP group it was agreed that we had sufficient evidence that there was a risk and that the only way to eradicate the risk was direct delivery to wards. There was a transport run at 1630 every day with direct delivery to wards in April. From Monday 14th December a second run will be introduced again with direct delivery to wards.	Can only be considered complete if the SSUMPP has been updated to include an explicit instruction that medicines must never be left unattended at their destination point and to provide guidance for staff delivering medicines on the steps to be taken if no-one is available to receive the medicines at the destination point. No evidence of this has been provided.

Audit Year/Report	Rec. Ref.	Finding & Recommendation	Priority	Responsible Officer & Action by Date	Follow-up Response	Internal Audit Opinion on Further Evidence Required to Allow Action to be Recorded as Complete [*This further evidence will be requested from the Responsible Officers through the Follow-up Process*]
		need for special storage conditions are not communicated when medicine requiring this is passed over to them • In relation to section 5.1.8 of the SSUMPP, 23% of clinical staff indicated that medicines are left for them without them being present to sign the Medicines Uplift and Delivery Form • In relation to section 5.1.9 of the SSUMPP regarding training staff to undertake their duties in line with the SSUMPP, the responding manager indicated that there was a an issue in North East Fife with signing on receiving medicines. Although sections 5.1.3 and 5.1.8 infer that medicines must not be left unattended at their destination following delivery there is not an explicit instruction to this effect nor guidance for staff delivering medicines on the steps to be taken if no-one is available to receive the medicines at the destination point. **Recommendation** **a** The methods for communicating Health and Safety risks and the need for special storage conditions to taxi drivers when passing medicines over for collection, and to clinical staff when handing medicines over at their final destination, must be examined to confirm that they are effective and address the weaknesses identified				

Audit Year/Report	Rec. Ref.	Finding & Recommendation	Priority	Responsible Officer & Action by Date	Follow-up Response	Internal Audit Opinion on Further Evidence Required to Allow Action to be Recorded as Complete [*This further evidence will be requested from the Responsible Officers through the Follow-up Process*]
		above. **b** The SSUMPP must be updated to include an explicit instruction that medicines must never be left unattended at their destination point and to provide guidance for staff delivering medicines on the steps to be taken if no-one is available to receive the medicines at the destination point.				
B27/20 Financial Process Compliance	1	**Finding** Cheques and cash receipts were appropriately recorded with evidenced documentation held on file. However two of the five cheques tested were not banked within the requirements set out in the FOP section 7c point 4 which states that '*All income received should be banked intact and lodgements should be made at least weekly for such sums in excess of £500 regardless of whether it is cash or cheque. For sums smaller than this amount, banking can take place at less regular intervals, but always at least monthly at the end of the month*'. The two cheques over £500 were banked two weeks four days, and three weeks respectively. Lodgements were confirmed to the bank statements. **Recommendation** We recommend that all income received should be banked intact and lodgements should be made at least weekly for all	MA	Assistant Director of Finance – Financial Services 31-Jan-2020	No follow-up evidence on file	No follow-up evidence on file In order to record this action as complete evidence is required of communication to staff regarding the need to comply with FOP section 7 point 4 related to the requirement *'All income received should be banked intact and lodgements should be made at least weekly for such sums in excess of £500 regardless of whether it is cash or cheque.*'

Audit Year/Report	Rec. Ref.	Finding & Recommendation	Priority	Responsible Officer & Action by Date	Follow-up Response	Internal Audit Opinion on Further Evidence Required to Allow Action to be Recorded as Complete [*This further evidence will be requested from the Responsible Officers through the Follow-up Process*]
		sums in excess of £500 regardless of whether it is cash or cheque in line with the requirements of the FOP section 7c point 2.4.				
B32/20 NHSScotland Waiting Times Methodology	7	**Finding** Finding 7 from Internal Audit Report B29/18 – NHS Scotland Waiting Times Methodology has not been addressed. This related to Appendix 1 of Patient Access Policy which does not specifically refer to the NHS Scotland Waiting Times Monthly Audit Methodology. **Recommendation** Appendix 1 of Patient Access Policy should be updated to specifically refer to the NHS Scotland Waiting Times Monthly Audit Methodology and to include this as a further appendix.	Merits Attention	Head of Information Management	This minor alteration has been implemented in the Patient Access Policy.	The methodology is referred to in section 3.3.6 but is not included as an appendix as is required to address the recommendation
2019/20 Sub Total	**6**					
Total	**10**					

Meeting:	**Audit & Risk Committee**
Meeting date:	**19 January 2021**
Title:	**Internal Audit Framework**
Responsible Executive/Non-Executive:	**M McGurk, Director of Finance**
Report Author:	**T Gaskin, Chief Internal Auditor**

1 Purpose

This is presented to the Audit & Risk Committee for:

- **Decision**

This report relates to a:
- Legal requirement
- Local policy

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

2 Report summary

2.1 Situation

Internal Audit Charter

Public Sector Internal Audit Standards (PSIAS) state:

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

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

A fully revised Internal Audit Charter was approved by the Audit and Risk Committee in September 2019.

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

Specification for Internal Audit Services

FTF Audit provides the internal audit service 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 Tayside Director of Finance.

FTF Clients include:

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

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

The Specification for NHS Fife is shown as Appendix 2. Any amendments to the Service Specification must be considered and approved by the Partnership Board.

The Service Specification incorporates both the Audit Follow-up Protocol and the NHS Fife Internal Audit Reporting Protocol. The Reporting Protocol has been enhanced with the addition of a flowchart.

Material changes (not including grammatical changes) since the last iteration of the Service Specification are tracked on the document and summarised as follows:

Appendix 1 – FTF Audit Charter	No changes – The Internal Audit Charter format is will be reviewed on a 'Once for Scotland' basis. FTF have contributed to this process.
Appendix 2 – Specification for Internal Audit Services	• Contents page – inclusion of Reporting Protocol flowchart • Page 3, Paragraph 4.5 – date for Audit & Risk Committee approval of strategic plan changed from March to June. This change reflects that the update to the strategic risk register is not available until March and allows for yearend audit issues to be built into the next audit plan. Page 6, Paragraph 6.8 – updated to reflect importance of Internal Control Evaluation (ICE) • Page 11, Appendix 1 Internal Audit Specification – KPIs updated • Page 12, Appendix 2 & change at bottom of page 14 – Responding officers previously had 3 weeks to formally respond after draft report issued. This has been amended to 2 weeks. • Page 16 - addition of flowchart • Internal Audit Reporting Protocol – this is broadly in line with the previous version, with timings and targets updated, flowchart added . • Audit Follow Up Protocol - updated and enhanced to reflect current practice.

2.2 Background

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

2.3 Assessment

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

2.3.1 Quality/ Patient Care

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

2.3.2 Workforce

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

2.3.3 Financial

Any financial implications will be highlighted and progressed appropriately if required.

2.3.4 Risk Assessment/Management

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. Key risks are highlighted within the Summary of Audit Findings.

2.3.5 Equality and Diversity, including health inequalities

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

An impact assessment has not been completed because it is not applicable to the reporting of the internal audit framework.

2.3.6 Other impacts

N/A

2.3.7 Communication, involvement, engagement and consultation

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

2.3.8 Route to the Meeting

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

The Internal Audit Framework was approved by the FTF Partnership Board on 23 October 2020.

2.4 Recommendation

The Audit and Risk Committee is asked to:

- Note the NHS Fife Specification for Internal Audit Services
- Decision - Approve the Internal Audit Charter
- Decision - Approve the updated NHS Fife Internal Audit Reporting Protocol (Appendix 2 within Specification)
- Decision – Approve the updated NHS Fife Audit Follow Up Protocol (Appendix 3 within Specification)

3 List of appendices

The following appendices are included with this report:

- Appendix 1- FTF Audit Charter
- Appendix 2 - Specification for Internal Audit Services

Introduction

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

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

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

Purpose and responsibility

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

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

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

Independence and Objectivity

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

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

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

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

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

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

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

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

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

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

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

Authority and Accountability

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

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

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

The Audit and Risk Committee approves all Internal Audit Plans and may review any aspect of its work. The Audit and Risk Committee also has regular private meetings with the Chief Internal Auditor and its remit requires it to '*To ensure that there is direct contact between the*

Audit and Risk Committee and Internal Audit and to meet with the Chief Internal Auditor at least once per year and as required, without the presence of Executive Directors'.

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

Relationships

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

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

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

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

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

Standards, Ethics, and Performance

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

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

Scope

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

- Reviewing the reliability and integrity of financial and operating information and the means used to identify measure, classify, and report such information;
- Reviewing the systems established to ensure compliance with those policies, plans, procedures, laws, and regulations which could have a significant impact on operations, and reports on whether the organisation is in compliance;
- Reviewing the means of safeguarding assets and, as appropriate, verifying the existence of such assets;

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

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

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

Risk Management

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

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

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

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

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

Reporting arrangements including Key Performance Indicators

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

The Annual Audit Report should contain:

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

- ✧ *The Accountable Officer has implemented a governance framework in line with required guidance sufficient to discharge the responsibilities of this role;*
- ✧ *The Internal Audit Plan has been delivered in line with PSIAS*

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

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

Assurances provided to parties outside the organisation;

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

Approach

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

Access and Confidentiality

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

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

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

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

(d) Explanations concerning any matter under investigation.

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

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

Irregularities, Fraud & Corruption

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

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

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

Quality Assurance

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

The Chief Internal Auditor has established a quality assurance programme designed to give assurance through internal and external review that the work of Internal Audit is compliant with the Public Sector Internal Audit Standards and to achieve its objectives. A commentary on compliance against PSIAS and against agreed KPIs will be provided in the Annual Internal Audit Report.

Resolving Concerns

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

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

Review of the Internal Audit Charter

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

Date: January 2021

Date of next review January 2022.

Appendix 1

Mission and values

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

WORKING TOGETHER TO PROVIDE ASSURANCE AND ADD VALUE

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

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

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

APPENDIX 2

Specification for Internal Audit Services

APPENDIX 2

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1. Introduction

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

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

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

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

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

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

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

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

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

2. Internal Audit Responsibilities

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

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

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

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

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

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

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

3. Internal Audit Standards

3.1. Public Sector Internal Audit Standards (PSIAS)

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

4. Planning

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

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

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

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

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 and Risk Committee members and management, and be presented by the Chief Internal Auditor for formal approval by the Audit and Risk Committee by ~~31 March~~ 30 June. 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 and Risk Committee an Annual Audit Plan, which should reflect the audit coverage identified in the Strategic Audit Plan. Each Annual Audit Plan should cover the next twelve month period (May-April) and should be submitted to the Senior Management team and Audit and Risk Committee by no later than 30 June, subject to timely receipt of the appropriate risk assessment scoring template from the Client or by agreement with the Client. The Annual Audit Plan should set out the planned scope of audit work and should identify the critical areas to be covered and resources required in each project.

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 and Risk Committee

5. Managing Audit Work

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

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

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

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

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

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

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

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

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

6. Reporting

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

6.2. The aim of every internal report should be to:

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

6.3. In addition, Internal Audit should provide the Director of Finance and Audit and Risk Committee with regular reports on progress (see 6.9 below)

6.4. The Audit and Risk Committee should approve a formal follow-up protocol for ensuring that agreed Internal Audit recommendations have been actioned. This is incorporated as Appendix 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 and Risk Committee and the appointed external auditors. Except as required by law or as agreed within an approved output sharing protocol with IJB partners, documents should not be divulged to any other third party without the written express permission of the Director of Finance and/or Audit and Risk Committee.

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 and Risk Committee and Director of Finance. The reporting protocol shall be approved by the Audit and Risk Committee and incorporated as Appendix II to this document and shall include target timescales for issue and responding to Internal Audit reports.

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

6.8. **Annual Audit Reporting**

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

- An opinion on whether:
  - Based on the work undertaken, there were adequate and effective internal controls in place throughout the year
  - The Accountable Officer has implemented a governance framework in line with required guidance sufficient to discharge the responsibilities of this role
- The Internal Audit Plan has been delivered in line with PSIAS
- Analysis of any changes in control requirements during the year
- Comment on the key elements of the control environment
- Summary of performance against this service specification
- Progress in delivering the Quality Assurance Improvement Programme.

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

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

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 and Risk Committee in a format agreed with the Client.

7. Quality Control and Quality Measurements

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

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

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

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

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 and Risk Committee within the Annual Internal Audit Report.

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

8. Liaison with External Audit

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

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

9. Best Value Reviews

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

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

10. Suspected Criminal Offences

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

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

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

Appendix II

INTERNAL AUDIT SPECIFICATION

INTERNAL AUDIT REPORTING PROTOCOL & FLOWCHART

To be approved at the 19 January 2021 Audit and Risk Committee meeting – this protocol has been substantially updated and enhanced to reflect current working practices

1. The timings for each stage are detailed in the table below.

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

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

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

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

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

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

8. The Directorate response the draft report is then issued to the Director of Finance for clearance and copied to the Responding Officer and Responsible Director so that they can confirm that their response has been recorded accurately.

9. Following clearance by the Director of Finance the final report is formally issued by Internal Audit to all officers on the distribution list, including External Audit.

10. Audit and Risk Committee members receive the Internal Audit reports as they are

finalised by the Office Manager and a summary is provided as an appendix to the progress report issued by the Regional Audit Manager for the next Audit and Risk Committee.

11. The recommendations will be added to the AFU System by Internal Audit and progress reported to the Audit and Risk Committee.

12. All final audit reports may be presented to the Executive Directors Group, relevant Standing Committee and, where appropriate, the Health & Social Care Partnership Audit and Risk Committee.

Dispute resolution

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

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

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

Flowchart

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

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

Appendix III

INTERNAL AUDIT SPECIFICATION

FOLLOW-UP OF AGREED INTERNAL AUDIT RECOMMENDATIONS

To be approved at the 19 January 2021 Audit and Risk Committee meeting – this protocol has been substantially updated and enhanced to reflect current working practices

Protocol agreed by Client Audit and Risk Committee:

NHS FIFE

FOLLOW-UP PROTOCOL ON INTERNAL AND EXTERNAL AUDIT REPORT ACTION PLANS

1. INTRODUCTION

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As Accountable Officer, the Chief Executive is ultimately responsible for ensuring that the organisation has effective management systems in place to safeguard public funds. Good practice guidance, as laid out in the Audit and Assurance Committee Handbook, emphasises the importance of follow up processes to ensure that the actions agreed by management to address control weaknesses identified by the work of Internal and External Audit are actually implemented.

2. MANAGEMENT FOLLOW-UP ON INTERNAL AUDIT REPORTS

- Internal Audit will follow up all agreed audit action points arising from Internal Audit reports. Internal audit will only review progress against external audit recommendations where relevant to internal audit fieldwork
- Once an action point falls due, the Responsible Officer (the officer noted in the Internal Audit Action Plan as responsible for implementing the agreed action) will provide Internal Audit with an update on the current status of the action point, indicating whether it has been completed or not and, if not completed, provide a reason for the outstanding element, together with a revised due date for completion of the entire action point.
- Actions classified by Responsible Officers as no longer relevant, or where an extension of the due date is requested, will require evidence to support to request. . Internal audit will conclude on whether these are reasonable.
- The Responding Officer will also provide supporting evidence to demonstrate that the required action has been taken and that it has been effective. Internal Audit will review in detail any responses which do not appear adequate to address the control weakness identified in the original report, or where the evidence does not fully support the conclusion drawn.

- Where significant inaction by a Responsible Officer is apparent and intervention is required, the internal audit will discuss this with the relevant Director/Senior Manager. Where the matter cannot be resolved in this way, it will be escalated to the Director of Finance and, ultimately, the Chief Executive.
- After each Audit and Risk Committee meeting where an Audit Follow Up report has been presented, the report will also be taken to the Executive Directors Group to allow consideration of any long outstanding responses, repeated extensions to due by dates, actions not completed and those which did not fully address the identified control weakness, either because of the content or the accuracy of the response.
- Internal Audit will be responsible for presenting regular reports on follow-up to each Audit and Risk Committee. These reports will contain a graphical representation of progress towards implementation of all internal audit recommendations, detail progress on all outstanding recommendations.
- The report will detail the most recent position on summary of progress, detailed action status by report, reasons for extensions granted, outstanding recommendations and Internal Audit validation.

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2.1 A database is maintained by Internal Audit of agreed management action listing the :

- Individual findings, recommendations and management responses arising from each Action Plan;
- Level of priority given to each recommendation;
- Dates by which the actions are due to be completed;
- Responsible Officer for each recommendation;
- Evidence of completion or updates on progress; and,
- Details or requests for extensions to action by dates
- Validation assessment by Internal Audit.

3. FOLLOW-UP OF EXTERNAL AUDIT REPORTS

3.1 The follow up of External Audit reports remains the responsibility of the Director of Finance. Audit Scotland reports are far fewer in number and generally speaking will identify a Director as being responsible for the action to be taken.

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

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

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

BARRY HUDSON
Regional Audit Manager

DATE OF ISSUE: December 2020

REVIEW DATE: December 2021

Appendix IV

INTERNAL AUDIT SPECIFICATION
AUDIT SERVICE

STAFFING SKILL MIX

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

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

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

Appendix V

INTERNAL AUDIT SPECIFICATION
AUDIT SERVICE

PUBLIC SECTOR INTERNAL AUDIT STANDARDS

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

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**19 January 2021**
Title:	**Update on NHS Fife Board Assurance Framework**
Responsible Executive:	**Helen Buchanan, Director of Nursing**
Report Author:	**Pauline Cumming, Risk Manager**

1 Purpose

This is presented to the Committee for:

- Information

This report relates to a:

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

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Board Assurance Framework (BAF) identifies risks to the delivery of NHS Fife's strategic objectives and priorities, including the NHS Fife Strategic Framework, the NHS Fife Clinical Strategy and the Fife Health & Social Care Integration Strategic Plan. The BAF integrates information on strategic risks, related operational risks, controls, assurances, mitigating actions and an assessment of current performance. This report is an update on the last report to the Committee on 13 July 2020.The Committee is asked to note the BAF.

2.2 Background

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

2.3 Assessment

The BAF currently has 7 components.

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

The risk levels and ratings are summarised in Table 1.

Table 1 - Risk Level and Rating over time

Risk ID	Risk Title	Initial Risk Level & Rating LxC	Likelihood (L)	Consequence (C)	Current Level & Rating April / May 2020	Current Level & Rating June / Jul 2020	Current Level & Rating Aug/Sept 2020	Current Level & Rating Oct/ Nov 2020
1413	**Financial Sustainability**	High 16	Likely 4	Major 4	16 (4x 4) High	16 (4x 4) High	16 (4x 4) High	16 (4x 4) High
1414	**Environmental Sustainability**	High 20	Likely 4	Extreme 5	20 (4x 5) High	20 (4x 5) High	20 (4x 5) High	20 (4x 5) High
1415	**Workforce Sustainability**	High 20	Almost certain 5	Major 4	16 (4x 4) High	16 (4x 4) High	16 (4x 4) High	16 (4x 4) High
1416	**Quality& Safety**	High 20	Likely 4	Extreme 5	15 (3x 5) High	15 (3x 5) High	15 (3x 5) High	15 (3x 5) High
1417	**Strategic Planning**	High 16	Likely 4	Major 4	16 (4 x 4) High	16 (4 x 4) High	16 (4 x 4) High	16 (4 x 4) High
1418	**Integration Joint Board**	High 16	Likely 4	Major 4	12 (3 x 4) Mod	12 (3 x 4) Mod	12 (3x4)) Mod	12 (3x4)) Mod
1683	**eHealth - Delivering Digital and Information Governance & Security**	High 20	Possible 3	Major 5	N/A	N/A	15 (3x5) High	15 (3x5) High

Since the last report to the Committee, the BAF risks, with the exception of Quality & Safety, were considered at the appropriate committees in September 2020 and during the October / November 2020 reporting cycle. This update summarises the key points from the most recent reports to the committees. The BAF details are provided separately in appendices. Content in this paper and appendices was previously reported to Fife NHS Board on 25 November 2020.

Key points

Financial Sustainability BAF

The Director of Finance reported on the BAF to the Finance, Performance & Resources (F,P&R) Committee on 10 November 2020. At that point, the BAF current score remained High, with the target score remaining Moderate. The score recognised the ongoing financial challenges facing Acute Services in particular, as well as the pressures within the Health & Social Care Partnership,

specifically in relation to social care budgets and the ongoing work to review the risk share arrangement. It also reflected the level of challenge and uncertainty associated with the mobilisation and remobilisation activity in relation to COVID -19 and the challenge in delivering the Board efficiency savings target as a consequence of the pandemic's impact. Since the last report to the Committee, the previously high linked risk relating to Test and Protect reduced its risk level to moderate and is no longer on the BAF.

Environmental Sustainability BAF
The Director of Estates, Facilities and Capital Services reported on the BAF to the F, P&R Committee on 10 November 2020. There had been no change to the status of this risk. Both PFI providers at St Andrews and the VHK continue with the flexible hose replacement programme.

Workforce Sustainability BAF
The Director of Workforce reported to the Staff Governance (SG) Committee on 29 October 2020 that there were no significant changes to the BAF, with risks remaining relating to the National Shortage of Radiologists, and Medical Staff Recruitment and Retention. Since the last report to the Committee, 2 previously high linked risks, one relating to Test and Protect, and the other to Workload resulting from deterioration in mental health, reduced their risk levels to moderate and are no longer linked to the BAF.

Assurance was given that NHS Fife has the systems and processes in place to ensure the right composition of the workforce, with the right skills and competencies deployed in the right place at the right time.

Quality & Safety BAF
The Medical Director reported on the BAF to the Clinical Governance Committee (CGC) on 4 November 2020. Following review, there has been no change to the overarching BAF risk or linked operational risks. The risk level remained high. He provided assurance that there are systems and processes in place to monitor quality and safety, and that work relating to managing the risks continues.

Strategic Planning BAF
The Medical Director reported on the above risk to the CGC on 4 November 2020 and to F, P&R on 10 November 2020.The current risk level remained high. It was reported that the Integrated Transformation Board (ITB) established in 2019, continues to provide strategic oversight of all of the NHS Fife, Fife IJB and Fife Council health transformation programmes.

A full review of the Transformation Programme and Strategic Planning has been undertaken in line with the Clinical Strategy and Remobilisation Plan. The remobilisation of services after phase 1 of COVID -19, identified lessons learned, including service redesign and transformation delivered at pace during the mobilisation phase. Due to the COVID-19 Emergency Planning Measures in place until 31 March 2021, the transformation work has been paused but will recommence when appropriate to do so.

eHealth - Delivering Digital and Information Governance & Security
The Medical Director reported on the above risk to the CGC on 4 November 2020. The risk remained high. Since the last report to the Committee, seven new high risks have been linked to the BAF:

- Lack of a central IT location to store guidance documents
- Risk of not meeting Software as a Medical Device (SaMD) full compliance
- Deliberate unauthorised access or misuse to email by insiders(staff, contractors etc
- Deliberate unauthorised access or misuse to email by outsiders Hackers etc
- Inability to audit nhs.scot mail accounts
- User error (including those supporting system) resulting in data breach
- Network connection failures

The Committee was assured that systems and processes are in place to monitor D&I performance, and work continues to manage the risks. This BAF is being reviewed as part of the assurance mapping process outlined below.

Integration Joint Board (IJB)
The last report to the Committee indicated that a review of the Integration Scheme had recommenced which was to include clarifying the delegation of functions to the IJB and specifically, the implications for risk management, governance and assurance. Considerable work is ongoing to support conclusion of the review. There is no change to the risk score at this time..

Developments
The risk mapping work reported previously to the Committee is ongoing. Following a pause to focus resources on the pandemic effort, the exercise to test the application of assurance mapping principles to the Digital & Information BAF has resumed and is currently being taken forward by the Risk Manager with Digital and Information, and Internal Audit colleagues.

Learning from this exercise will inform the approach taken to applying these principles to the development of the BAF specifically, and to strengthening our overall systems for internal control and assurance. Following the approval of the updated Risk Management Framework, and in light of COVID -19 and other challenges, work has started to review the Board's overall risk profile.

In the first instance, the Risk Manager has met Executive Directors to take forward this work; the initial focus has been on making connections between risks and the delivery of objectives, the appropriateness of risk coverage, the effectiveness of controls and supporting evidence, and the validity of risk scores. The meetings have provided an opportunity to introduce the principles cited above, which when embedded, will increase the level of assurance and confidence that can be taken from the BAF and other risk management reports.

2.3.1 Quality/ Patient Care

Risks to quality and safety are detailed in Appendix 4.

2.3.2 Workforce

Risks to workforce sustainability are detailed in Appendix 3.

2.3.3 Financial

Risks to financial sustainability risks are detailed in Appendix 1.

2.3.4 Risk Assessment/Management

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

2.3.5 Equality and Diversity, including health inequalities

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

2.3.6 Other impact

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

2.3.7 Communication, involvement, engagement and consultation

This report and the appendices reflect the iterative process involving Executive Directors, their teams, Non Executives and other stakeholders.

2.3.8 Route to the Meeting

Helen Buchanan, Director of Nursing & Deputy Chief Executive on 29 December 2020 and EDG on 7 January 2021.

2.4 Recommendation

The paper is presented for noting.

3 List of appendices

The following appendices are included with this report:

- Appendix 1, NHS Fife BAF Financial Sustainability - F,P& RC 101120
- Appendix 2, NHS Fife BAF Environmental Sustainability – F,P& RC 101120
- Appendix 3, NHS Fife BAF Workforce Sustainability - SGC 291020
- Appendix 4, NHS Fife BAF Quality & Safety - CGC 041120
- Appendix 5, NHS Fife BAF Strategic Planning - CGC 041120 & F,P&R 101120
- Appendix 6, NHS Fife BAF Integration Joint Board (IJB)
- Appendix 7, NHS Fife BAF e Health Delivering Digital and Information Governance & Security - CGC 041120

Report Contact
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NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	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	31.10.2020	30.11.2020	There is a risk that the funding required to deliver the current and anticipated future service models will exceed the funding available. Thereafter there is a risk that failure to implement, monitor and review an effective financial planning, management and performance framework would result in the Board being unable to deliver on its required financial targets.	4 - Likely - Strong possibility this could occur	4 - Major	16	High	4 - Likely - Strong possibility this could occur	4 - Major	16	High	Current financial climate across NHS/public sector. This risk must now be considered in the context of managing the financial impact of the COVID 19 pandemic.	Director of Finance	Finance, Performance & Resources (F,P&R) Chair: Rona Laing	*Ongoing actions designed to mitigate the risk including:* 1. Ensure budgets are devolved to an appropriate level aligned to management responsibilities and accountabilities. This includes the allocation of any financial plan shortfall to all budget areas. This seeks to ensure all budget holders are sighted on their responsibility to contribute to the overall requirement to deliver breakeven. 2. Refreshed approach established for a system-wide Transformation programme to support redesign; reduce unwarranted variation and waste; and to implement detailed efficiency initiatives. Lessons will be learned from the successes of the medicines efficiency programme in terms of the system-wide approach and use of evidence based, data-driven analysis 3. Engage with external advisors as required (e.g. property advisors) to support specific aspects of work. In addition, appoint external support to accelerate a programme of cost improvement across Acute Services.	Nil	1. Continue a relentless pursuit of all opportunities identified through the transformation programme in the context of sustainability & value. 2. Continue to maintain an active overview of national funding streams to ensure all NHS Fife receives a share of all possible allocations. 3. Continue to scrutinise and review any potential financial flexibility. 4. Engage with H&SC / Council colleagues on the risk share methodology and in particular ensure that EDG, FP&R and the Board are appropriately advised on the options available to manage any overspend within the IJB *prior* to the application of the risk share arrangement	Director of Finance / Chief Operating Officer / Director of Health & Social Care Director of Finance	Ongoing Ongoing	1. Produce monthly reports capturing and monitoring progress against financial targets and efficiency savings for scrutiny by all responsible managers and those charged with governance and delivery. 2. Undertake regular monitoring of expenditure levels through managers, Executive Directors' Group (EDG), Finance, Performance & Resources (F,P&R) Committee and Board. As this will be done in parallel with the wider Integrated Performance Reporting approach, this will take cognisance of activity and operational performance against the financial performance.	1. Internal audit reviews on controls and process; including Departmental reviews . 2. External audit review of year end accounts and governance framework.	1. Enhanced reporting on various metrics in relation to supplementary staffing. 2. Confirmation via the Director of Health & Social Care on the robustness of the social care forecasts and the likely outturn at year end	The response to the COVID 19 pandemic required the organisation to focus all our efforts initially on mobilising the response plan and then on remobilising services, the next challenge will be winter and the potential second COVID 19 peak. The financial impact of COVID 19 is significant however we have now received full funding for 2020/21 Q1 addtional costs and 70% of the forecast costs to the year-end. There is a signficant challenge remaining however regarding undelivered savings as as a consequence of COVID 19 and the IJB Risk-Share arrangement.	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 McGurk
1364	Efficiency Savings - failure to identify level of savings to achieve financial balance	High 20	M McGurk
1513	Financial and Economic impact of Brexit	High 20	M McGurk
1784	Finance (Short Term/Immediate)	High 16	N Connor

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 12	Dr C McKenna
1357	Financial Planning, Management & Performance	No longer a high risk	Moderate 12	M McGurk
1846	Test and Protect	No longer a high risk	Moderate 9	N Connor

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	18.08.2020	18.11.2020	There is a risk that Environmental & Sustainability legislation is breached which impacts negatively on the safety and health of patients, staff and the public and the organisation's reputation.	4 - Likely - Strong possibility this could occur	5 - Extreme	20	High	4 - Likely - Strong possibility this could occur	5 - Extreme	20	High	Estates currently have significant high risks on the E&F risk register; until these have been eradicated this risk will remain. Action plans have been prepared and assuming capital is available these will be reduced in the near future.	Director of Estates, Facilities & Capital Services (E,F &CS)	Finance, Performance & Resources (F,P&R) Chair: Rona Laing	*Ongoing actions designed to mitigate the risk including:* 1. Operational Planned Preventative Maintenance (PPM) systems in place 2. Systems in place to comply with NHS Estates 3. Action plans have been prepared for the risks on the estates & facilities risk register. These are reviewed and updated at the monthly risk management meetings. The highest risks are prioritised and allocated the appropriate capital funding. 4. The SCART (Statutory Compliance Audit & Risk Tool) and EAMS (Estates Asset Management System) systems record and track estates & facilities compliance. 5. Sustainability Group manages environmental issues and Carbon Reduction Commitment(CRC) process is audited annually. 6. Externally appointed Authorising Engineers carry out audits for all of the major services i.e. water safety, electrical systems, pressure systems, decontamination and so on.	Nil	1. Capital funding is allocated depending on the E&F risks rating 2. Increase number of site audits	Director of Estates, Facilities & Capital Services Estates Quality Manager	Ongoing as limited funding available Ongoing	1. Capital Investment delivered in line with budgets 2. Sustainability Group minutes. 3. Estates & Facilities risk registers. 4. SCART & EAMS 5. Adverse Event reports	1. Internal audits 2. External audits by Authorising Engineers 3. Peer reviews	None	High risks still exist until remedial works have been undertaken, but action plans and processes are in place to mitigate these risks.	1 - Remote - Can't believe this event would happen	5 - Extreme	5	Low	All estates & facilities risk can be eradicated with the appropriate resources but there will always be a potential for failure i.e. component failure or human error hence the target figure of 5.

Linked Operational Risk(s)

Risk ID	Risk Title		Current Risk Rating	Risk Owner
1296	Emergency Evacuation - VHK- Phase 2 Tower Block		High 20	A Fairgrieve
1007	Theatre Phase 2 Remedial work		High 15	M Cross
1252	Flexible PEX hoses Phase 3 VHK - Legionella Risk		High 15	A Fairgrieve

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Reason for unlinking from BAF	Current Risk Rating	Risk Owner
735	Medical Equipment Register	Risk Closed		
749	VHK Phase 2 - Main Foul Drainage Tower Block	Risk Closed		
1083	VHK CL O2 Generator - Legionella Control	Risk Closed		
1207	Water system Contamination STACH	No longer high risk	Moderate 10	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
1306	Risk of pigeon guano on VHK Ph2 Tower Windows	No longer high risk	Moderate 12	D Lowe
1312	Vertical Evacuation - VHK Phase 2 Tower Block	Risk Closed		
1314	Inadequate Compartmentation - VHK - Escape Stairs and Lift Enclosures	Risk Closed		
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 8	A Fairgrieve
1335	Fife College of Nursing - Fire alarm potential failure	Risk Closed		
1341	Oil storage - risk of SEPA prosecution/ HSE enforcement due to potential leak/ contamination/ non compliant tanks	No longer high risk	Moderate 10	G Keatings
1342	Oil Storage - Fuel Tanks	No longer high risk	Moderate 10	J Wishart
1352	Pinpoint malfunction	Risk Closed		
1384	Microbiologist Vacancy	Risk Closed		
1473	Stratheden Hospital Fire Alarm System	Risk Closed		

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	**25.08.2020**	**05.03.2021**	There is a risk that failure to ensure the right composition of workforce, with the right skills and competencies deployed in the right place at the right time will adversely affect the provision of services and quality patient care and impact on organisational capability to implement the new clinical and care models and service delivery set out in the Clinical Strategy	5 - Almost Certain - Expected to occur frequently - more likely than not	4 - Major	20	High	4 - Likely - Strong possibility this could occur	4 - Major	16	High	Failure in this area has a direct impact on patients' health. NHS Fife has an ageing workforce with recruitment challenges in key specialities. Failure to ensure the right composition of workforce with the right skills and competencies gives rise to a number of organisational risks including: reputational and financial risk; a potential adverse impact on the safety and quality of care provision; and staff engagement and morale. Failure would also adversely impact on the implementation of the Clinical strategy. The current score reflects the existing controls and mitigating actions in place.	Director of Workforce/ Partnership	Staff Governance Chair: Margaret Wells	*Ongoing actions designed to mitigate the risk including:* 1. • Implementation of the Workforce Strategy 2019 - 2022, to support the Clinical Strategy and Strategic Framework. 2. • Implementation of the Health & Social Care Workforce Strategy to support the Health & Social Care Strategic Plan for 2019 - 2022. 3. • Implementation of the NHS Fife Strategic Framework particularly the "exemplar employer"	Nil	Implementation of the Workforce Strategy and associated action planning to support the Clinical Strategy and Strategic Framework. Actions are currently being reviewed with a view to updating priorities following the impact of COVID-19.	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. • The Brexit Assurance Group which was established to consider the impact on the workforce with regard to these arrangements once they are known has been disbanded, however, organisational support is still being provided and publicised. 5. An Assurance Group has also been established which will link to existing resilience planning arrangements - now disbanded but as above. 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 revised approach to nurse recruitment has been taken this year, enabling student nurses already in the system to remain in post at point of registration, to maintain service delivery. 8 •Work continues to strengthen the control and monitoring associated with supplementary staffing to identify and implement solutions that may reduce the requirement and costs associated with supplementary staffing. NHS Fife currently have a COVID-19 supplementary staffing resource to be deployed to support the substantive workforce where the need is greater thereby reducing any external costs on staffing. 9. • NHS Fife participation in regional and national groups to address national and recruitment challenges and specific key group shortage areas, e.g. South East Region Transformation Programme Board and International Recruitment. 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. The Director of Workforce has now convened a Strategic Workforce Planning Group which will be complemented by an Operational Worforce Planning Group.													
																11. • NHS Fife Promoting Attendance Group and local divisional groups established to drive a range of initiatives and improvements aligned to staff health and wellbeing activity, 12. • Well@Work initiatives continue to support the health and wellbeing of the	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. Lessons to be													
																13. • The iMatter 2020 cycle has been paused during the Covid-19 pandemic. Staff engagement activity is being evaluated to reflect the impact of the pandemic.	Nil	Optimise use of iMatter process and data to improve staff engagement and retention. As agreed Nationally, a Pulse Survey will be run instead of iMatter in September 2020, Directorate and Board													
																14. • Staff Governance and Partnership working underpins all aspects of workforce activity within NHS Fife and is key to development of the workforce. 15. • Training and Development	Nil	Continue to implement and promote Staff Governance Action plans and staff engagement													
																16. • Development of the Learning and Development Framework strand of the Workforce Strategy 17. • Leadership and management development provision is constantly under review and updated as appropriate to ensure continuing relevance to support leaders at all levels	Nil	Implementation of the Learning and Development Framework strand of the Workforce Strategy. Increased utilisation of virtual learning opportunities.	Director of Workforce/Partnership													
																18. • Improvement to be made in Core Skills compliance to ensure NHS Fife meets its statutory obligations	Nil	Review of L&D processes , planning and resources to ensure alignment to priorities													
																19. • The implementation of the Learning Management System module of eESS to ensure all training and development data is held and to facilitate reporting and analysis	Nil	Full roll out of learning management self service													
																20. • Continue to address the risk of non compliance with Staff Governance Standard and HEAT standard requirements relating to TURAS Appraisal.	Nil	Continuing implementation of the KSF Improvement and Recovery Plan													
																21. • Utilisation of the Staff Governance Standard and Staff Governance Action Plans (the "Appropriately trained" strand) is utilised to identify local priorities and drive local actions	Nil													
																22. • The development of close working relationships with L&D colleagues in neighbouring Boards, with NES and Fife Council to optimise synergistic benefits from collaborative working	Nil		Director of Workforce												

Linked Operational Risk(s)

Risk ID	Risk Title	Current Risk Rating	Risk Owner
90	National shortage of radiologists	High 16	J Anderson
1324	Medical Staff Recruitment	High 16	J Kennedy

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Reason for unlinking from BAF	Current Risk Rating	Risk Owner
503	Lack of capacity in Podiatry Service unable to meet SIGN/ NICE Guidelines	Risk Closed		
1042	Staffing levels Community Services East unable to meet staffing establishment	No longer high risk	Moderate 12	K Nolan
1349	Service provision- GP locums may no longer wish to work for NHS Fife salaried practices	Risk Closed		
1353	Medical Cover- Community Services West- expected shortfalls on nurse staffing and GP cover	Risk Closed		
1375	Breast Radiology Service	No longer high risk	Moderate 12	M Cross
1420	Loss of consultants	No longer high risk	Moderate 12	H Bett
1846	Test and Protect	No longer high risk	Moderate 9	N Connor
1858	Longevity of current situation and impact	Risk Closed		

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Responsible Person	Timescale	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Quality & Safety																													
1416	Person Centred, Clinically Excellent	02.11.2020	14.01.2021	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 - Extreme	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: Implementation of: 1. Strategic Framework 2. Clinical Strategy 3. Clinical Governance Structures and operational governance arrangements 4. Clinical & Care Governance Strategy 5. Participation & Engagement Strategy 6. Risk Management Framework 7. Governance arrangements established to support delivery of the UK Coronavirus (COVID-19) action plan 8.Processes established for reporting and escalation of COVID-19 related incidents & risks 9. Remobilisation plan for clinical services These are supported by the following: 10. Risk Registers 11. Integrated Performance and Quality Report (IPQR), Performance reports dashboard data 12. Performance Reviews 13. Adverse Events Policy 14. Scottish Patient Safety Programme 15. Implementation of SIGN and other evidence based guidance 16. Staff Learning & Development 17.System of governance arrangements for all clinical policies and procedures 18. Participation in relevant national and local audit 19.Complaints handling process 20.Using data to enhance quality control 21.HIS Quality of Care Approach & Framework,Sept 2018 22. Implementing Organisational Duty of Candour legislation 23.Adverse event management process 24.Sharing of learning summaries from adverse event reviews 25.Implementing Excellence in Care 26. Using Patient Opinion feedback 27.Acting on recommendations from internal & external agencies	1.Reviewing together of patient experience, complaints, adverse events and risk information to provide an overview of good practice, themes, trends,and exceptions to the norm. 2.Weaknesses in the process for recording completion of actions from adverse event reviews incl evidence of steps taken to implement and share learning from actions . 3.Weaknesses in related oversight and monitoring processes. 4.Risk Management Framework requires update.	1. Give due consideration to how to balance the remobilisation of clinical services and manage staff and public expectations, while dealing with the ongoing COVID-19 pandemic. 2.Continually review the Integrated Performance and Quality (IPQR) to ensure they provide an accurate, current picture of clinical quality / performance in priority areas . 3. Refresh the extant Clinical Governance structures and arrangements to ensure these are current and fit for purpose. 4..Review the coverage of mortality & morbidity meetings in line with national developments and HIS workshop on 09/12/19. 5.Review and refresh the current content and delivery models for key areas of training and development e.g. corporate induction, in house core, quality improvement, leadership development, clinical skills, interspecialty programmes. 6.Review annually, all technology & IT systems that support clinical governance e.g. Datix, Formic Fusion Pro, Clinical Effectiveness Register. 7. Establish a short life working group to begin to assess our position against the Quality of Care Framework and understand our state of readiness. 8.Further develop the culture of person centred approach to care. 9. Only Executive commissioning of reviews as appropriate e.g.	Medical Director	31.12.2020	1. Assurance statements from clinical & clinical & care governance groups and committees. 2. Assurances obtained from all groups and committees that: i. they have a workplan ii.all elements of the work plan are addressed in year 3. Annual Assurance Statement 4. Annual NHS Fife CGC Self assessment 5. Reporting bi annually on adequacy of systems & processes to Audit & Risk Committee 6. Accreditation systems e.g.. Unicef - Accredited Baby Friendly Gold. UKAS Inspection for Labs. 7.External agency reports e.g. GMC 8..Quality of Care review	1. Internal Audit reviews and reports 2. External Audit reviews 3. HIS visits and reviews 4. Healthcare Environment Inspectorate (HEI) visits and reports 5. Health Protection Scotland (HPS) support 6. Health & Safety Executive 7. Scottish Patient Safety Programme (SPSP) visits and reviews 8. Scottish Govt DoC Annual Report 9.Scottish Public Service Ombudsman (SPSO) 10. Patient Opinion 11. Specific National reporting	1.Key performance indicators relating to corporate objectives e.g. person centred, clinically excellent, exemplar employer & sustainable. 2.We require additional assurances that there is a system in place for oversight of actions from a variety of sources e.g. audit, adverse events, SPSO. 3.We require additional assurances that there are systems in place for oversight of operational risks.	Overall, NHS Fife has in place sound systems of clinical governance and risk management as evidenced by Internal Audit and External Audit reports and the Statement of Annual Assurance to the Board.	2 - Unlikely	5 - Extreme	10	Moderate	The organisation can identify the actions required to strengthen the systems and processes to reduce the risk level.

Linked Operational Risk(s)

Risk ID	Risk Title	Current Risk Rating	Risk Owner
1667	Infusion pumps, volumisers and Syringe Divers in Paediatrics and Neonatal Units	High 25	Lynne Holloway
1652	Lack of Medical Capacity in Community Paediatric Service	High 25	Gemma Couser
1296	Emergency Evacuation - VHK- Phase 2 Tower Block	High 20	Andrew Fairgrieve
1514	Impact of the UK's withdrawal from the EU on the availability and cost of medicines and medical devices	High 20	Scott Garden
43	Vascular access for haematology/Oncology	High 20	Shirley-Anne Savage
521	Capacity Planning	High 16	Miriam Watts
529	Information Security	High 16	Margo McGurk
1287	Overcapacity in AU1 Assessment Unit	High 16	Angie Shepherd
1365	Cancer Waiting Times Access Standards	High 15	Gemma Couser
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	Jane Anderson
1670	Temperature within fluid storage room within critical care	High 15	Miriam Watts

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Reason for unlinking from BAF	Current Risk Rating	Risk Owner
356	Clinical Pharmacy Input	Closed Risk		
528	Pandemic Flu Planning	No longer a high risk	Moderate 12	Dona Milne
637	SABHEAT Target	No longer a high risk	Moderate 9	Julia Cook
1297	Obsolete Equipment In Use – No Replacement Plan In Place (Graseby 3000 Series)	Closed Risk		
1366	T34 syringe drivers in the Acute Division	Closed Risk		
1502	3D Temperature Monitoring System (South Lab)	Closed Risk		
1524	Oxygen Driven Suction	Closed Risk		

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Responsible Person	Timescale	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Strategic Planning																													
1417	Person Centred, Clinically Excellent, Exemplar Employer, Sustainable	29.10.2020	01.01.2021	There is a risk that NHS Fife will not deliver the recommendations made by the Clinical Strategy within a timeframe that supports the service transformation and redesign required to ensure service sustainability, quality and safety at lower cost. **Key Risks** 1. Community/Mental Health redesign is the responsibility of the H&SCP/IJB which hold	4 - Likely - Strong possibility this could occur	4 - Major	16	High	4 - Likely - Strong possibility this could occur	4 - Major	16	High	Integrated Transformation Board has been in place after the review of transformation in 2019. Following period of COVID-19, transformation planning is being revised and new structure being put in place following transformation workshop planned for 3 September 2020. New programme management approach	Chief Executive	Clinical Governance	*Ongoing actions designed to mitigate the risk including:* 1. Establishment of Integrated Transformation Board (ITB) in 2019 to oversee transformation programmes across NHS Fife, Fife IJB and Fife Council to drive the delivery of the H&SC Strategic Plan and the Clinical Strategy. 2. Establishment of programme management framework with a stage and gate approach. 3. 3 of the 4 key strategic priorities are being taken forward by the H&SCP/IJB. The remaining priority is being taken forward by Acute services and progress shared through regular highlight reports. Programme Boards provide oversight and	JSTG not performing role adequately and replaced by the newly formed Integrated Transformation Board. but transformation programmes being progressed.	Leadership to strategic planning coming from the Executive Directors Group. Clinical Strategy workstream update has been produced to reflect progress against recommendations. Establishment of ITB should provide assurance to the committees and Board that the transformation programme has strategic oversight and delivery. Senior Leadership for Transformation is being reviewed and revised .	Chief Executive	31.03.2021	1. Minutes of meetings record attendance, agenda and outcomes. 2. New governance in place with newly formed Integrated Transformation Group meeting every 6 weeks. 3. Performance and Accountability Reviews now underway which will provide assurance to committees on performance of all	1. Internal Audit Report on Strategic Planning (no. B10/17) 2. SEAT Annual Report 2016 3.Governance committee oversight of performance assurance framework	Business cases have been developed in support of the transformation programmes which address issues such as resource implications, workforce and facilities redesign. Standardised documentation will introduce a consistent	Current challenges associated with delivery of our strategic objectives include the focus on the 4 strategic priorities (Acute Transformation, Joining Up Care, Mental Health Redesign and Medicines Efficiencies), the interdependencies of workplans (NHS Fife/H&SCP/ Region) in terms of the whole system oversight of operational plans, delivery measures and	Possible - May occur occasionally - reasonable char	4 - Major	12	Moderate	Once governance and monitoring is in place and transformation programmes are being realised, the risk level should reduce. WILL BE REVIEWED AFTER COVID19 PERIOD

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
Integration Joint Board																													
1418	Sustainable	31.01.2020	31.03.2020	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 reviewed its Integration Scheme in March 2018 to reflect the implementation of the Carers (Scotland) Act 2016 as required by the Scottish Government. 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 was approved in June 2018. The IJB Code of Corporate Governance forms part of a consolidated governance framework, including an action plan and assurance map. This will ensure all risks, responsibilities and other appropriate matters are understood by all parties and considered effectively for ongoing assurance and the annual Governance Statement. 4. A Governance Manual, bringing all relevant governance information in to one reference document for all IJB members and officers is currently being finalised. 5. Key recommendations and proposals from the Audit Scotland report of November 2018 and the Ministerial Strategic Group review of February 2019 were considered by the IJB and its partners. An integration stocktake self assessment was submitted to the Scottish Government in May. Subsequently an action plan was produced to drive forward changes. This was submitted to the Scottish Government in August 2019. The Action plan sets out actions to improve governance arrangements including initiation of discussions with partners to provide further clarity on the Integration Scheme. The action plan covers the period to July 2020 6. A group, including representatives from NHS Fife, Fife Council and the HSCP, has been set up to review the Integration Scheme. This review will focus on governance arrangements and take into account the actions from the Ministerial Strategic Group action plan and also the Scottish Government's Model Scheme for Integration. The review is now in progress with agreed timescales. Following the review of the Integration Scheme the IJB will undertake a further review of its Governance Framework and structures. 7. A development session for officers and IJB members was held in Nov 2019. This was facilitated by David Williams, Director of Delivery, Health and Social Care Integration, Scottish Government and focussed on Governance. Further development sessions will be planned in 2020	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.

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
eHealth - Delivering Digital and Information Governance & Security																													
	Person Centred, Clinically Excellent, An Exemplar Employee, Sustainable	**16.10.2020**	**16.02.2021**	There is a risk that due to failure of Technical Infrastructure, Internal & External Security, Organisational Digital Readiness, ability to reduce Skills Dilution within eHealth and ability to derive Maximum Benefit from Digital Provision, NHS Fife may be unable to provide safe, effective, person centred care.	4 - Likely - Strong possibility this could occur	5 - Extreme	20	High	3 - Possible	5 -Extreme	15	High	Failure in this area could have a direct impact on patients care, organisational reputation and exposure to legal action. While it is recognised that several adverse events ranging from minor to extreme can occur daily, the proportion of these in relation to overall activity is very small and reporting to competent authorities is minimal.	Medical Director & SIRO	Clinical Governance - Chair: Dr Les Bisset FP&R - Chair: Rona Laing	*Ongoing actions designed to mitigate the risk including:* 1. Implementation of the NHS Fife Strategic Framework and Clinical Strategy 2. Operational Governance arrangements 3. Risk Management Framework. The risk management framework is underpinned by Robust Policy & Process, Asset Management Controls, Monitoring and Detection, Defence in Depth security measures and technology; all of which are receiving a higher percentage of budget allocation. 4. Robust Internal and External Audit reports. 5. Working towards General Data Protection Regulation (GDPR), Directive on security of network and information systems (NIS) & Cyber Essentials Compliance 6. Corporate and eHealth policies & Procedures: GP/A4 Acceptable Use Policy GP/B2 eHealth Remote Access Policy GP/C10 Clear Screen Clear Desk Policy GP/D6 Data Encryption Policy GP/E7 Non NHS Fife Equipment GP/H6 eHealth Equipment Home Working Policy GP/I3 Internet Policy GP/I4 eHealth Procurement Policy GP/I5 Information Security Policy GP/M5 Mobile Device Policy GP/P2 Password Policy GP/M4 Media Handling Policy GP/E6 Email Policy GP/S8 eHealth Incident Management Policy GP/D3 Data Protection and Confidentiality Policy GP/I6 IT Change Management Policy GP/V2 IT Virus Protection Policy This is supported by the following: 7. eHealth Risk Register (incl Programme/project risks)	The organisation is not consistently fully compliant with the following key controls: GDPR/DPA 2018 NIS Directive Cyber Essentials Plus. Compliance is at 'a point in time' , Risks identified, linked and recorded. The organisation is also lacking in training resource to ensure our staff are digitally ready.	1. Improving and maintaining strong governance and procedures following Information Technology Infrastructure Library (ITIL) professional standards 2. Ensure new systems are not introduced without sufficient skilled resources to maintain on an ongoing basis. 3. Work to become fully compliant with GDPR, DPA 2018, NIS Directive, Information Security Policy Framework and thereafter maintain compliance.	Head of eHealth - Lesly Donovan	31.03.2021	Second Line of Defence 1. Reporting to eHealth Board, Information Governance & Security Group (IG&SG), clinical & clinical & care governance groups and committees. 2. Annual Assurance Statements for the eHealth Board and IG&SG. 3. Locally designed subject specific audits. 4. Compliance and monitoring of policies & procedures to ensure these are up to date. 5. Reporting bi annually on adequacy of risk management systems and processes to Audit & Risk Committee. 6. Monthly SIRO report 7. SGHSCD Annual review 8. SG Resilience Group Annual report on NIS & Cyber compliance 9. Quarterly performance report. 10. Accreditation systems. 11. Locally designed subject specific audits. 12. From June 2019	Third line of Defence: 1. Internal Audit reviews and reports on controls and process; including annual governance review / departmental reviews. 2. External Audit reviews. 3. Formal resilience testing / DR testing using an approved scope and measured success and mechanism for lessons learned and action plans. 4. Cyber Essentials/Plus Assessments. 5. NISD Audit Commissioned by the Competent Authority for Health.	1. Well developed reporting, which can highlight potential vulnerabilities and provide assurances (including assurances that confirm compliance with GDPR, DPA 2018, NIS Directive, the Information Security Policy Framework is being maintained). 2. Implementation of improvements as recommended in Internal and external Audit Reports and an internal follow-up mechanism to confirm that these have addressed the recommendations made 3. Improvements to SLA's (in line with 'affordable performance') 4. Output from national Digital maturity due late 2019	Overall, NHS Fife ehealth has in place a sound systems of 1. Governance 2. Reasonable security defences and risk management as evidenced by Internal Audit and External Audit reports 3. Attainment of the ISO27001 standard in the recent past and the Statement of Annual Assurance to the Board. 4. Investment has been made to support NIS, GDPR and Cyber resilience and some tools which will improve visibility of the Network.	2 - Unlikely	5 - Extreme	10	Moderate	1. Difficulty in securing investment in people, tools and maintaining systems that are resilient and always within support cycles. 2. Fully implementing resistance to attack through 'resilience by design', well practised response plans and recovery procedures. 3. Reduce the 'human factor' through ongoing 'user base education' and improving organisational digital readiness. 4. Enhanced controls and continuing improvements to systems and processes for improved usage, monitoring, reporting and learning are continually being put in place. Aim for Moderate Risk as target rather than Low Risk is due to the fact that likelihood whilst unlikely may still happen and consequence will be extreme due to level of fines that may be imposed, reputational damage and patient harm.

Risk ID	Risk Title	Current Risk Rating	Risk Owner
1422	Unable to meet cyber essentials compliance	High 20	A Young
1338	End of support for MS Office 2007	High 16	A Young
1393	Patch Management	High 16	A Young
226	Lost of confidential or personal data	High 16	L Donovan
529	Information Security	High 16	M McGurk
1424	End of support for MS Server 2003	High 16	A Young
1746	Introduction of O365 will cause disruptive levels of Network traffic overhead	High 16	A Young
537	Failure of local Area Network causing loss of access to IT systems	High 15	A Young
1504	Lack of a central IT location to store guidance documents	High 20	Dr C McKenna
1576	Risk of not meeting SaMD full compliance	High 16	Dr C McKenna
1927	Deliberate unauthorised access or misuse to email by insiders (staff, contractors etc.)	High 16	M Richmond
1928	Deliberate unauthorised access or misuse of email accounts by outsiders (e.g. hackers)	High 16	A Young
1929	Inability to audit nhs.scot mail accounts	High 20	A Young
1932	User error (including those supporting system) resulting in data breach	High 16	M Fowles
1934	Network connection failures	High 16	A Young

Previously Linked Operational Risk(s)

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

913	MiDIS replacement	Closed Risk		

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**19 January 2021**
Title:	**Risk Management Key Performance Indicator (KPI) Report**
Responsible Executive:	**Helen Buchanan, Director of Nursing**
Report Author:	**Pauline Cumming, Risk Manager**

1 Purpose

This is presented to the group for:

- Discussion

This report relates to a:

- Government policy/directive from Healthcare Improvement Scotland (HIS)
- Local framework and policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Audit and Risk Committee and by extension the Board, require assurance that risk management KPIs are in place and used to measure if we are on track to meet our goals and objectives. This is the second report on performance against the NHS Fife Risk Management KPIs.

2.2 Background

NHS Fife agreed to introduce risk management KPIs to strengthen the governance around key elements of risk management activity and provide a mechanism through which to give additional assurance on the adequacy and effectiveness of the risk management systems, processes and oversight in NHS Fife. There are currently 7 indicators:

- KPIs 1 - 3 relate to risk registers and are intended to show overall organisational performance on the effectiveness of current management actions and controls, and overall governance arrangements.

- KPI 4 relates to BAF reports submitted to the governance committees to which they are aligned.
- KPI s 5 - 7 relate to adverse events and are intended to show overall organisational performance on the effectiveness of arrangements for managing adverse events in line with national guidance[1] and local policy,[2]

2.3 Assessment

Appendix 1 provides an assessment of compliance against the KPIs. Presentation of data is under continuing review and will be refined over time. Additionally, consideration is being given to (i) which adverse event KPI could replace the current information within the Board Integrated Quality and Performance Report (IPQR), and (ii) what potential target levels would be appropriate for these events.

All services currently have access to risk management information in Datix for their areas of responsibility. Staff are provided with access to and training in the risk register and incidents (adverse events) modules; the running of reports from Datix, and how to make the most of the system's functionality.

With regards to adverse events, a suite of pre configured reports have been created in Datix which enable users to access live information relating to outstanding SBARs, LAERs, SAERs, related actions, and Organisational Duty of Candour. These are available to any staff member with a Datix account.

The processes governing local risk management arrangements, including the review of risk registers and adverse events at service, directorate and divisional levels vary across the organisation and are currently being clarified. As previously reported, it is recognised that these have evolved in line with internal structures and processes, but that going forward, some standardisation is likely to be implemented. The Risk Management Team will support related developments.

2.3.1 Quality/ Patient Care

Effective risk management can identify opportunities for improvement, e.g. by highlighting gaps in capacity, procedures or service delivery, actions required to change or improve the services delivered and avoid, prevent and reduce risk. Adverse events have an impact on the quality and safety of patient care and experience. Managing adverse events including undertaking reviews, is to ultimately improve patient care.

[1] Learning from adverse events through reporting and review - A national framework for Scotland (Healthcare Improvement Scotland (HIS)
[2] NHS Fife Adverse Events Policy , 2018

2.3.2 Workforce

Risk management requires all staff to identify and assess risk, take action to mitigate or anticipate, and monitor and review progress to reduce or eliminate risk. The Risk Management team, with the support of Executive Directors, will continue to work with services to review and further develop effective risk management arrangements.

2.3.3 Financial

No issues identified.

2.3.4 Risk Assessment / Management

The arrangements for managing risk affect patients, staff and others in contact with the Board's services. Healthcare provision is complex and involves a degree of risk. Risks must therefore, be properly managed to mitigate against harm to patients, staff and others, and to the reputation and assets of the organisation.

2.3.5 Equality and Diversity, including health inequalities

This paper provides information in relation to risk management processes and does not raise any specific equality and diversity issues.

2.3.6 Other impact

None identified.

2.3.7 Communication, involvement, engagement and consultation

KPIs 1- 3 (Adverse Events) were shared with the NHS Fife Adverse Events & Duty of Candour Group on 17 December 2020. All KPI s were shared with the Director of Nursing and the Medical Director on 29 December 2020.

2.3.8 Route to the Meeting

EDG

2.4 Recommendation

Discussion – Examine and consider the implications of a matter.

3 List of appendices

Appendix 1, Risk Management Key Performance Indicators (KPIs) Summary

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Appendix 1

Risk Management Key Performance Indicators (KPIs)

Report Criteria

Risks - KPI 1 to 3 - All Active Risks at 22/12/2020
Risks - KPI 4 - BAF reports to Committees at 22/12/2020
Adverse Events - KPI 5 - where event reported 01/01/2020 to 31/10/2020
Adverse Events - KPI 6a / 6b / 6c - where event closed 01/01/2020 to 31/10/2020
Adverse Events - KPI 7 - where event reported 01/04/2018 to 31/10/2020

KPI	KPI Descriptor	Total number of active risks	Compliance		Target
			Number still within timeframe set for next review	%	%
1	All risks are within timescale for review	597	378	63	100

NOTE: 548 risks previous at 61%

1. There is still room for improvement in relation to the timely review and update of risks. Performance may have been affected in part to the pandemic's impact on workload. Recent discussions with Directors demonstrate recognition of the need to maintain or in some cases strengthen oversight and local governance arrangements.

KPI	KPI Descriptor	Total number of active risks	Number of risks at each level		Number of risks with scheduled review date commensurate with level				Target
					Each Level		Overall		
			Risk Level (Rating)	Number	Number	%	Number	%	%
2	All risks must have a review date scheduled commensurate with the assessed risk level:* Very High: 25 at least monthly High: 15 - 20 at least quarterly Moderate: 8 -12 at least 6 monthly Low: 4 - 6 at least annually Very Low: 1 - 3 at least annually	597	Very High (25)	9	3	33	313	52	100
			High (15-20)	82	38	46			
			Moderate (8-12)	360	171	48			
			Low (4-6)	134	92	69			
			Very Low (1-3)	11	9	82			
			No value	1	N/A	#VALUE!			

NOTE:
108 records have NO previous review date which impacts on data results
548 risks previous at 45%

2.313 risks have review dates in line with the stated risk level. The remainder are being audited to ascertain the reason for no previous review date and to identify appropriate remedial actions.

KPI	KPI Descriptor	Number of risks at		Length of time risks have been open			Initial risk level			Target
		Risk Level (Rating)	Number	Time period	Number	%	Risk Level (Rating)	Number	%	%
3a	Length of time 'Very High' level risks have been at that level	Very High (25)	9	Number of risks open <= 1 year	6	67	Very High (25)	6	100	100
							High (15-20)	0	0	
							Moderate (8-12)	0	0	
							Low (4-6)	0	0	
							Very Low (1-3)	0	0	
				Number of risks open >1 year	3	33	Very High (25)	3	100	100
							High (15-20)	0	0	
							Moderate (8-12)	0	0	
							Low (4-6)	0	0	
							Very Low (1-3)	0	0	

KPI	KPI Descriptor	Number of risks at		Length of time risks have been open			Initial risk level			Target
		Risk Level (Rating)	Number	Time period	Number	%	Risk Level (Rating)	Number	%	%
3b	Length of time 'High' level risks have been at that level	High (15-20)	82	Number of risks open <= 1 year	31	38	Very High (25)	2	6	100
							High (15-20)	28	90	
							Moderate (8-12)	1	3	
							Low (4-6)	0	0	
							Very Low (1-3)	0	0	
				Number of risks open >1 year	51	62	Very High (25)	1	2	100
							High (15-20)	41	80	
							Moderate (8-12)	9	18	
							Low (4-6)	0	0	
							Very Low (1-3)	0	0	

NOTE: 1 risk has no rating applied
3a <=1 year = 75, >1 year = 25
3b <=1 year = 46, >1 year = 54

3. This information reflects the current position against the review timescales. The Risk Manager has initiated conversations with Directors and where indicated, will work with them to support their teams to carry out risk register reviews, and work towards establishing more reliable systems for managing risks.

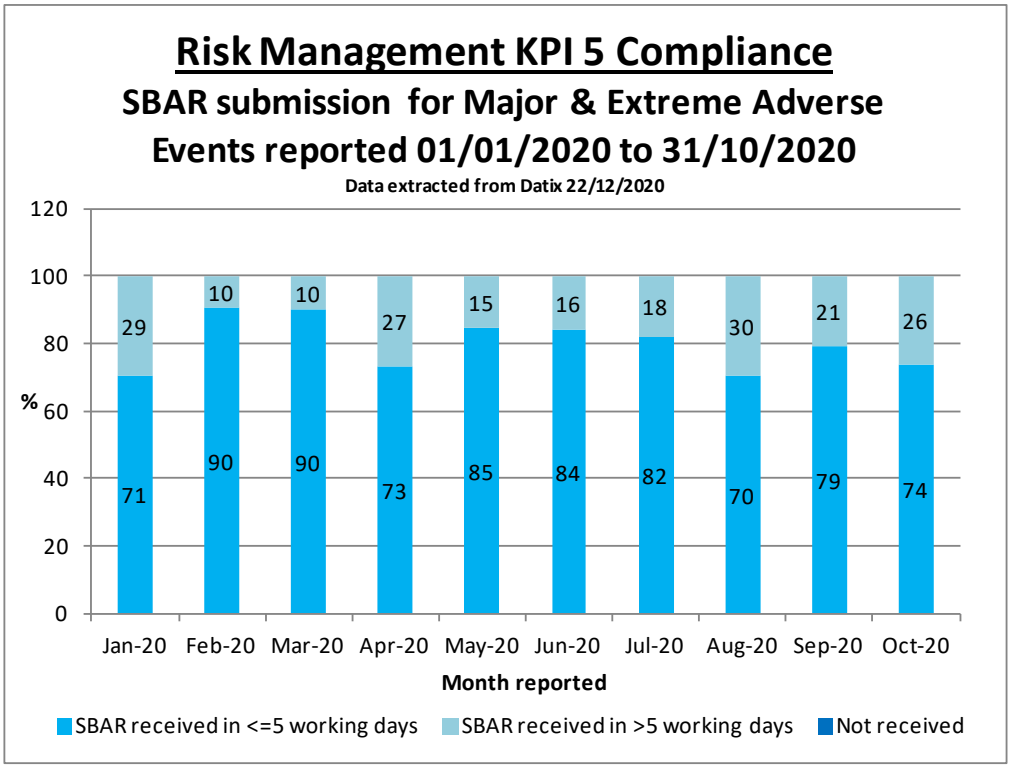
KPI	KPI Descriptor	Committee Meetings	BAFs due for submissio	Number submitted	%	Target
4	A bi monthly Board Assurance Framework (BAF) report is submitted bi monthly to the aligned governance committee	Finance, Performance & Resources (FPR) Clinical Governance (CGC) Staff Governance **5 of each**	35	34	97	100

Committee		Jan-20	Mar-20	May-20	Jul-20	Sep-20	Nov-20
Finance, Performance & Resources (FPR)							
BAF	Financial Sustainability	√	√	*	√	√	√
	Environmental Sustainability	√	√	*	√	√	√
	Strategic Planning	√	√	*	√	√	√
Clinical Governance (CGC)							
BAF	Quality & Safety	√	√	*	√	~	√
	Digital & information	√	√	*	√	√	√
	Strategic Planning	√	√	*	√	√	√
Staff Governance							
BAF	Workforce Sustainability	√	√	*	√	√	√
Note: * denotes report not produced. May 2020 meetings did not take place due to stage of COVID-19 pandemic.							

Previous 100% based on 21 meeting requirements

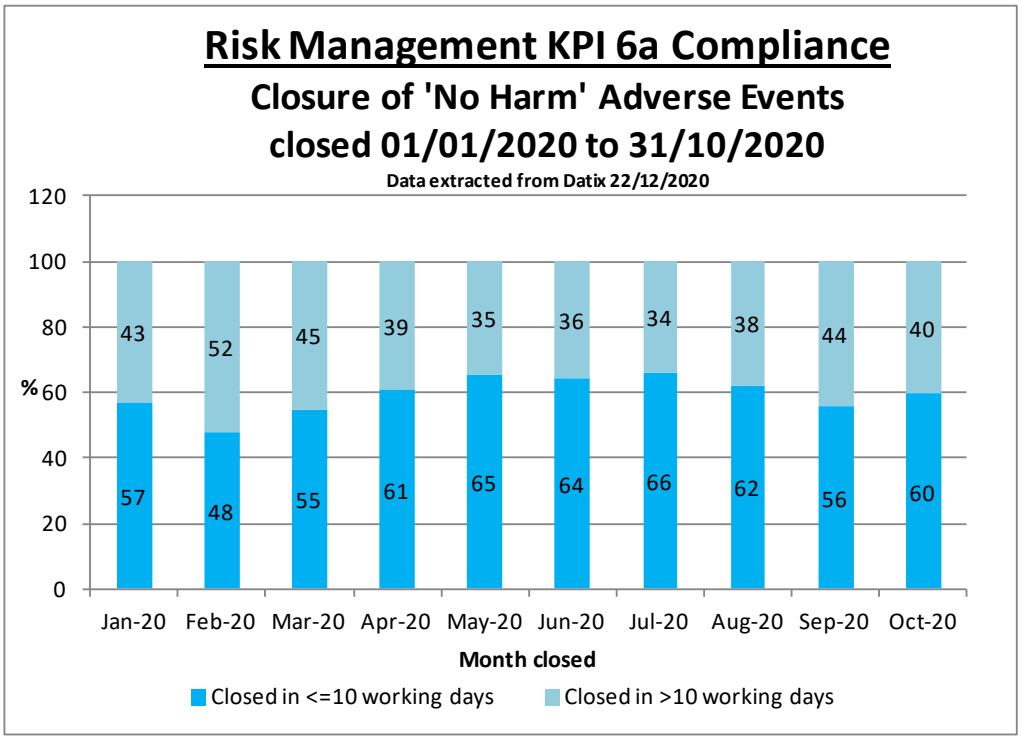
4. The Quality & Safety BAF was not submitted to the Sept 2020 CGC. A verbal update was provided.

KPI	KPI Descriptor
5	Decision Making SBAR for Major and Extreme Adverse Events should be submitted in line with Adverse Events Policy GP/I9 - within 5 working days of reported date (or upgraded if applicable)

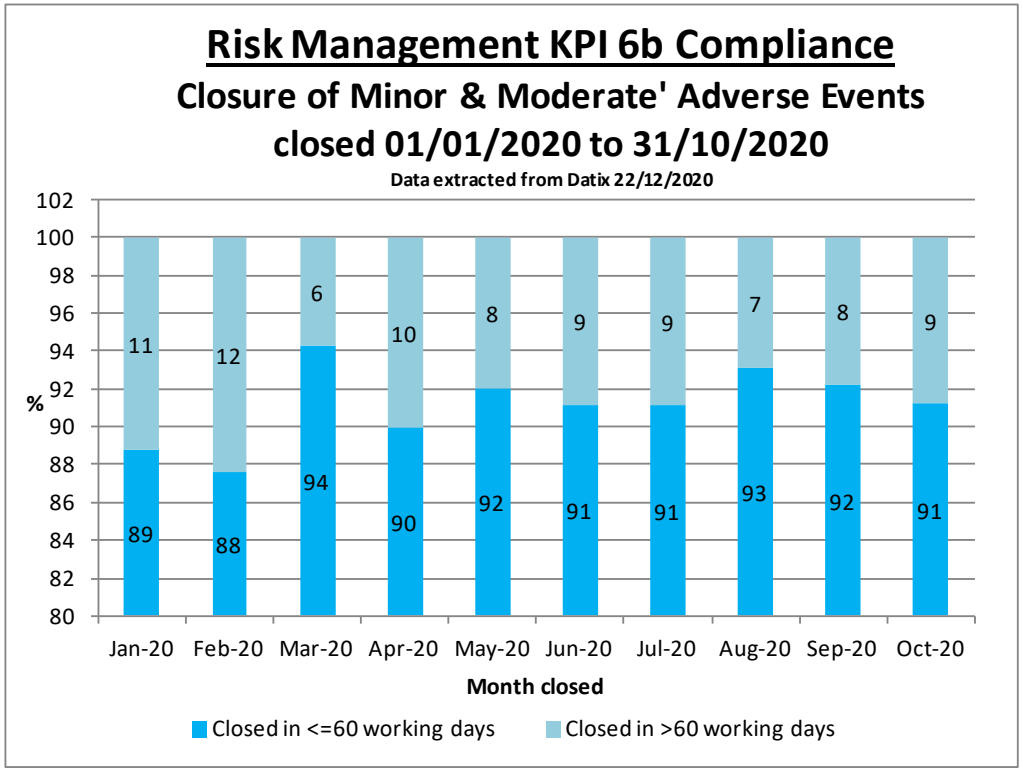


5. Performance has reduced since the last report but averages 80% this year to date. Services complete the SBAR and submit for executive directors' decision on the type of review required. Timely submission is key to a review being commissioned and initiated at the earliest possible date, in order to complete within the stated timescales.

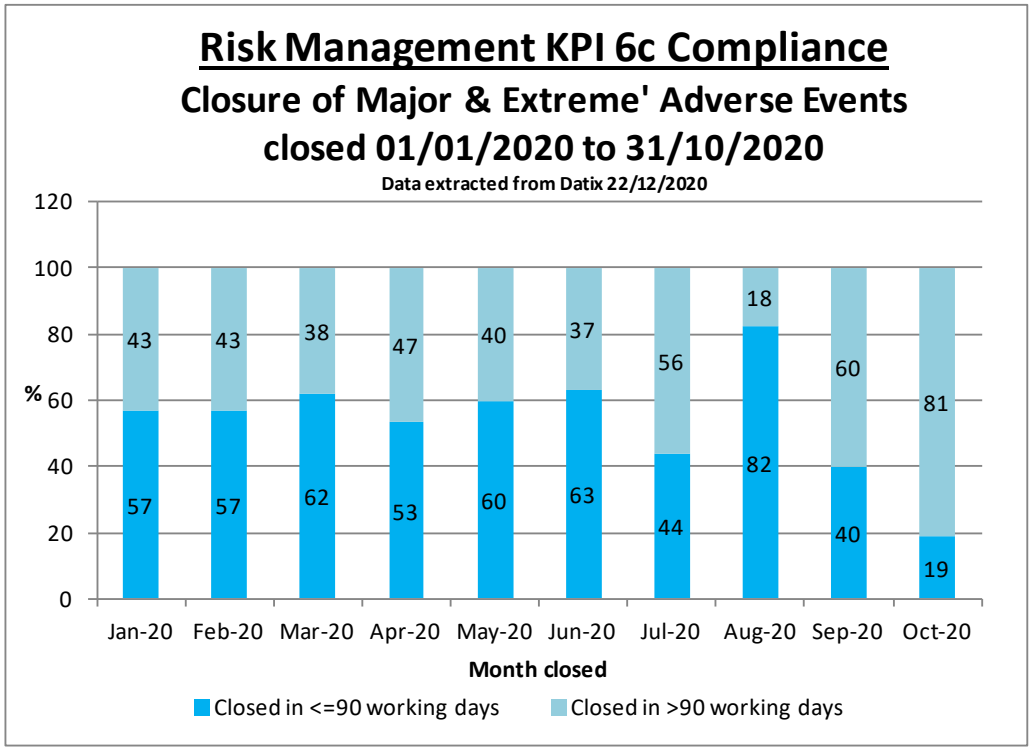
KPI	KPI Descriptor
6a	Adverse Events with severity reported as 'No Harm' should be closed within 10 working days of reported date



KPI	KPI Descriptor
6b	Adverse Events with severity reported as 'Minor' or 'Moderate' should be closed within 60 working days of reported date



KPI	KPI Descriptor
6c	Adverse Events with severity reported as 'Major' or 'Extreme' shoud be closed within 90 working days of commissioned date



6a), 6b) & 6c).The Board Medical and Nurse Director continue to reinforce the expectation that **all** adverse events will have timely reviews, action completion and closure, and that this will be done in accordance with local Policy GP/I9 and the national framework for adverse events management.

This is being taken forward with oversight and monitoring by the Associate Medical and Nurse Directors and other senior managers through their local governance arrangements, and by the Adverse Events & Duty of Candour Group.

An analysis of the reasons for delayed closure of events in Datix is being considered, for example, in relation to ‘no harm’ events, when these offer potential ‘quick wins’ in terms of performance.

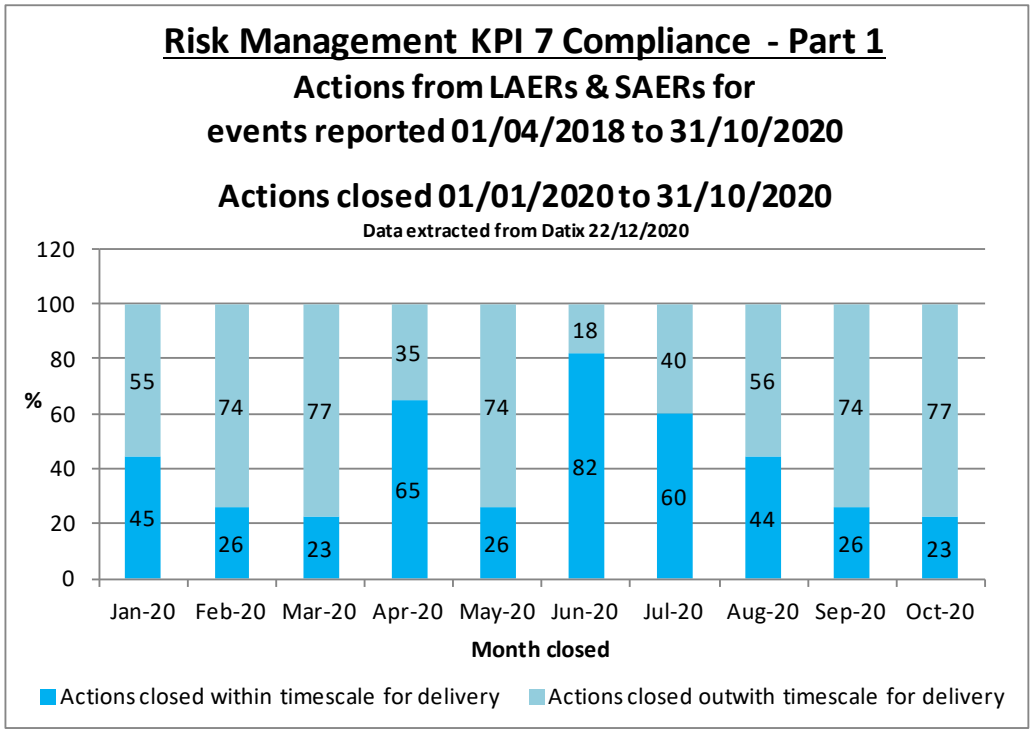
As may be expected, closure of major and extreme events within 90 days continues to be challenging; these events are often complex and multifaceted. This has been exacerbated in 2020, partly due to the impact of the pandemic, requiring a temporary suspension of SAER and LAER activity to be put in place in March. In the post peak phase, a decision was taken to restart SAER activity from 1 June 2020. This included:

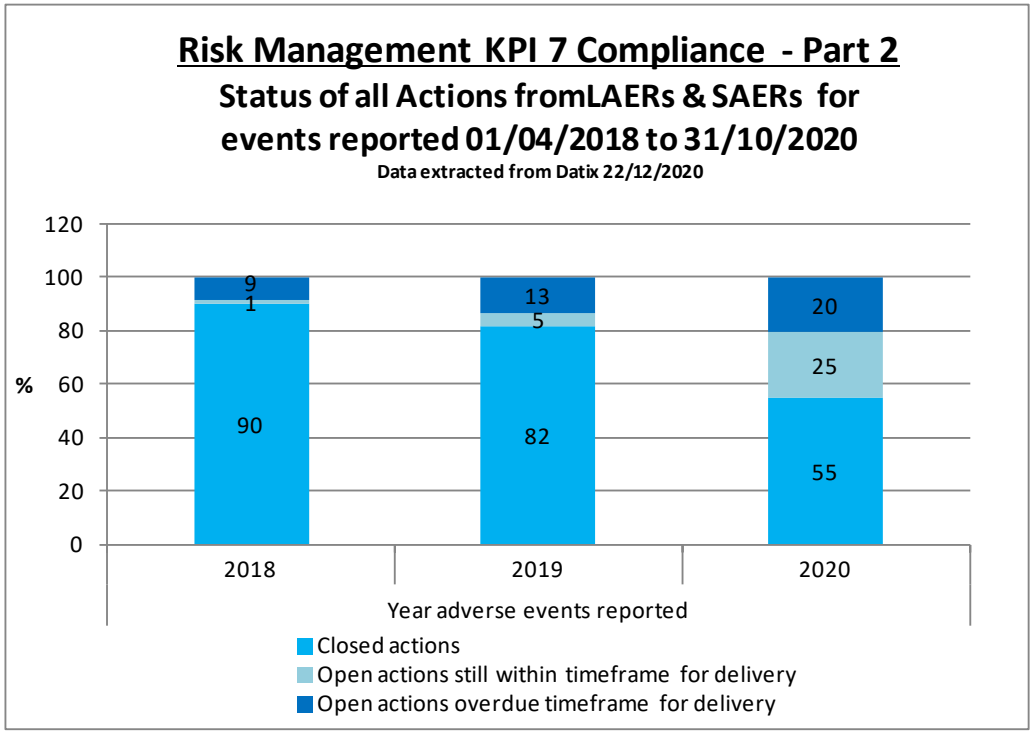
- concluding established SAERs including reports and learning summaries
- rescheduling SAERs that were suspended and agreeing revised timescales
- reconvening SAER Oversight Group meetings

LAER activity resumed from 1 August 2020. This required services to conclude outstanding LAERs including reports and learning summaries, and to carry out all other LAERs in line with local policy GP/I9.

The recovery of this activity has required and continues to require considerable and sustained effort from all parties; moreover it is being undertaken against a back drop of mobilisation and remobilisation of services amidst the ongoing response to COVID - 19, with its associated pressures and constraints.

KPI	KPI Descriptor
7	Actions resulting from LAER and SAER reviews should be completed by target date (LAER & SAER review requirements set out in Policy GP/I9 from 01/04/18)





As previously reported, weaknesses in performance were identified in the Internal Audit report Adverse Event Management B19/20 and several improvement actions have since been implemented.

As mentioned above, discussions about establishing processes for reporting the status of actions through local governance routes have begun. This is now included in the reports which are presented by directorates to the Acute Services Division Clinical Governance Committee. The HSCP are also improving reporting which is to be extended to include the reporting of outstanding actions.

Reports with data and information relating to actions are now part of the information reviewed and monitored as a standing agenda item at the Adverse Events & Duty of Candour Group.

An extension of the adverse event management review reported on within Audit Report B19/ is underway - B20/21 – Adverse Event Management. The purpose of the audit is to ascertain whether there are instances of actions being implemented, but their completion is not being recorded on Datix and to identify the reason for such should that be the case. Future reports to the committee will note this audit's findings and respond accordingly.