Audit & Risk Committee

Thu 13 May 2021, 14:00 - 16:30

Via MS Teams

Agenda

14:00 - 14:00
0 min

1. Apologies for Absence

14:00 - 14:00
0 min

2. Declaration of Members' Interests

14:00 - 14:00
0 min

3. Minutes of Previous Meeting held on 18 March 2021

Martin Black

Item 3 - Mins Audit & Risk 031821 FINAL.pdf (6 pages)

14:00 - 14:00
0 min

4. Action List / Matters Arising

Martin Black

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

14:00 - 14:00
0 min

5. GOVERNANCE - GENERAL

5.1. Committee Assurance Principles

Tony Gaskin

Item 5.1 - SBAR Committee Assurance Principles.pdf (3 pages)
Item 5.1 - Committee Assurance Principles with risk guidance.pdf (5 pages)

5.2. Committee Workplan 2021/22

Margo Mcgurk

Item 5.2 - A&R Annual Workplan 21-22.pdf (5 pages)

5.3. Audit & Risk Committee Self-Assessment Report

Gillian MacIntosh

Item 5.3 - SBAR Committee Self-Assessment A&R.pdf (11 pages)

5.4. Draft Committee Annual Assurance Statement

Gillian MacIntosh

Item 5.4 - SBAR A&R Annual Report.pdf (3 pages)
Item 5.4 - DRAFT A&R Annual Statement of Assurance 202021.pdf (17 pages)

5.5. Payments to Primary Care Practitioners

Margo Mcgurk

Item 5.5 - SBAR Payment to Primary Care Practitioners ARC May 21mm (004) (1).pdf (8 pages)

5.6. Annual Review of Code of Corporate Governance

Gillian MacIntosh

Item 5.6 - SBAR A&R Revised Code of Corp Gov.pdf (3 pages)
Item 5.6 - Code of Corporate Governance MAY 21.pdf (122 pages)

5.7. NHS Fife Strategy Development

Margo Mcgurk

14:00 - 14:00
0 min

6. GOVERNANCE - INTERNAL AUDIT

6.1. Internal Audit Progress Report & Summary Report

Barry Hudson

Item 6.1 Progress Cover FINAL for A&R.pdf (4 pages)
Item 6.1 Appendix 1 - NHSF Progress Report May 2021 FINAL for ARC.pdf (6 pages)
Item 6.1 Appendix 2 Updated definitions for Audit Reports v3.pdf (4 pages)

6.2. Draft Internal Audit Plan 2021/22

Tony Gaskin

Item 6.2 - Annual Plan Final for EDG.pdf (11 pages)

6.3. Internal Audit – Follow Up Report

Barry Hudson

Item 6.3 - 13 May 2021 AFU Report FINAL for EDG re-issue.pdf (25 pages)

14:00 - 14:00
0 min

7. GOVERNANCE - EXTERNAL AUDIT

7.1. Audit Planning Memorandum – Patients' Private Funds

Margo Mcgurk

Item 7.1 SBAR Audit And Risk Committee PF Audit Planning cover130521.pdf (2 pages)
Item 7.1 - Patients' Private Fund 2021 Audit Planning Memo.pdf (25 pages)

7.2. Audit Planning Memorandum – Fife Health Charity

Margo Mcgurk

Item 7.2 - External Audit Planning Memorandum.pdf (2 pages)
Item 7.2 - Appendix 1 Audit Planning Memo - Fife Health Charity.pdf (35 pages)

14:00 - 14:00
0 min

8. RISK

8.1. Board Assurance Framework

Margo Mcgurk

Item 8.1 - SBAR Update on Board Assurance Framework to Audit & Risk Committee on 130521 V 1.0.pdf (6 pages)
Item 8.1 - Appendix 1, NHS Fife BAF - Financial Sustainability - F.P&RC 120121.pdf (1 pages)
Item 8.1 - Appendix 2, NHS Fife BAF - Environmental Sustainability - F,P&RC 120121.pdf (1 pages)

- Item 8.1 - Appendix 3, NHS Fife BAF Workforce Sustainability - SGC 130121.pdf (2 pages)
- Item 8.1 - Appendix 4, NHS Fife BAF Quality & Safety - CGC 140121.pdf (2 pages)
- Item 8.1 - Appendix 5, NHS Fife BAF Strategic Planning - F,P&R 120121 and CGC 140121.pdf (1 pages)
- Item 8.1 - Appendix 6, NHS Fife BAF - Integration Joint Board at 101220.pdf (1 pages)
- Item 8.1 - Appendix 7 , NHS Fife BAF Digital & Information - CGC 140121.pdf (2 pages)

8.2. Key Performance Indicators – Risk Management

Margo Mcgurk

- Item 8.2 - Risk Management Key Performance Indicator Report to NHS Fife Audit and Risk Committee on 130521 V1.0.pdf (3 pages)
- Item 8.2 - Appendix 1, Risk Management KPI Report to Audit & Risk Committee on 13 May 2021 V 1.0.pdf (5 pages)

8.3. Update on Risk Management Workplan 2020-21

Margo Mcgurk

- Item 8.3 - SBAR Risk Management Workplan Update to Audit and Risk Committee on 130521 V1.0.pdf (4 pages)
- Item 8.3 - Appendix 1, Risk Management Workplan 2020 - 2021 Update to NHS Fife Audit and Risk Committee on 130521 V 1.0.pdf (2 pages)

14:00 - 14:00
0 min

9. OTHER

9.1. Issues for escalation to NHS Board

Martin Black

14:00 - 14:00
0 min

10. Any Other Competent Business

Martin Black

Fife NHS Board

Unconfirmed

MINUTE OF THE AUDIT & RISK COMMITTEE MEETING HELD ON 18 MARCH 2021 AT 10AM VIA MS TEAMS

Present:

Mr M Black, Chair
Ms S Braiden, Non-Executive Member
Cllr D Graham, Non- Executive Member
Ms A Lawrie, Non-Executive Member

In Attendance:

Mrs C Potter, Chief Executive
Mr K Booth, Head of Financial Services
Ms A Clyne, Audit Scotland
Ms P Fraser, Audit Scotland
Mrs P King, minutes
Mr T Gaskin, Chief Internal Auditor
Mr B Hudson, Regional Audit Manager
Dr G MacIntosh, Head of Corporate Governance & Board Secretary
Mrs M McGurk, Director of Finance

1. Welcome / Apologies for Absence

The Chair welcomed everyone to the meeting, in particular Aileen Lawrie, the new Chair of the Area Clinical Forum, and Kevin Booth, who has recently joined NHS Fife as Head of Financial Services. He thanked Janette Owens for her previous service to the Committee in her role as Chair of the Area Clinical Forum and gave congratulations on her appointment as Director of Nursing. Thanks were also recorded to Helen Buchanan, who has recently retired from NHS Fife as Director of Nursing.

The notes are being recorded with the Echo Pen to aid production of the minutes. These recordings are also kept on file for any possible future reference.

Apologies for absence were received from Janette Owens.

2. Declaration of Members' Interests

There were no declarations of interest made by members.

3. Minute of the last Meeting held on 19 January 2021

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

4. Action List

The Committee **noted** the update on the outstanding action and agreed to retain this item on the action list until fully completed.

5. GOVERNANCE - GENERAL

5.1. Annual Review of Committee's Terms of Reference

Dr MacIntosh presented the revised Terms of Reference to the Committee, with the proposed changes tracked within the document.

In response to questions, clarity was provided about the regular attendance of both the Director of Finance and Head of Financial Services at meetings of the Committee, and the specific responsibility of the Director of Finance, as Executive Lead for Risk Management from 1 April, to report through the Audit & Risk Committee on risk for the whole organisation.

Attention was drawn to section 5.15, where a proposed Private meeting of members be scheduled with the auditors at least annually. It was agreed that a meeting of Committee Members with the auditors be scheduled to follow the May Audit & Risk Committee. The Chair had recently met on a 1:1 basis with External Audit, and a similar meeting would also be arranged with the Chief Internal Auditor.

Action: G MacIntosh / T Gaskin

The Committee **approved** the revised Terms of Reference and **agreed** that a meeting be arranged with the auditors, as noted above.

5.2. Draft Annual Accounts Timetable

Mrs McGurk introduced the paper setting out the draft Annual Accounts 2020/21 timetable, noting that NHS Fife will prepare unaudited 2020/21 accounts by 1 June 2021 and submit audited accounts by 28 September 2021. Mrs McGurk reported that planning has been undertaken in preparation for the Annual Accounts 2020/21 process, reflecting on lessons learned from the 2019/20 process and working closely with colleagues at Audit Scotland. She gave assurance that the Finance team capacity and capability was in an improved position to last year and that these deadlines were realistic and achievable, subject to activity relating to Covid-19 continuing to progress positively. It had already been anticipated that the majority of work would be done remotely, due to the Covid situation, and this was factored into the planning.

Ms Fraser also assured the Committee that Audit Scotland had measures in place to ensure the accounts process was undertaken efficiently, working with Mrs McGurk and the wider Finance team. Working papers had been provided to NHS Fife that would help facilitate the audit.

The Committee **noted** the planned timetable for awareness. Appendix 1 would be amended to align the key dates in ascending date order.

Action: M McGurk

6. GOVERNANCE – INTERNAL AUDIT

6.1. Internal Audit Progress Report

Mr Hudson introduced the paper, which provided comprehensive assurance to the Committee on the progress of the 2020/21 Internal Audit Plan and amendments to the 2020/21 Plan. Section 2.3 of the SBAR provided details of further advice/input provided to NHS Fife, together with ongoing improvement activities and a section on how Covid-19 has impacted on delivery of the plan.

Appendix A provided detail around the internal audit progress and showed those reports which are at the stages of finalised draft and work in progress. Many of the reviews are nearing draft report stage and it is anticipated that the majority of these will be reported to the May 2021 Audit & Risk Committee meeting.

The Committee **noted** the progress on the delivery of the Internal Audit Plans and **approved** the minor changes to the 2020/21 Internal Audit Plan set out in Appendix B.

6.2. Internal Audit – Follow Up Report Recommendations

Mr Hudson spoke to the standard follow-up report provided by Internal Audit. Since January, the total number of recommendations had increased, reflecting reviews undertaken in the current financial year. Responding officers reported delays in progressing actions due to the impact of Covid-19, but accelerated progress was expected once staff return to more normal times. Internal Audit is considering further control around the extension of audit recommendations, which would have to be approved by the Director of Finance prior to acceptance, and discussions would take place with the Director of Finance to give more rigour to the process.

The importance of progressing follow-up actions was emphasised, and it was noted that the follow-up report is considered and discussed at the Executive Directors Group on a quarterly basis, which will help drive forward the completion of the remaining outstanding recommendations.

In response to questions about the clarity of the responsible officers' section, Mr Gaskin agreed to take comments on board for the next iteration of the report and he welcomed further comments on how to improve its content.

The Committee **noted and considered** the current status of Internal Audit recommendations recorded with the audit follow-up system and **agreed** that a review of the recommendations be undertaken to ensure they remained relevant.

6.3. Interim Evaluation of Internal Control Framework

Mr Gaskin referred to the written report, the content of which had been presented in summary at the last meeting of the Committee. He highlighted that it is important to remember that NHS Fife is still in unprecedented times due to the current pressures of responding to the Covid-19 pandemic. However, being able to generate recurring savings, to deliver services and achieve the Board's strategic aims remain critical. It was highlighted that transformation and governance of transformation had been the subject of audit reports over the past few years and the evidence of achievement and progress in this area remained of concern. Mr Gaskin noted that NHS Fife is in a more

positive position now compared to last year and he recognised the enormous amount of work which had been done by the organisation to address the challenges of the pandemic, in which remobilisation remains one of the key focus areas as Covid activity reduces.

Whilst the Scottish Government continued to direct Health Boards and have mandated that the NHS must focus on Covid vaccination, testing, winter planning and remobilisation, it was noted that discussions had commenced nationally to consider the vision and strategy for NHS Scotland post Covid-19, with a strong focus on the population health and wellbeing. Mrs Potter advised that NHS Fife continued to move forward on strategy and transformation, with sessions planned for the Executive Team and Board Members in April. She emphasised that the organisation can demonstrate transformation in Fife, which was apparent over the past year especially in dealing with the tremendous pressures of Covid, and she remained concerned that this was not fully reflected in the report.

Mrs McGurk noted that the report suggests that NHS Fife had not delivered against the transformation agenda and she outlined a few examples of transformation that had taken place during 2020/21, notably in relation to digital enhancements, Mental Health services, Health Centre re-provision and the great progress made with the Elective Orthopaedic Centre. Mrs McGurk also suggested that the Internal Audit recommendation gradings should ideally be expanded to include a fourth grading (i.e. one of "Moderate", between "significant" and "merits attention"), to give a more nuanced assessment.

In responding, Mr Gaskin advised that the inclusion of a fourth grade has already been proposed to the Partnership Board and it was hoped that this would be used from next year. However, he stated that this would not have affected the report for this year, as the issues of risk and effective oversight remained. The interim evaluation work noted that there has been a positive response in terms of governance arrangements during the pandemic period and the Board has engaged well with this. Internal Audit is aware that the Board has had to accommodate delivering business-as-usual governance processes and, where appropriate and agreed by the Board, “light governance” arrangements. As Chief Internal Auditor, he has a professional duty to describe and report on risks and generate an appropriate grade based on that opinion.

Mr Gaskin reminded Members that this was a mid-year report, which aimed to provide early warning of any significant issues that may affect the Governance Statement. He noted that it did not cover the full financial year and the progress made on a number of fronts since the mid-year point will be captured in the next iteration. There had been considerable discussion on the report since January and changes had already been reflected in the report. Mrs McGurk noted that Executive colleagues will work with Internal Audit over the next few months to support the development of the content for the final report. The Chair also noted that he appreciated the effort and work that had gone into the report and proposed that he discuss further with Mr Gaskin to support the final annual report which would be developed as part of the annual accounts process.

Ms Fraser advised that, from an Audit Scotland viewpoint, colleagues would meet with Internal Audit when undertaking interim audit work in the spring and consider their reports in detail at that point. Reference is made to transformation in the External Audit

Report and this will be given due consideration going forward, noting the focus on the new Strategic Planning & Resource Allocation process which NHS Fife is now working on.

The Committee **discussed** the findings of the report and the issues raised therein. It was **agreed** that further discussion would be taken forward with the Chair and the Chief Internal Auditor.

7. GOVERNANCE - EXTERNAL AUDIT

7.1. Audit Scotland Annual Audit Plan

Ms Fraser presented the Audit Scotland Annual Audit Plan 2020/21, which contained an overview of the planned scope and timing of the audit and set out work necessary to allow an independent auditor's report on the annual accounts to be produced. Ms Clyne talked to the key points of the plan and noted that she would welcome feedback on any other audit risks to be considered.

Attention was drawn to the timetable under Exhibit 2, whereby the interim management report would be submitted to the June meeting. It had been proposed to cancel this date, given the revised annual accounts timetable. It was therefore agreed to retain the June date for a Committee meeting and the Chair would consider with Ms Fraser how this could be factored in with a further training event, to make best use of the time available.

Action: M Black/P Fraser

The Committee **noted** the Plan.

7.2. Annual Accounts – Progress Update on Audit Recommendations

Mrs McGurk introduced the paper, which provided an update on progress against the recommendations from the External Audit Annual Report on the 2019/20 Accounts.

Mrs McGurk highlighted that the issue of holiday pay accrual for medical and dental staff (Issue 2) was unlikely to be resolved by 31 March 2021 due to the pandemic, but work was underway to resolve the issue.

Regarding Medium Term Finance Plans (Issue 4), Mrs McGurk confirmed that considerable work has been undertaken since October 2020 and this will be reported back to the May governance committees. A medium-term plan is in development to deliver against the savings target and presentations were made to the February Board Development Session and Finance, Performance & Resources Committee on this earlier this week.

The Committee **noted** the progress made on last year's recommendations.

7.3. Audit Scotland Report – NHS Scotland in 2020

Ms Fraser presented the recently published Audit Scotland Report on the NHS in Scotland and gave an overview of the key messages. A number of comments/observations were made and these were responded to.

The Committee commended that clarity and format of the report and **noted** its findings.

8. ISSUES FOR ESCALATION TO NHS BOARD

The Committee **agreed** to highlight to the Board, via its minutes, the discussions held on the conclusions of the Interim Internal Control Evaluation report.

9. ANY OTHER BUSINESS

None.

Date of Next Meeting: 13 May 2021 at 2pm within The Boardroom, Staff Club, Victoria Hospital (location TBC)

ACTION LIST FROM AUDIT & RISK COMMITTEE – 2021-22

	Title	Action	Lead	Outcome
1	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	NSS DOF advised that Practitioner Services has been working to redesign the control framework for these areas to ensure all recommendations and actions from the 2019-20 report have been incorporated and delivered. The 2020/21 audit report will confirm the level of progress in-year.
2	Private meetings scheduled	Agreed a proposed Private meeting of members be scheduled with the auditors at least annually. The Chair had recently met on a 1:1 basis with External Audit, and a similar meeting would also be arranged with the Chief Internal Auditor.	GM	Private meetings have been timetabled in the workplan and 1:1 between Chair and Chief Internal Auditor has taken place.

Completed Updated

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**13 May 2021**
Title:	**Committee Assurance Principles**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Tony Gaskin, Chief Internal Auditor**

1 Purpose

This paper is presented to the Audit and Risk Committee for endorsement.

This report relates to a:

- Local policy

This aligns to monitoring and assurance over all of the NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Chief Internal Auditor been working with the NHS Fife Board Secretary and Risk Manager and their peers from NHS Lanarkshire, NHS Forth Valley and NHS Tayside to develop a consistent and coherent approach to the provision of assurance in line with the governance mapping principles recommended for all NHSScotland Health Boards. As part of this process, a set of Committee Assurance principles was produced, together with a series of questions which would help Standing Committees assess the assurances they receive on risks delegated to them.

As the Committee with responsibility for assessing the adequacy and effectiveness of the systems of internal control, governance and risk, it was agreed that it would be helpful for the Audit & Risk Committee to review and endorse these principles as a way of helping all Standing Committees to formulate their assurance.

2.2 Background

NHSScotland Audit and Risk Committees are guided by the SPFM Audit and Risk Committee Handbook. Section 4 of the guidance sets out the Committee's role in relation

to assurance, promotes the 'three lines of defence' model and emphasises the importance of good assurance frameworks as set out in the relevant Treasury Guidance.

These documents, together with other relevant good practice guidance, has been used to develop the set of principles shown in Appendix 1.

In addition, the SGHSCD has recognised the particular burden on officers during the Covid-19 pandemic and asked NHS boards to consider their governance arrangements so as to allow officers to focus on their front-line duties whilst maintain effective governance and assurance. The attached principles provide a means of ensuring that only the most important issues are considered at Standing Committees and also that they focus on the key areas of assurance, reducing the need for extraneous information which may obscure areas of genuine importance.

2.3 Assessment

The attached principles are congruent with national guidance and would provide a mechanism for consideration of which items should be considered by Standing Committees and how best to ensure that all papers maintain a focus on the key risks facing NHS Fife. Whilst particularly relevant at this time, they would be useful going forward for all Standing Committees and their supporting groups further to enhance NHS Fife's governance and assurance framework. They would also fit will with the wider assurance mapping work which will eventually encompass all Strategic risks and streamline year-end assurance processes.

It is anticipated that the principles would be of particular use to Committee Chairs and Lead Executives as they plan agendas for each Committee and keep under regular review each Committee's workplan and development needs. The risk questions should also help Directors to frame their assurance papers so as to ensure that Committee members will have the necessary information to allow them to form a conclusion.

2.3.1 Quality / Patient Care

The principles would enhance focused, risk-based assessment of the quality and safety of care.

2.3.2 Workforce

The principles would enhance focused, risk-based assessment of staff health and wellbeing, compliance with the Staff Governance Standard and the mitigation of workforce risks.

2.3.3 Financial

There is no direct financial impact, although there may be some benefit from a reduction in the quantity and size of Committee papers, as meeting packs become more focused.

2.3.4 Risk Assessment/Management

The principles are designed to focus attention on the description and scoring of strategic risks, on the adequacy and effectiveness of associated controls and on the quality of assurances received.

2.3.5 Equality and Diversity, including health inequalities

Eventually, the wider Assurance Mapping process would provide assurance on equality as part of the wider assurance on Best Value, which includes a section on equality.

An impact assessment has not been completed as the principles are purely focused on internal assurance mechanisms

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

- The principles were developed and approved by the Assurance Mapping Group, which includes members form NHS Fife, Forth Valley, Tayside and Lanarkshire.
- The principles have been discussed with the Director of Finance and Board Secretary. Further discussion with Committee Chairs as a group is anticipated, to review how these could potentially be used in agenda planning etc.

2.3.8 Route to the Meeting

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

- EDG, 6 May 2021

2.4 Recommendation

The Audit & Risk Committee is asked to **consider** the attached principles and **endorse** them for use by committees in the manner described above, following further discussion with Committee Chairs.

3 List of appendices

The following appendices are included with this report:

- Appendix 1 - Committee Assurance Principles

Report Contact
A Gaskin Bsc ACA
Chief Internal Auditor
Email tony.gaskin@nhs.scot

Committee Assurance Principles

Purpose and remit

The overall purpose of the Board is to ensure efficient, effective and accountable governance, to provide strategic leadership and direction, and to focus on agreed outcomes**.** Detailed scrutiny should take place at committee level, with each committee providing assurance and escalating key issues as required. For this to be achieved successfully, Standing Committees must be clear about their priorities, have focused agendas and workplans and must monitor their own performance rigorously. Standing Committee remits are approved by the Board with input from Committees and increasingly from national governance initiatives. However, Standing Committees must ensure that they are focused on Board priorities and on the risks delegated to them.

Sub-committees and groups will frequently have an operational focus but must ensure that they are in a position to provide the required assurances on their operations and on any risks, actions and controls for which they are responsible.

Board or Standing Committee agenda

In general, for an item to be included on the agenda it should meet the following criteria unless the Committee Chair and Lead Officer agree there are good reasons for its inclusion:

a. It is a decision delegated to that Committee
b. It relates to and/or provides assurance upon a risk delegated to that Committee. In this context, performance reports etc should be overtly related to the specific risk and should contain a conclusion on whether the performance reports indicate that controls are operating effectively to mitigate the risk as intended
c. It is a statutory or regulatory requirement or required by SG guidance
d. The Committee can add value to a decision or issue by providing a different perspective, setting boundaries, generating ideas etc.

Assurance

At the start of the year, the Committee should consider its remit and determine its assurance requirements together with how these will be met, using assurance mapping principles. This should be set out in the Committee assurance plan or clearly identified within the Committee work plan. The 'three lines of assurance' are often used to help categorise assurances

- First line: management assurance from "front line" or business operational areas;
- Second line: oversight of management activity, including effective management information, separate from those responsible for delivery, but not independent of the organisation's management chain;
- Third line: independent and more objective assurance, including the role of Internal Audit and from external bodies

Assurances should be:

a. Overtly linked to the relevant risk with an overt conclusion from the responsible director or officer
b. Streamlined so that there is no omission, no unnecessary duplication

c. Relevant: data should not be presented just because it is readily available
d. Reliable: assurances should be evaluated so that it is clear how much weight should be placed on any piece of evidence and how they fit in with other relevant evidence
e. Sufficient: there should be sufficient evidence in total to allow a reasonable conclusion to be reached

The Board has delegated responsibility for most strategic risks to Standing Committees. Following a discussion of an agenda item, the committee should formally assess the level of assurance received. This is reported to the Board via the Chair's assurance report (see below). The following criteria (based on work undertaken by the Good Governance Institute) can help in assessing the level of assurance:

a. Independent assurance (e.g. an auditor's opinion) carries more weight than internal evidence produced by management
b. The best assurance is commissioned specifically to assure that a control is effective: reams of evidence with only indirect relevance does not provide good assurance
c. Assurances are time-limited and should only be relied upon if current
d. Differentiate between positive, negative and neutral opinion when using independent assurance
e. Ensure that assurance is consistent: triangulate different sources and use independent evidence to assess the accuracy of internal assurance sources

Appendix A provides examples of questions that Committees and groups should ask about risks.

Chair's report /Assurance Report

Minutes are valuable for the group itself but are not normally an efficient and effective source of assurance. An assurance report allows issues to be collated and presented in a way that gives readers a quick and comprehensive summary of the key issues, without considering unnecessary detail or having to decode or investigate areas of interest. The following questions should be considered at the end of every Standing Committee and sub-group meeting and areas for recording agreed. These should then be included in the Chair's summary/assurance report and taken forward by the Responsible Director:

a. Are there any issues which could be a disclosure in the Governance Statement (see below) or should be included within the Committee year-end report
b. Are there any new risks emerging which require escalation to the Board or recording in the Strategic or operational risk registers
c. Is the Committee fulfilling its workplan and if not, would any omissions have an impact on its ability to provide assurance at year-end
d. For the risks delegated to the Committee:

    - Are the scores correct?
    - Have there been any significant movements?
    - Has the committee received assurances that internal controls intended to mitigate the risk are working as intended and are effective?
    - Does performance reporting support this?
    - Has the committee received assurances that actions intended to reduce the risk to its target level are working as intended and will be effective?

Year-end reports

At the end of the financial year, Standing Committees provide their annual report to the A&RC (and Board). Standing Committee annual reports are an opportunity to reflect on the year just gone and should be used to consider overall progress and key issues going forward. The annual report should be focused on the most important issues and should include, as a minimum:

a. A clear description of movement in strategic risks aligned to the committee and areas where actions were not effective
b. Overt identification of areas of non-compliance and explanation of the impact on the control environment
c. Clear performance information and highlighting of areas of poor performance
d. Inclusion of Key Performance Indicators where possible
e. Rather than stating that a report was presented, providing a broad conclusion on whether the level of assurance provided was acceptable (noting that the new process for assessing assurance will aid this recommendation)
f. Any specific requirements for that Committee based on its remit or duties such as an overt opinion by the SGC on whistle-blowing arrangements based on an appropriate annual report or the FP&RC opinion on whether value for money was achieved
g. Consideration of key risks and concerns and how these will be reflected in the workplan for the year ahead.

The Audit & Risk Committee must decide whether an item is of sufficient significance to be included in the narrative of, or disclosed within, the Governance statement. By extension Standing Committees should consider whether an item should be brought to the attention of the Audit & Committee within their annual report/assurance statement. Useful considerations in deciding whether an item should be disclosed include:

a. Is it material? The HIS risk management 'impact' criteria provide a helpful guide.
b. Does it represent a control weakness? Some issues could not reasonably have been prevented.
c. Was the control weakness in place in the year in question? A weakness in place throughout most of the year should be mentioned, even if resolved after or at year-end. However, if the issue was discovered in year but related to a weakness in previous years now rectified then it need not be disclosed.

Appendix A - Assessing risks

Questions for Risk Owners:

- Would you know if your controls are working effectively as intended or failing?
- Can you evidence the effectiveness of the controls?
- Can you assure your Governance Committee of the effectiveness of controls?
- Do you have assurance for all three lines of defence?
    - 1st line - management / performance / data trends
    - 2nd line – oversight / compliance / audits
    - 3rd line – internal audit and/or external audit reports / external assessments
- If Yes - why above appetite?
- If No – How are the mitigating controls reflecting improvement or is there an action plan?
- Do you understand both the criticality and effectiveness of controls
    - Criticality: How important to the mitigation of the risk? The higher the importance of the control in mitigating the risk, the more assurance is required. If the control is of low importance is it a valid control to attach resource / effort
    - Effectiveness: This should measure if the controls are well designed / appropriate as well as how effectively they are implemented

Risk Questions for Committees

General questions:

- Do the current controls match the stated risk?
- How weak or strong are the controls? Are they both adequate i.e. well-designed and effective i.e. implemented properly
- Will further actions bring risk down to the planned level?
- Does the assurance you receive tell you how controls are performing?
- Are we investing in areas of high risk instead of those that are already well-controlled?
- Do Committee papers identify risk clearly and overtly link to the BAF/risk?

Specific questions when analysing a risk delegated to the committee in detail:

- History of the risk (when was risk opened)- has it moved towards target at any point?
- Is there a valid reason given for the current score
- Is the target score:
    - In line with appetite
    - Realistic/achievable or does the risk require to be tolerated at a higher level?
    - Sensible/worthwhile
- Is there an appropriate split between:
    - Controls – processes already in place which take the score down from its initial/inherent position to where it is now
    - Actions – planned initiatives which should take it from its current to target
    - Assurances which monitor the application of controls/actions
    - Ensuring there is clarity over what the listed controls etc. actually do e.g. if there is a group, what is it for (noting a group might be all three or actually none)?

- Assessing controls
    - Are they 'Key' i.e. are they what actually reduces the risk to its current level (not an extensive list of processes which happen but don't actually have any substantive impact)
    - Overall, do the controls look as if they are applying the level of risk mitigation stated
    - Is their adequacy assessed by the risk owner– if so , is it reasonable based on the evidence provided
- Assessing Actions – as controls but accepting that there is necessarily more uncertainty :
    - are they are on track to be delivered
    - are the actions achievable or does the necessary investment outweigh the benefit of reducing the risk?
    - are they likely to be sufficient to bring the risk down to the target score
- Assess Assurances:
    - Do they actually relate to the listed controls and actions (surprisingly often they don't)?
    - Do they provide relevant, reliable and sufficient evidence either individually or in composite?
    - Do the assurance sources listed actually provide a conclusion on whether:
        - the control is working
        - action is being implemented
        - the risk is being mitigated effectively overall (e.g. performance reports look at the overall objective which is separate from assurances over individual controls) and is on course to achieve the target level
    - What level of assurance is given or can be concluded and how does this compare to the required level of assurance (commensurate with the nature or scale of the risk):
        - 1st line - management / performance / data trends
        - 2nd line – oversight / compliance / audits
        - 3rd line – internal audit and/or external audit reports / external assessments

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**13 May 2021**
Title:	**Committee Annual Workplan 2021-22**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Gillian MacIntosh, Board Secretary**

1. Purpose

This is presented to the Board for:

- Assurance

This report relates to a:

- Local policy

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

- Effective

2. Report Summary

2.1 Situation

The Audit & Risk Committee last agreed its annual workplan in July 2020, to manage effectively the work of the Committee throughout the year. The extant plan took account of the impact of Covid on the Committee's schedule of business, particularly the extended timetable for the approval of the 2019-20 annual accounts. The version of the workplan for this year similarly reflects the September 2021 date for the consideration of this year's annual financial statements.

2.2 Background

The Audit & Risk Committee normally sets out the planned work for the financial year in its annual workplan, which is used to inform the content of individual meeting agendas. The NHS Fife *Code of Corporate Governance* states that all Committees "will draw up and approve, before the start of each year, an annual workplan for the Committee's planned work during the forthcoming year". It was not possible to consider the workplan at the Committee's last meeting in March, due to the prioritised agenda then being followed, hence the paper's submission in May in this particular year.

2.3 Assessment

An updated version of the Audit & Risk Committee workplan is attached for the Committee's consideration. Included therein, as agreed at the Committee's last meeting, are two post-meetings each year (May and December) for members to meet privately with the Internal and External Auditors, without management present.

2.3.1 Quality/ Patient Care

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

2.3.2 Workforce

N/A.

2.3.3 Financial

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

2.3.4 Risk Assessment/Management

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

2.3.5 Equality and Diversity, including health inequalities

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

2.3.6 Other impact

N/A.

2.3.7 Communication, involvement, engagement and consultation

N/A.

2.3.8 Route to the Meeting

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

2.4 Recommendation

The paper is provided for:

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

3 List of appendices

The following appendices are included with this report:

- Appendix 1 – Annual Workplan 2021-22

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

AUDIT & RISK COMMITTEE – ANNUAL WORKPLAN 2021/22

	Lead	May	June	September	December	March
General						
Minutes of Previous Meetings	**Chair**	√	√	√	√	√
Annual Workplan	**Board Secretary**	√				√
Corporate Calendar	**Board Secretary**			√		
Escalation of Issues to NHS Board	**Chair**	√	√	√	√	√
Review of Terms of Reference	**Board Secretary**					√
Annual Review of Code of Corporate Governance	**Board Secretary**	√				
Governance – General						
Committee Self-Assessment	**Board Secretary**	√				√
Annual Assurance Statement	**Board Secretary**	√ draft		√		
Annual Assurance Statements from Standing Committees	**Board Secretary**			√		
IJB Annual Assurance Statement	**Board Secretary**			√		
Significant Issues of Wider Interest	**DoF**		√			
Governance Statement	**DoF**		√ draft	√		
Review of Property Transactions	**Chief Internal Auditor**			√		
Governance – Internal Audit						
Internal Audit Progress Report	**Chief Internal Auditor**	√	√	√	√	√
Annual Internal Audit Report	**Chief Internal Auditor**		√ draft	√		
Internal Audit – Follow Up Report on Audit Recommendations	**Chief Internal Auditor**	√		√	√	√
Annual Internal Audit Plan	**Chief Internal Auditor**	√ draft	√			
FTF Shared Service Agreement / Service Specification	**Chief Internal Auditor**				√	
External Quality Assessment (5 yearly)	**Chief Internal Auditor**			√		
Governance – External Audit						
Interim Management Report	**External Audit**		√			
Annual Audit Report	**External Audit**			√		
Annual Audit Plan	**External Audit**				√	
Audit Planning Memorandum – Fife Health Charity	**External Audit**	√				
Audit Planning Memorandum – Patients' Private Funds	**External Audit**	√				
External Audit – Follow Up Report on Audit Recommendations	**DoF**				√	√
Service Auditor Reports on Third Party Services	**DoF**			√		

	Lead	May	June	September	December	March
Annual Accounts						
Annual Accounts & Financial Statements	**DoF / External Auditor**			√		
Patients' Funds Accounts	**DoF / External Auditor**			√		
Annual Statement of Assurance to the NHS Board	**Board Secretary**			√		
Letter of Representation	**DoF**			√		
Risk						
Annual Risk Management Report	**DoF**		√			
Report against Risk Management Workplan	**DoF**	√		√		√
Risk Management Key Performance Indicators	**DoF**	√		√	√	√
Quarterly Report Corporate Risk Register	**DoF**		√	√	√	√
Board Assurance Framework (BAF)	**DoF**	√	√	√	√	√
Counter Fraud						
Counter Fraud Service – Quarterly Report (Alerts & Referrals)	**HoFS**	√		√	√	√
Partnership Agreement Between Health Boards and CFS	**HoFS**					√
Other / Adhoc						
Private Meeting with Internal / External Auditors	**Committee**	√			√	
Appointment of Statutory Auditor	**DoF**	**As required**				
Appointment of Patients' Funds Auditor	**DoF**					
Progress on National Fraud Initiative (NFI)	**HoFS**					
Legal & regulatory updates (e.g. Audit Scotland reports; Technical Bulletin etc)	**DoF**					

May 2021

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**13 May 2021**
Title:	**Committee Self-Assessment Report 2020-21**
Responsible Executive:	**Margo McGurk, Director of Finance**
Report Author:	**Gillian MacIntosh, Board Secretary**

1 Purpose

This is presented to the Board for:

- Discussion

This report relates to a:

- Local policy

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

- Effective

2 Report summary

2.1 Situation

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

2.2 Background

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

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

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

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

2.3 Assessment

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

Chairs' Checklist (completed by Chair only)

It was agreed that the Committee was currently operating as per its Terms of Reference. The two vacancies at the time of completion were however noted (which are being addressed through the recruiting process). Scheduling private meetings between the Chair and Internal and External Auditors, plus arranging time for the Committee to meet with both in private also, will be timetabled for the year ahead.

Self-Assessment questionnaire (completed by members and attendees)

In total, 2 members (excluding the Chair) and 3 regular attendees completed the questionnaire. The reduction in responses from previous years is indicative of the membership vacancies at the time of the survey's completion amongst the Non-Executive members. In general, the Committee's current mode of operation received a positive assessment from its members and attendees who participated. The recent training opportunities have been welcomed, particularly those timed around the scrutiny of the annual accounts. The quality and detail of reports and minutes, and the timeliness of the issue of meeting papers, were highlighted positively. Satisfaction was also expressed as to how the Committee has operated during the pressures of the Covid-19 pandemic period.

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

- the present membership challenges, impacting on the potential quoracy of meetings, and the need for enhanced financial skills amongst the membership (an update on Board member recruitment can be given at the meeting); and
- an appetite for further training sessions from members (suggestions for topics always welcome).

2.3.1 Quality/ Patient Care

N/A

2.3.2 Workforce

N/A

2.3.3 Financial

N/A

2.3.4 Risk Assessment/Management

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

2.3.5 Equality and Diversity, including health inequalities

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

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

N/A

2.3.8 Route to the Meeting

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

2.4 Recommendation

This paper is provided for:

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

3 List of appendices

The following appendices are included with this report:

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

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

		Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Comments
A. Committee membership and dynamics							
A1.	The Committee has been provided with sufficient membership, authority and resources to perform its role effectively and independently.	-	4 (80%)	1 (20%)	-	-	There have been concerns recently about the Committee not being quorate if all invited attendees are not present. Financial experience may be lacking. Although due to recent changes in the Board it has left the Committee membership in a very challenging position should someone be unable to attend. I would imagine that this will be in the process of being rectified though.
A2.	The Committee's membership includes appropriate representatives from the organisation's key stakeholders.	-	5 (100%)	-	-	-	Chief Executive attendance is important.
A3.	Committee members are clear about their role and how their participation can best contribute to the Committee's overall effectiveness.	-	5 (100%)	-	-	-	
A4.	Committee members are able to express their opinions openly and constructively.	2 (40%)	2 (40%)	1 (20%)	-	-	Have had no issues in taking part in any discussion or topic.
A5.	There is effective scrutiny and challenge of the Executive from all Committee members, including on matters that are critical or sensitive.	1 (20%)	4 (80%)	-	-	-	
A6.	The Committee has received appropriate training / briefings in relation to the areas applicable to the Committee's areas of business.	-	4 (80%)	1 (20%)	-	-	Training from internal audit and external audit provided As far as I am aware, although there will always be new things added as time moves on.

A7.	Members have a sufficient understanding and knowledge of the issues within its particular remit to identify any areas of concern.	-	4 (80%)	1 (20%)	-	-	
B. Committee meetings, support and information							
B1.	The Committee receives timely information on performance concerns as appropriate.	-	5 (100%)	-	-	-	
B2.	The Committee receives timely exception reports about the work of external regulatory and inspection bodies, where appropriate.	-	3 (60%)	2 (40%)	-	-	Mostly Audit Scotland reports.
B3.	The Committee receives adequate information and provides appropriate oversight of the implementation of relevant NHS Scotland strategies, policy directions or instructions.	-	4 (80%)	1 (20%)	-	-	
B4.	Information and data included within the papers is sufficient and not too excessive, so as to allow members to reach an appropriate conclusion.	1 (20%)	4 (80%)	-	-	-	Accompanying SBAR with papers helpful in this respect. On the most part.
B5.	Papers are provided in sufficient time prior to the meeting to allow members to effectively scrutinise and challenge the assurances given.	1 (20%)	4 (80%)	-	-	-	I don't remember late papers being a particular issue with this committee.
B6.	Committee meetings allow sufficient time for the discussion of substantive matters.	2 (40%)	3 (60%)	-	-	-	
B7.	Minutes are clear and accurate and are circulated promptly to the appropriate people, including all members of the Board.	2 (40%)	3 (60%)	-	-	-	Minutes are excellent.

B8.	Action points clearly indicate who is to perform what and by when, and all outstanding actions are appropriately followed up in a timely manner until satisfactorily complete.	1 (20%)	4 (80%)	-	-	-	
B9.	The Committee is able to provide appropriate assurance to the Board that NHS Fife's policies and procedures (relevant to the Committee's own Terms of Reference) are robust.	-	5 (100%)	-	-	-	Limited but would expect that.
B10.	Committee members have confidence that the delegation of powers from the Board (and, where applicable, the Committee to any of its sub-groups) is operating effectively as part of the overall governance framework.	-	5 (100%)	-	-	-	
C. The Role and Work of the Committee							
C1.	The Committee reports regularly to the Board verbally and through minutes and makes clear recommendations on areas under its remit when necessary.	2 (40%)	3 (60%)	-	-	-	
C2.	In discharging its governance role, the focus of the Committee is at the correct level.	1 (20%)	4 (80%)	-	-	-	
C3.	The Committee's agenda is well managed and ensures all topics within the Committee's Terms of Reference are appropriately covered.	1 (20%)	4 (80%)	-	-	-	
C4.	Key decisions are made in a structured manner and can be publicly evidenced.	-	5 (100%)	-	-	-	Evidence is through the detailed minutes of the meetings as held. I'm happy that all decisions that have been taken have been based on evidence from supporting reports.

C5.	What actions could be taken, and in what areas, to further improve the effectiveness of the Committee in respect of discharging its remit?	The committee appears to function effectively, although I am not aware of discussions being taken outside of the committee if there are disagreements (although these may be happening without it being stated). With the exception of the short membership at the moment I am happy with the committee and how it operates. In relation to the scrutiny of the Annual Accounts and Report, there are no members with a financial background. Perhaps some training and awareness sessions would help. There was a session pre the review of the accounts in 2019/20, it would be helpful if this could be repeated.					
C6.	Particularly in reference to the challenges faced during the ongoing Covid pandemic, are you content with the Committee's input and oversight of areas of NHS Fife's response relevant to the Committee's particular remit? Please provide comments.	Yes, I am happy. The Committee were very supportive of reviewing and using the Internal Audit Governance Checklist (COVID). The Committee also looked for evidence of positive assurance from the other governance committees that this was being considered throughout the year.					
D. Audit & Risk Committee specific questions							
AR1.	At least one of the Audit & Risk Committee members has sufficient relevant and recent financial experience.	-	-	4 (80%)	1 (20%)	-	I am unaware as to others' financial experience; however I have been assured that there are members of the committee with sufficient experience as this has been an issue I have previously raised. I am not aware whether any of the Non-Executive members have relevant and recent financial experience.
AR2.	All members, including the chair, are suitably independent of the Executive function.	2 (40%)	2 (40%)	1 (20%)	-	-	
AR3.	Members are sufficiently independent of the other key committees of the Board.	1 (20%)	4 (80%)	-	-	-	I have confidence in the ability of the members to scrutinise anything that comes before the committee without any issues.
AR4.	The Audit & Risk Committee annual schedule of meetings is suitable for NHS Fife's business and governance needs, as well as the requirements of the financial reporting calendar.	1 (20%)	4 (80%)	-	-	-	Meetings adapted last year to meet financial accounts

AR5.	The Audit & Risk Committee appropriately satisfies itself that the arrangements for risk management, control and governance have operated effectively throughout the reporting period.	1 (20%)	4 (80%)	-	-	-	
AR6.	The Audit & Risk Committee effectively considers how accurate and meaningful the Governance Statement is.	-	5 (100%)	-	-	-	Agree, this is an area where focus should be evidenced on an ongoing basis.
AR7.	The Audit & Risk Committee appropriately considers how it should coordinate with other Committees that may have responsibility for risk management and corporate governance.	-	5 (100%)	-	-	-	
AR8.	The Audit & Risk Committee has satisfied itself that NHS Fife has adopted appropriate arrangements to counter and deal with fraud.	1 (20%)	4 (80%)	-	-	-	We have regular updates from the relevant parts of the service regarding efforts to reduce fraud.
AR9.	The Audit & Risk Committee has been made aware of the role of risk management in the preparation of the internal audit plan.	1 (20%)	4 (80%)	-	-	-	
AR10.	The Audit & Risk Committee's role in the consideration of the annual accounts is clearly defined.	2 (40%)	3 (60%)	-	-	-	
AR11.	The Audit & Risk Committee has gained an appropriate understanding of management's procedures for preparing NHS Fife's annual accounts.	1 (20%)	4 (80%)	-	-	-	
AR12.	The Audit & Risk Committee approves, annually and in detail, the internal audit plans, including consideration of whether the scope of internal audit work addresses NHS Fife's significant risks.	1 (20%)	3 (60%)	1 (20%)	-	-	

AR13.	Outputs from follow-up audits by internal audit are appropriately monitored by the Audit & Risk Committee and the Committee considers the adequacy of implementation of recommendations.	1 (20%)	3 (60%)	1 (20%)	-	-	There was an issue last year regarding outstanding actions / follow ups, however this was effectively addressed.
AR14.	There is appropriate co-operation between the internal and external auditors.	1 (20%)	3 (60%)	1 (20%)	-	-	As far as I am aware. I have never had any concerns to note from the reports as presented.
AR15.	The Audit & Risk Committee reviews the adequacy of internal audit staffing and other resources.	-	4 (80%)	1 (20%)	-	-	
AR16.	Internal audit performance measures are appropriately monitored by the Audit & Risk Committee.	2 (40%)	3 (60%)	-	-	-	
AR17.	The external auditors effectively present and discuss their audit plans and strategy with the Audit & Risk Committee (recognising the statutory duties of external audit).	1 (20%)	4 (80%)	-	-	-	
AR18.	The Audit & Risk Committee appropriately reviews the external auditor's annual report to those charged with governance.	1 (20%)	4 (80%)	-	-	-	
AR19.	The Audit & Risk Committee adequately ensures that officials are monitoring action taken to implement external audit recommendations.	-	4 (80%)	1 (20%)	-	-	
AR20.	The Audit & Risk Committee assesses effectively the performance of external audit.	-	3 (60%)	1 (20%)	1 (20%)	-	
AR21.	Agenda papers are circulated timely in advance of the meeting, to allow adequate preparation by Audit & Risk Committee members.	2 (40%)	3 (60%)	-	-	-	

AR22.	Reports to the Audit & Risk Committee communicate relevant information at the right frequency, time and in a format that is effective.	1 (20%)	4 (80%)	-	-	-	

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**13 May 2021**
Title:	**Draft Audit & Risk Committee Annual Statement of Assurance 2020-21**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Gillian MacIntosh, Board Secretary**

1 Purpose

This is presented to the Board for:

- Assurance

This report relates to a:

- Legal requirement
- Local policy

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

- Effective

2 Report summary

2.1 Situation

All formal Committees of the NHS Board are required to provide an Annual Statement of Assurance for the NHS Board. The requirement for these statements is set out in the Code of Corporate Governance. The Audit & Risk Committee is invited to review the draft of this year's report and comment on its initial content, with a view to considering a final paper at the Committee's meeting in September.

2.2 Background

Each Committee must consider its proposed Annual Statement at the first Committee meeting of the new financial year, as per the Committee's workplan. There are some areas within the Statement for which content cannot as yet be provided (largely with Section 4), as the Committee has not yet reviewed the assurance statements from the Board's other governance committees and the IJB, which help to inform any areas of potential disclosure in the final Governance Statement. Each Board Committee is reviewing their respective draft statements at their meetings in April / May and comments received at those meeting will help inform the versions that come to Audit & Risk. The IJB assurance statement will

be considered by their Audit & Risk Committee in early June and will be provided to us shortly thereafter.

Given the extended timeframe for approval of the accounts this year, amendments can be discussed and recommended and a final version brought back to Committee for formal approval. This process is being followed for all the governance committees meeting in this cycle.

2.3 Assessment

In addition to recording practical details such as membership and rates of attendance, the format of the report includes a more reflective and detailed section (Section 4) on agenda business covered in the course of 2020-21, with a view to improving the level of assurance given to the NHS Board.

2.3.1 Quality/ Patient Care

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

2.3.2 Workforce

N/A.

2.3.3 Financial

The production and review of year-end assurance statements are a key part of the financial year-end process.

2.3.4 Risk Assessment/Management

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

2.3.5 Equality and Diversity, including health inequalities

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

2.3.6 Other impact

N/A.

2.3.7 Communication, involvement, engagement and consultation

N/A.

2.3.8 Route to the Meeting

This paper has been considered in draft by the Committee Chair and the Director of Finance & Strategy and takes account of any initial comments thus received.

2.4 Recommendation

The paper is provided for:

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

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

ANNUAL STATEMENT OF ASSURANCE
FOR THE AUDIT & RISK COMMITTEE 2020/21

1. Purpose of Committee

1.1 The purpose of the Audit & Risk Committee is to provide the Board with assurance that the activities of Fife NHS Board are within the law and regulations governing the NHS in Scotland and that an effective system of internal control is maintained.

1.2 The duties of the Audit & Risk Committee are in accordance with the principles and best practice outlined in the Scottish Government Audit & Assurance Committee Handbook, dated April 2018.

2. Membership of Committee

2.1 During the financial year to 31 March 2021, membership of the Audit & Risk Committee comprised:

Martin Black	Chair / Non-Executive Member
Sinead Braiden	Non-Executive Member
Cllr David Graham	Stakeholder Member
Aileen Lawrie	Area Clinical Forum Representative (from March 2021)
Katy Miller	Non-Executive Member (until November 2020)
Janette Owens	Area Clinical Forum Representative (until January 2021)

2.2 The Committee may choose to invite individuals to attend the Committee meetings for the consideration of particular agenda items, but the Board Chief Executive, Director of Finance & Strategy, Director of Nursing (as the Executive lead for risk), Board Secretary, Chief Internal Auditor and statutory External Auditor are normally in routine attendance at Committee meetings. Other attendees, deputies and guests are recorded in the individual minutes of each Committee meeting.

3. Meetings

3.1 The Committee met on six occasions during the year to 31 March 2021, on the undernoted dates:

- 18 June 2020
- 13 July 2020
- 17 September 2020
- 19 November 2020
- 19 January 2021
- 18 March 2021

3.2 The attendance schedule is attached at Appendix 1.

4. Business

4.1 The business of the Committee during the year has been impacted greatly by the need for NHS Fife as a whole to address the ongoing challenges of the global Coronavirus pandemic. In recognition of the rapid mobilisation of services to tackle rising rates of Covid-19 infection, approval to revise governance arrangements across NHS Boards was given by the Scottish Government in a letter to Board Chairs in late March 2020 (the NHS in Scotland has remained on

an Emergency Footing continually since that date). At their April 2020 meeting, the Board approved a 'governance-lite' approach aimed at allowing NHS Fife to effectively respond to Covid-19 pressures, maximise the time available for management and operational staff to deal with the significant challenges of addressing demand within clinical services, and, at the same time, allow the Board to appropriately discharge its governance responsibilities.

4.2 Whilst the scheduled dates in May 2020 for the Board's governance committees were stood down due to the ongoing impact of the pandemic, a series of Covid-19 related briefing sessions were held for each Board Committee in June, tailored to each Committee's specific remit. Committee meetings largely resumed on their regular schedule from July 2020 onwards, though the normal timeline for the approval of the Board's Annual Accounts was delayed by five months. Agendas for Committee meetings since that time have reflected the priorities of the Board's ongoing response to Covid-19, in addition to the consideration of business otherwise requiring formal approval or scrutiny for assurance purposes. The Chair, Vice-Chair and Committee Chairs have liaised closely with the Executive Team to identify what business must be considered by the Board and its committees and what must be prioritised in agenda planning. In the period covered by this report, some routine business has been suspended or deferred. Each Committee's workplan has however been reviewed to ensure that new items related to Covid-19 are covered appropriately and that the required assurances can still be provided to the Board as part of the year-end process. Each Committee has also actively considered a governance checklist, prepared initially by Internal Audit and recommended by the Audit & Risk Committee for adoption by all standing committees, to help enhance agenda planning and ensure that no areas of risk have been overlooked.

4.3 The range of business covered at meetings held throughout the year, as detailed below, demonstrates that the full range of matters identified in the Audit & Risk Committee's remit is being addressed. In line with its Constitution and Terms of Reference, the Committee has considered standing agenda items concerned with the undernoted aspects:

- Internal Control frameworks and arrangements;
- Internal & External Audit planning and reporting;
- Corporate Governance, including implementation of and compliance with the NHSScotland *Blueprint for Good Governance*;
- Updates to the NHS Fife Code of Corporate Governance;
- Scrutiny of the Board's Annual Statutory Financial Statements including the Governance Statement;
- Risk Management arrangements and reporting, including the Board Assurance Framework; and
- other relevant matters arising during the year.

4.4 The Audit & Risk Committee's first meeting of the 2020-21 reporting year took place in June 2020, where a briefing was given on the changes made to the Board's usual governance arrangements and structures in consequence of Covid-19. The report included detail on the Gold / Silver / Bronze Command groups set up to manage the day-to-day response to the pandemic, including how this structure enhanced agile operational decision-making to support a rapid response to the increase in clinical activity, and detailing also the reporting routes to established groups that provide formal assurance to the Board. Also considered was a briefing from Audit Scotland on the potential impact of the pandemic on their audit approach for financial year 2019/20, changes to the usual reporting timelines for the annual accounts, and their phased approach to future audit work.

4.5 The Committee also considered a report providing members with appropriate assurance that there was a robust structure and process in place for the reporting, review and management of Covid-19 related risks. This noted that the process for identifying, reviewing and monitoring risks was well established within the organisational Command structure, with a template and reporting schedule in place for the Bronze and Silver Commands to review and update all risks in Datix. A

fortnightly report on the high level risks identified by these groups was considered by Gold Command on a fortnightly basis. Many of the Covid-related risks were not Board-specific but relate to national risks common across the health sector, as NHS Scotland as a whole responded to the pandemic. Members noted the intention to mainstream the Covid-related risks into the existing Board Assurance Framework on a long-term basis where appropriate.

4.6 In relation to the Annual Accounts process for 2019-20, as the year began it became apparent that the local capacity and capability within the Finance Directorate to deliver the annual statutory accounts was limited, principally as a result of the departure of two key members of the financial services team. Arrangements were put in place to deliver support from NHS Grampian and NHS Lothian. However, the annual accounts draft submission timeline was significantly delayed as a consequence. The final audit process was concluded in November 2020 and no significant audit issues were raised. Nevertheless, it has been critical to address the capacity issues as quickly as possible. Recruitment commenced for a new Head of Financial Services and an appointment made in December 2020. The new Head of Financial Services commenced employment in March 2021, which the Committee note will support planning and preparations for the 2020-21 annual accounts and audit process.

4.7 In reference to External Audit, the Committee has considered in detail the annual audit plan and the annual audit report. The annual audit report includes a report to those charged with governance on matters arising for the audit of the annual financial statements, as well as comment on financial sustainability, governance and best value. The Committee has also considered national reviews undertaken by Audit Scotland, including their report 'NHS in Scotland 2020', and its implications locally. The Committee has also approved the planning memorandum for both the Endowment Funds and Patients' Private Funds from the respective External Auditor.

4.8 (*Text TBC*) *For assurance purposes, the Audit & Risk Committee has received and considered the annual assurance statements of each of the governance committees of the Board, namely: Clinical Governance Committee; Finance, Performance & Resources Committee; Remuneration Committee; and Staff Governance Committee. These detail the activity of each committee during the year, the business they have considered in discharging their respective remit and an outline of what assurance the Board can take on key matters under their respective remits. No significant issues were identified from these reports for disclosure in the financial statements. In reference to the assurance statement received from the Integration Joint Board, …*

4.9 In relation to internal audit, members have reviewed and discussed in detail at meetings the annual audit plans; the interim evaluation of the internal control framework; reports from the internal auditors covering a range of service areas; and management's progress in completing audit actions raised. A specific progress update from the Clinical Governance Committee, in reference to addressing the recommendations from the Internal Audit review of Adverse Events, was given to members in September 2020, to provide assurance that prompt action was being taken to complete the work required. Across a number of separate reports, Internal Audit have flagged the need for NHS Fife to improve the governance, control framework and assurance processes in place related to Information Governance & Security, and work to address these recommendations has been significantly advanced in the year of reporting. Reporting on compliance with the control framework has now been developed and will be embedded in practice during 2021-22. A review of current transformation programmes will be encompassed within the overall development of a new Health & Well-Being Strategy for Fife, which will succeed the current Clinical Strategy. The Committee looks forward to receiving the assessment of Internal Audit on these developments in due course.

4.10 In relation to internal audit follow-up work, whilst improvements in reducing the number of outstanding actions has been seen in this reporting year, the Committee has noted that further effort is required to enhance the effectiveness and timeliness of completing audit recommendations. The Director of Finance & Strategy has undertaken to improve this as a

priority action, with quarterly consideration of the outstanding actions by the Executive Directors' Group to drive forward prompt resolution.

4.11 On behalf of the Board, the Audit & Risk Committee receives regular updates on the workstreams being progressed within NHS Fife for compliance with the NHSScotland *Blueprint for Good* Governance, including the national work ongoing to develop a suite of standard documentation on a 'Once for Scotland' approach. Whilst many of the national workstreams have been delayed due to the impact of the pandemic on NHSScotland, the Committee has received an update on the Board's Blueprint action plan at its September 2020 meeting. A number of the outstanding actions have been completed, and progress with the remainder was reported within, in tandem with revised target dates for completion. The Board's own Code of Corporate Governance has undergone annual review and a number of clarifying changes made, to ensure it remains up-to-date with current practice.

4.12 During the year, members of the Committee have engaged in a number of training opportunities, covering best practice arrangements for Audit & Risk Committees. A discussion session with the Internal and External Auditors was held in March 2020, outlining the year-end processes each undertake as part of the review of the financial statements and systems of internal control, in preparation for the review of the annual accounts. A follow-up training session by Audit Scotland, covering the annual accounts scrutiny process, was delivered in September 2020, prior to the Committee's formal consideration of the 2019-20 financial statements.

4.13 In January 2021, the Committee received a training and awareness-raising session from Gordon Young, Head of the Counter Fraud Service (CFS) at NHS NSS. Mr Young delivered an informative presentation on the work being undertaken to detect, investigate and prevent fraud, including new activity linked to opportunities for fraud brought about by the Covid pandemic. It has been agreed to make widely available to staff, via the new employee app StaffLink, details from CFS intelligence alerts, to ensure all staff are aware of current scams and frauds that might be perpetrated within NHS Fife.

4.14 Progress with fraud cases and counter fraud initiatives were discussed by the Committee in private session on a regular basis throughout the year. The Committee received quarterly fraud updates, which provided members with updates on NHS Fife fraud cases, counter fraud training delivered to staff, initiatives undertaken to identify and address fraud, and the work carried out by Practitioner & Counter Fraud Services in relation to detecting, deterring, disabling and dealing with fraud in the NHS. This has provided the Committee with the assurance that the risk of fraud is being managed and addressed across NHS Fife. The Committee has also considered the Annual Report on Patient Exemption Checking, which detailed the work undertaken by CFS in checking the propriety of exemptions claimed by patients for ophthalmic and dental work and summarised the write offs and recoveries for NHS Fife.

4.15 Minutes of Committee meetings have been approved by the Committee and presented to Fife NHS Board. The Board also receives a verbal update at each meeting from the Chair, highlighting any key issues discussed by the Committee at its preceding meeting. The Committee maintains an action register to record and manage actions agreed from each meeting, and reviews progress against deadline dates at subsequent meetings.

5. Best Value

5.1 Since 2013/14 the Board has been required to provide overt assurance on Best Value. A revised Best Value Framework was considered and agreed by the NHS Board in January 2018. Appendix 3 provides evidence of where and when the Committee considered the relevant characteristics during 2020/21.

6. Risk Management

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

6.2 All of the key areas within the organisation maintain a risk register. All risk registers are held on the Datix (Risk Management Information System). Training and support for all Datix modules including risk registers, are provided by the Risk Management team according to the requirements of individuals, specialities and teams etc.

6.3 In line with the Board's agreed risk management arrangements, the Audit & Risk Committee, as a governance committee of the Board, has considered risk through a range of reports and scrutiny, including oversight on the detail of the Board Assurance Framework (BAF). Progress and appropriate actions were noted, and a number of changes to mitigating and operational risks amended, including those to reflect Covid-related risks. In line with assurance mapping principles, the Digital & Information BAF has been reviewed and updated by the former General Manager for Digital & Information, in collaboration with Internal Audit and the Risk Manager. Approval of the revised version through the internal governance routes is underway. The Quality & Safety BAF is scheduled for review as part of Audit B19/21 in line with assurance mapping principles, and this will include an assessment of whether the risk has been appropriately updated to take account of the full impact of Covid-19.

6.4 The Committee received updates on activity related to the risk management workplan during the year, including reports on a suite of key performance indicators. The Risk Framework was updated in September 2020 to incorporate the approach to risk management within the organisation, detailing the responsibilities for managing risks and processes for effective risk management. The Board's approach to risk appetite / tolerance has been outlined therein, as are the appropriate governance structures that are in place to ensure that the relevant committees are aware of the risks that are in our system.

6.5 The revised arrangements relating to the Corporate Risk Register require to be finalised. This register will be subject to a high level Internal Audit review in the coming months. The Board initially agreed its risk appetite in November 2019. The risk appetite statement was due to be reviewed and updated by November 2020, though this activity was delayed due to competing priorities arising from the coronavirus pandemic. Further work is required to update and agree a risk appetite statement that states the type, and level of risks to be eliminated, tolerated or managed based on an assessment of the balance of risk versus reward. The review will take place in Q3 of 2021.

7. Self-Assessment

7.1 The Committee has undertaken a self-assessment of its own effectiveness, utilising a revised questionnaire considered and approved by the Committee Chair. Attendees were also invited to participate in this exercise, which was carried out via an easily-accessible online portal. A report summarising the findings of the survey was considered and approved by the Committee at its May 2021 meeting, and action points are being taken forward at both Committee and Board level.

8. Conclusion

8.1 As Chair of the Audit & Risk Committee during financial year 2020/21, I am satisfied that the integrated approach, the frequency of meetings, the breadth of the business undertaken and the range of attendees at meetings of the Committee has allowed us to fulfil our remit as detailed in the Code of Corporate Governance. As a result of the work undertaken during the year, I can confirm that adequate and effective governance arrangements were in place throughout NHS

Fife during the year. Audit & Risk Committee members conclude that they have given due consideration to the effectiveness of the systems of internal control in NHS Fife, have carried out their role and discharged their responsibilities on behalf of the Board in respect of the Committee's remit as described in the Standing Orders.

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

8.3 I would pay tribute to the dedication and commitment of fellow members of the Committee and to all attendees. I would thank all those members of staff who have prepared reports and attended meetings of the Committee, particularly in this most challenging of years, set against the backdrop of the Coronavirus pandemic.

Signed: _____ Date: _____

Martin Black, Chair
On behalf of the Audit & Risk Committee

Appendix 1 – Attendance Schedule
Appendix 2 – Best Value

APPENDIX 1

AUDIT & RISK COMMITTEE - ATTENDANCE RECORD 2020/21

	18.06.20	13.07.20	17.09.20	19.11.20	19.01.21	18.03.20
Members						
M Black	✓	✓	✓	✓	✓	✓
S Braiden	✓	✓	✓	✓	✓	✓
Cllr D Graham	x	✓	x	x	✓	✓
A Lawrie						✓
K Miller	✓	✓	✓	✓		
J Owens	✓	✓	✓	✓		
In attendance						
C Potter, Chief Executive	✓	✓	✓	✓	✓	✓
M McGurk, Director of Finance & Strategy	✓	✓	✓	✓	✓	✓
H Buchanan, Director of Nursing	✓	x	✓	x	✓	
J Owens, Director of Nursing					✓	x
G MacIntosh, Board Secretary	✓	✓	✓	✓	✓	✓
K Booth, Head of Financial Services						✓
T Gaskin, Chief Internal Auditor	✓	✓	✓	✓	✓	✓
B Hudson, Regional Audit Manager, Fife	✓	✓	✓	✓	✓	✓
P Fraser, Audit Scotland	✓	✓	✓	✓		✓
P Cummings, Risk Manager		✓				
A Clyne, Audit Scotland			✓	✓		✓
B Howarth, Audit Scotland			✓			
L Donovan, eHealth General Manager		✓				
R Mackinnon, Ass. Director of Finance			✓			
A Mitchell, Thomson Cooper (Annual Accounts Endowments)				✓		
S Slayford, Principal Auditor					✓	
R Robertson, Deputy Director of Finance				✓		
C Leith, Financial Planning, Projects & Costing Accountant				✓		
O Notman, Head of Financial Control, NHS Lothian				✓		
G Young, Head of Counter Fraud Service, NSS					✓	

APPENDIX 2

BEST VALUE FRAMEWORK

Vision and Leadership

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

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

GOVERNANCE AND ACCOUNTABILITY

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

OVERVIEW

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

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

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

USE OF RESOURCES

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

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

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

PERFORMANCE MANAGEMENT

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

OVERVIEW

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

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

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
The Board and its Committees approve the format and content of the performance reports they receive	The Board / Committees review the Integrated Performance Report and agree the measures.	**COMMITTEES** **BOARD**	Annual	Integrated Performance & Quality Report
Reports are honest and balanced and subject to proportionate and appropriate scrutiny and challenge from the Board and its Committees.	Committee Minutes show scrutiny and challenge when performance is poor as well as good; with escalation of issues to the Board as required	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance & Quality Report Minutes of Committees
The Board has received assurance on the accuracy of data used for performance monitoring.	Performance reporting information uses validated data.	**COMMITTEES** **BOARD**	Every meeting Annual	Integrated Performance & Quality Report Annual Accounts including External Audit report
NHS Fife's performance management system is effective in addressing areas of underperformance, identifying the scope for improvement, agreeing remedial action, sharing good practice and monitoring implementation.	Encompassed within the Integrated Performance & Quality Report	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance & Quality Report Minutes of Committees

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
NHS Fife overtly links Performance Management with Risk Management to support prioritisation and decision-making at Executive level, support continuous improvement and provide assurance on internal control and risk.	Board Assurance Framework	**AUDIT & RISK COMMITTEE** **BOARD**	Ongoing	Board Assurance Framework Minutes of Committees

CROSS-CUTTING THEME – SUSTAINABILITY

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

OVERVIEW

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

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

Individual Public Bodies may wish to consider comparisons within the wider public sector, rather than within their usual public sector "family". This will assist them in getting an accurate gauge of their true scale and level of influence, as well as a more accurate assessment of the potential impact of any decisions they choose to make. A Best Value organisation will demonstrate an effective use of resources in the short-term and an informed prioritisation of the use of resources in the longer-term in order to bring about sustainable development. Public bodies should also prepare for future changes as a result of emissions that have already taken place. Public Bodies will need to ensure that they are resilient enough to continue to deliver the public services on which we all rely.

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

CROSS-CUTTING THEME – EQUALITY

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

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

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

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

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE:
Wherever relevant, NHS Fife collects information and data on the impact of policies, services and functions on different equality groups to help inform future decisions.	In accordance with the Equality and Impact Assessment Policy, Impact Assessments will collect this information to inform future decisions.	**BOARD** **COMMITTEES**	Ongoing	EQIA forms on reports

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**13 May 2021**
Title:	**Payments to Primary Care Practitioners**
Responsible Executive:	**Margo McGurk, Director of Finance**
Report Author:	**Jacqueline Watson, Primary Care Accountant**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive
- Legal requirement
- Local policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The expenditure budget for Primary Care Practitioners (PCPs) in Fife was £110m, excluding prescribing, for 2020/21. Ensuring that payments made to PCPs on behalf of (and charged to) NHS Fife are accurate and valid is a key element of financial control in the use of resources in NHS Fife. This report provides the Audit and Risk Committee with the annual update on these payments for 2020/21 and the monitoring arrangements in place

2.2 Background

NHS Fife has not met routinely with Dental, Ophthalmic of Medical representatives from the Practitioner Services Division (PSD) of NHS National Services Scotland (NSS) to monitor the payment verification (PV) work undertaken by PSD on behalf of the Health Board for Medical Dental or Ophthalmic. This was due to the Covid-19 pandemic disruption and restriction of services.

Covid-19 Protocol Update:

Following the outbreak of Covid-19 and subsequent lockdown the decision from PSD was made to suspend all PV practice visits for Dental, Ophthalmic and Medical until the situation became clearer. This was not restricted to Fife.

Partnership Agreement Meetings

1. **Covid-19 Contingency Period**. Our annual visits from the Partnership were put on hold due to the Covid-19 restriction throughout 2020

As the Pharmacy service continued in 2021, routine meetings with Pharmacy and finance also continued through MS Teams. Representation at these meetings ensures any significant issues are communicated to the Deputy Director of Finance. Reports were produced and outcomes and issues arising from any of these discussions were documented. Dates of meetings are below in 2.3.7

Scottish Government Health & Social Care Directorates (SGHSCD) issued circular DL (2020) 26 Payment Verification Procedures during 2020/21, notifying the revised payment verification protocol for Primary Medical Services,

This revision includes the following main changes:

- Dental the revision for 2020-21 to the PV Protocol reflects that all claims are now electronic.

- Medical the revision for 2020-21 reflects the continuing changes to the GP contract effective from 1/4/2018 and the introduction of the Scottish Workload Formula.

- Introduction of the Minimum Earnings Expectation and arrangements for assurance review.

- A revision of the Global Sum section in respect of data quality exercises and reporting to NHS Board of registration information.

- Clarification that the 17C Practices section applies to all non GMS contract practices DL (2020)26 01 October 2020

- Ophthalmic the revision for 2020-21 to the PV Protocol reflects that all claims are now electronic.

- Pharmacy The revision for 2020-21 has no significant changes to the PV Protocol, but there will be an update to the risk assessment that determines the priority of PV work to be carried out.

The NHS Fife Payment Verification (PV) Review Group, which includes representatives from both PSD and NHS Fife, ensures that procedures are in place to implement the protocol to give assurance to the Board of the validity and accuracy of payments.

2.3 Assessment

PAYMENT VERIFICATION REPORTS – GENERAL MEDICAL SERVICES

PV reports and visits have been suspended due to the pandemic. Local agreements are in place for the payment of the enhanced services. There was no detriment to practices and an income guarantee from 19/20 was assured.

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

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

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

DIRECTED ENHANCED SERVICES

The Primary Medical Services (Directed Enhanced Services) (Scotland) Directions 2018 was amended to include the Covid-19 Vaccination Programme.

GP practices supported the programme by providing vaccinations by agreement, providing updated data and making their refrigeration facilities available for vaccine storage. The arrangements below apply where GP practices deliver vaccinations directly and where practices provide and update data. GP partners and staff may also be asked to undertake vaccination sessions by their Health Boards: arrangements for these will be made separately. These arrangements were? set locally and rates were? sensitive to local circumstances and local arrangements for the delivery of the programme.

Practice Vaccinations

Health Boards determine how many vaccinations are sought from their GP practices by reference to their local needs, consulting their Local Medical Committees (LMCs) and GP Sub-committees as appropriate. Health Boards then reach agreement with participating practices regarding the number of Vaccinations sought from each practice. Health Boards also agreed? which cohorts of patients will be targeted by practices.

Timing

Contractors were? required to deliver vaccinations in timescales agreed with their Health Boards. Practices were asked to prioritise early vaccination to maximise the timely immuno-protection of eligible individuals. Checks were carried out to ensure that anaphylaxis management was in order.

Reporting arrangements

Apart from monitoring uptake for payment purposes, it is important to provide timely data in the interest of patient safety, particularly in situations where vaccinations will be offered in more than one setting. Health Boards will require all necessary data from practices to support the delivery of the programme. In addition practices need to enter the vaccination data timeously in an electronic record and assist in monitoring uptake. This may include vaccination data delivered through alternative Health Board organised clinics (digital solutions are under development to minimize this requirement). This will be a contractual requirement for all practices regardless of whether individual practices will provide vaccinations, and should be provided timeously to ensure data on uptake rates is up to date and has been agreed with SGPC. Health Boards and contractors are reminded of their need to comply with data protection requirements at all times.

OPHTHALMIC PAYMENTS

No Ophthalmic meetings were held in 20/21 due the disruption and restriction of services due to the pandemic.

MEMORANDUM TO NHS:
PCA(O)2020(6)

1. This Memorandum provides a further important update to all community optometry practices and staff regarding the provision of community eye care services during the Covid-19 pandemic.

DENTAL PAYMENTS

No dental meetings were held in 20/21 due the disruption and restriction of services due to the pandemic.

MEMORANDUM TO NHS: PCA(D)(2020)6 Dentists/Dental Bodies Corporate National Health Service General Dental Services Covid-19 – Business Continuity And Financial Support Measures

1. This Memorandum provides information and guidance to independent contractors, (dentists and dental bodies corporate) providing NHS General Dental Services (GDS) on the steps to take during the Covid-19 outbreak.

PHARMACY PAYMENTS

Pharmacy meetings continued via Teams in 20/21. The last meeting of the Pharmacy Review Group was held on 1st October 2020, The purpose of the meeting was to discuss the PV work for Quarter 1, 2020/21, including PV work completed on Level 3. Minutes are available of each meeting.

The Tableau reports were discussed which highlight the ability to review the costs per NHS Board/service flag type/average per item & rank. NHS Fife is the 7th largest board in Scotland. After discussion at a national level, risk categories targeted by the Payment Verification team for particular scrutiny in are:

- Gluten Free foods
- MAS Pharmacy First July 2020
- MCR
- AMS
- CMS renamed MCR (Medicines Care & Review) Feb 2021

PV check levels are as follows:

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

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

Level 3
Checking will be undertaken as appropriate where the outcome of the above analysis proves unsatisfactory or inconclusive. This may include:
a) Targeted letters to patients to confirm provision of service.
b) Sampling of patient's medication record and associated documentation.

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

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

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

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

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

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

The Board and PV team discussed various service flag outliers: AMS – The NHS Board requested that PV analyse six contractors with an increased average GIC is related to a high cost item/patients; GFF – NHS Board requested that PV monitor for one contractor with a high no of items dispensed in October 2019; MAS – NHS Board requested that PV monitor for one contractor with the largest increase in registrations; CMS - NHS Board requested PV monitor data for two contractors given the increased averages in cost per item and cost per patient. PV is carrying out analysis on MCR at a National level.

Acute Medication Service (AMS) – Q2, 17/18

PV highlighted average costs per item at Contractor levels & discussed the 'NC/ND' endorsing issue.
P&CFS SMT are currently in discussions to find a way forward for NC/ND items. PV will update the NHS Board at the next Quarterly Report meeting.

COMMUNITY PHARMACY CONTRACT

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

- Minor Ailments Service (MAS) Pharmacy First July 2020
- Public Health Service (PHS)
- Acute Medication Service (AMS)
- Chronic Medication Service (CMS) MCR Feb 2021

The first two elements MAS and PHS were introduced in July 2006. AMS now Pharmacy first from July 2020 was introduced in February 2010 allowing electronic transfer of prescriptions data between GP systems and Pharmacies by use of a bar code system. All 85 Community Pharmacies in NHS Fife were scanning and claiming their prescriptions electronically.

CMS renamed MCR (Medicines Care & Review) Feb 2021was implemented on 11th May 2010. CMS provides personalised pharmaceutical care by a pharmacist to patients with long term conditions. Within Fife all 85 pharmacies have registered patients, undertaking review of medicines and completion of Pharmaceutical Care Plans through the on-line support tool; PCR. Serial prescribing is one element of CMS and all GP practices are enabled to provide serial prescriptions (a prescription that can last for 24, 48 or 56 weeks). Community pharmacies are able to receive and process serial prescriptions with a serial prescription. We are also strengthening and refreshing the Chronic Medication Service in order [to] improve how it enables community pharmacists to provide personalised care for people with stable long-term conditions. In Feb 2021 the shape of this service will be enhanced by building in medication review, pharmacist prescribing and monitoring of patient medicines.

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

The total NHS Fife Community Pharmacy expenditure for 2020/21 including the above services was £18m.

COUNTER FRAUD SERVICES (CFS)

PATIENT EXEMPTION CHECKING 2020 - ANALYSIS OF FRAUD/ERROR The programme of patient exemption eligibility checking within the CFS Patient Claims Team (PCT) was suspended in April 2020 due to the Covid-19 pandemic. The PCT were subsequently redeployed to work in the NHS Scotland Test and Protect contact tracing programme. In addition to this, Dental and Ophthalmic services were severely disrupted and restricted for a large part of 2020. As a direct result of this interruption to service provision, and combined with the lack of sampled exemption claim cases, there is not sufficient information available to CFS to allow for a robust and meaningful extrapolation calculation to be produced this year. The PCT resumed their programme of work in January 2021, and CFS anticipate that the production of the annual Extrapolation calculation will resume in 2022.

2.3.1 Quality/ Patient Care

The impact on quality / patient care is a key consideration for all aspects of governance

2.3.2 Workforce

The impact on workforce is a key consideration for all aspects of governance.

2.3.3 Financial

Financial governance is a key function of the payment verification process.

2.3.4 Risk Assessment/Management

Risk management is a key function of the payment verification process.

2.3.5 Equality and Diversity, including health inequalities

N/A

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

The Board has carried out its duties to involve and engage external stakeholders where appropriate:

All Teams meetings have been held via MS Teams.

- Pharmacy PV 27/04/2020 Q3 19/20
- Pharmacy PV 20/07/2020 Q4 19/20
- Pharmacy PV 01/10/2020 Q1 20/21
- Pharmacy PV 27/01/2021 Q2 20/21

2.3.8 Route to the Meeting

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

- N/A

2.4 Recommendation

- **Awareness** – For Members' information only.

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

3 List of appendices

The following appendices are included with this report:

- N/A

Report Contact
Jacqueline Watson
Primary Care Accountant
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NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**13 May 2021**
Title:	**Annual Review of Code of Corporate Governance**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Gillian MacIntosh, Board Secretary / Kevin Booth, Head of Financial Services & Procurement**

1. Purpose

This is presented to the Board for:

- Assurance

This report relates to a:

- Local policy

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

- Effective

2. Report Summary

2.1 Situation

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

The amended Code of Corporate Governance, provided as an appendix to this paper, incorporates recent reviews by each Board Committee of their individual Terms of Reference.

Also proposed are a number of clarifying changes to the Standing Financial Instructions, recommended by the Director of Finance and Head of Financial Services & Procurement. These amendments seek to bring the current version of the Code up-to-date and reflective of current practice. The first amendment (p.48) relates to a request from the Counter Fraud Services (CFS) Steering Group for Boards to make explicit in their SFIs that CFS staff have right of access to any necessary information or

material required in the course of progressing an investigation into fraud (this has been achieved by amending an existing clause). The second amendment established separate project bank accounts for large scale capital projects, as the Board has approved previously for the Elective Orthopaedic Centre.

2.2 Background

The most recent version of the Board's Code of Corporate Governance was formally approved in September 2020. At agreed previously, an annual update of the Code is considered by the Audit & Risk Committee and thence the Board.

2.3 Assessment

In addition to containing each Board Committee's reviewed remits, the attached version of the Code has been reviewed to ensure that the current text reflects present structures, terminology and job titles. Proposed textual changes of note have been tracked in the document for ease of identification.

The Committee should note that further changes to the Code will likely be required in the near future to reflect the work currently underway aligned to the ongoing implementation of the NHS Scotland Blueprint for Good Governance. It is expected that this will produce 'template' Schemes of Delegation and Standing Financial Instructions on a 'Once for Scotland' approach, which individual Boards will be expected to adopt locally as part of implementing the Blueprint, as has already been achieved for the Board's Standing Orders. Additionally, standard Terms of Reference for 'mandatory' Board committees (i.e. Audit, Clinical Governance and Staff Governance) are presently being discussed, again to be adopted locally when finalised by the national group. This work has been delayed due to coronavirus pressures across Boards and limited meetings of the Corporate Governance Steering Group during the pandemic, though it is anticipated these workstreams will be revived in due course.

2.3.1 Quality/ Patient Care

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

2.3.2 Workforce

N/A.

2.3.3 Financial

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

2.3.4 Risk Assessment/Management

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

2.3.5 Equality and Diversity, including health inequalities

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

2.3.6 Other impact

N/A.

2.3.7 Communication, involvement, engagement and consultation

N/A.

2.3.8 Route to the Meeting

This paper has been considered in draft by the Director of Finance & Strategy and takes account of any initial comments thus received.

Each Board Committee reviewed their respective remits and agreed any changes thereto at the cycle of meetings held in March 2021.

2.4 Recommendation

The paper is provided for:

- **Recommending approval to the Board** – subject to members' comments regarding any amendments necessary

3 List of appendices

The following appendices are included with this report:

- Appendix 1 – Revised Code of Corporate Governance

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

CODE OF CORPORATE GOVERNANCE

FIFE NHS BOARD

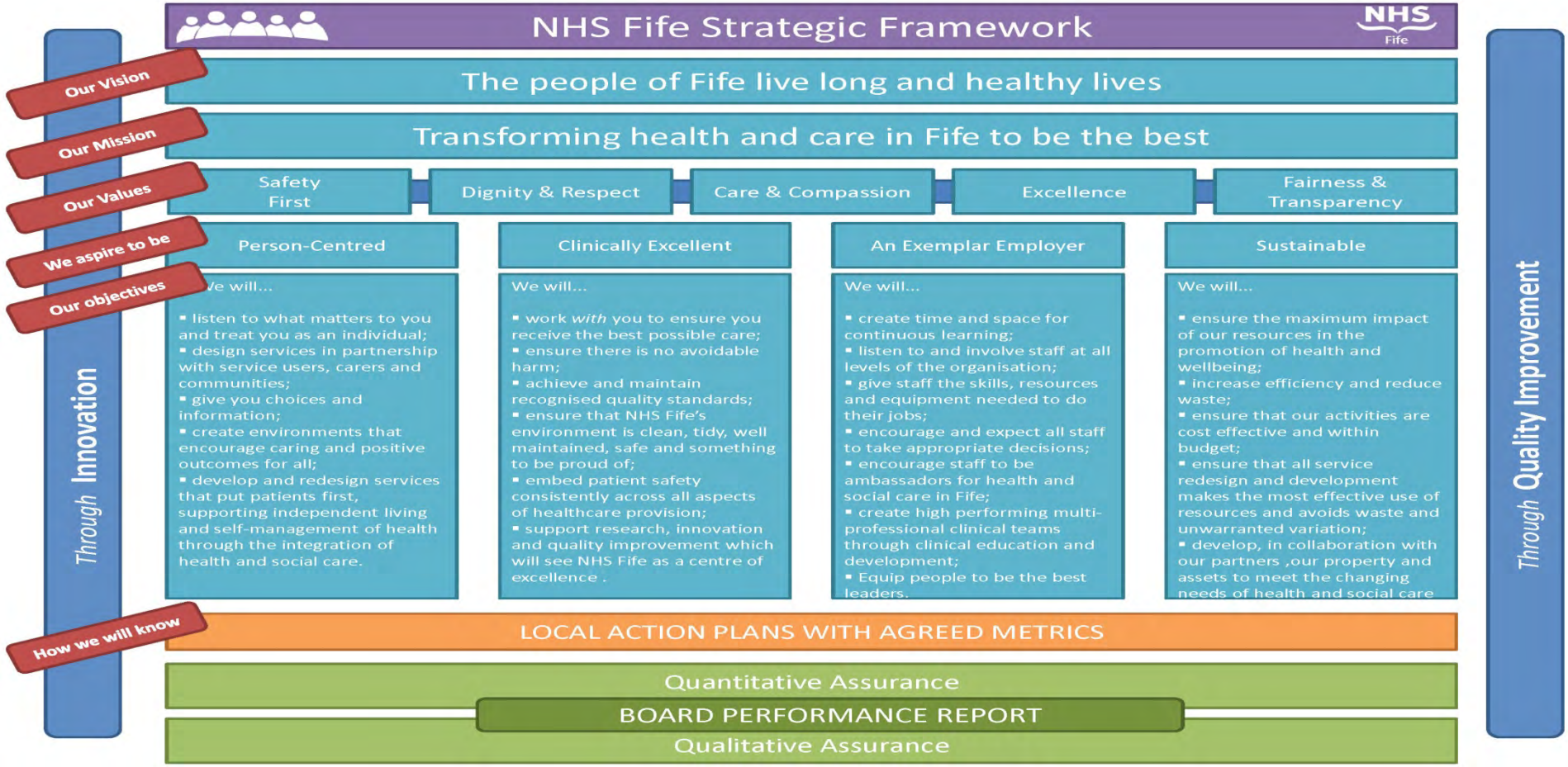
Reviewed by: Board Secretary
Date of Board Approval: ***
Next Review Date: April 2022~~1~~

Issue no. 1~~6~~7 – Master

CONTENTS

NHS FIFE
STRATEGIC FRAMEWORK

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



STANDING ORDERS FOR THE PROCEEDINGS AND BUSINESS OF FIFE NHS BOARD

1 General

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

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

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

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

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

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

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

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

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

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

Board Members – Ethical Conduct

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

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

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

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

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

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

2 Chair

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

3 Vice-Chair

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

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

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

4 Calling and Notice of Board Meetings

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 Conduct of Meetings

Authority of the Person Presiding at a Board Meeting

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

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

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

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

Quorum

5.5 The Board will be deemed to meet only when there are present, and entitled to vote, a quorum of at least one third of the whole number of members, including at least two members who are not employees of a Board. The quorum for

committees will be set out in their terms of reference, however it can never be less than two Board members.

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

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

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

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

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

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

Adjournment

5.12 If it is necessary or expedient to do so for any reason (including disorderly conduct or other misbehaviour at a meeting), a meeting may be adjourned to

another day, time and place. A meeting of the Board, or of a committee of the Board, may be adjourned by the Chair until such day, time and place as the Chair may specify.

Business of the Meeting

The Agenda

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

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

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

Decision-Making

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

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

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

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

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

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

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

Board Meeting in Private Session

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

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

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

Minutes

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

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

6 Matters Reserved for the Board

Introduction

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

6.2 This section summarises the matters reserved to the Board:

a) Standing Orders
b) The establishment and terms of reference of all its committees, and appointment of committee members
c) Organisational Values
d) The strategies for all the functions that it has planning responsibility for, subject to any provisions for major service change which require Ministerial approval.
e) The Annual Operational Plan for submission to the Scottish Government for its approval. (Note: The Board should consider the draft for submission in private session. Once the Scottish Government has approved the Annual Operational Plan, the Board should receive it at a public Board meeting.)
f) Corporate objectives or corporate plans which have been created to implement its agreed strategies.
g) Risk Management Policy.
h) Financial plan for the forthcoming year, and the opening revenue and capital budgets.
i) Standing Financial Instructions and a Scheme of Delegation.
j) Annual accounts and report. (Note: Note: This must be considered when the Board meets in private session. In order to respect Parliamentary Privilege, the Board cannot publish the annual accounts or any information drawn from it before the accounts are laid before the Scottish Parliament. Similarly the Board cannot publish the report of the external auditors of their annual accounts in this period.)
k) Any business case item that is beyond the scope of its delegated financial authority before it is presented to the Scottish Government for approval. The Board shall comply with the Scottish Capital Investment Manual.
l) The Board shall approve the content, format, and frequency of performance reporting to the Board.
m) The appointment of the Board's chief internal auditor. (Note: This applies either when the proposed chief internal auditor will be an employee of the Board, or when the chief internal auditor is engaged through a contract with an external provider. The audit committee should advise the Board on the appointment, and the Board may delegate to the audit committee oversight of the process which leads to a recommendation for appointment.)
n) The contribution to Community Planning Partnerships through the associated improvement plans.
o) Health & Safety Policy
p) Arrangements for the approval of all other policies.
q) The system for responding to any civil actions raised against the Board.
r) The system for responding to any occasion where the Board is being investigated and / or prosecuted for a criminal or regulatory offence.

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

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

7 Delegation of Authority by the Board

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

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

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

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

8 Execution of Documents

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

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

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

9 Committees

9.1 Subject to any direction issued by Scottish Ministers, the Board shall appoint such committees (and sub-committees) as it thinks fit. NHS Scotland Board

Development website will identify the committees which the Board must establish.

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

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

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

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

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

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

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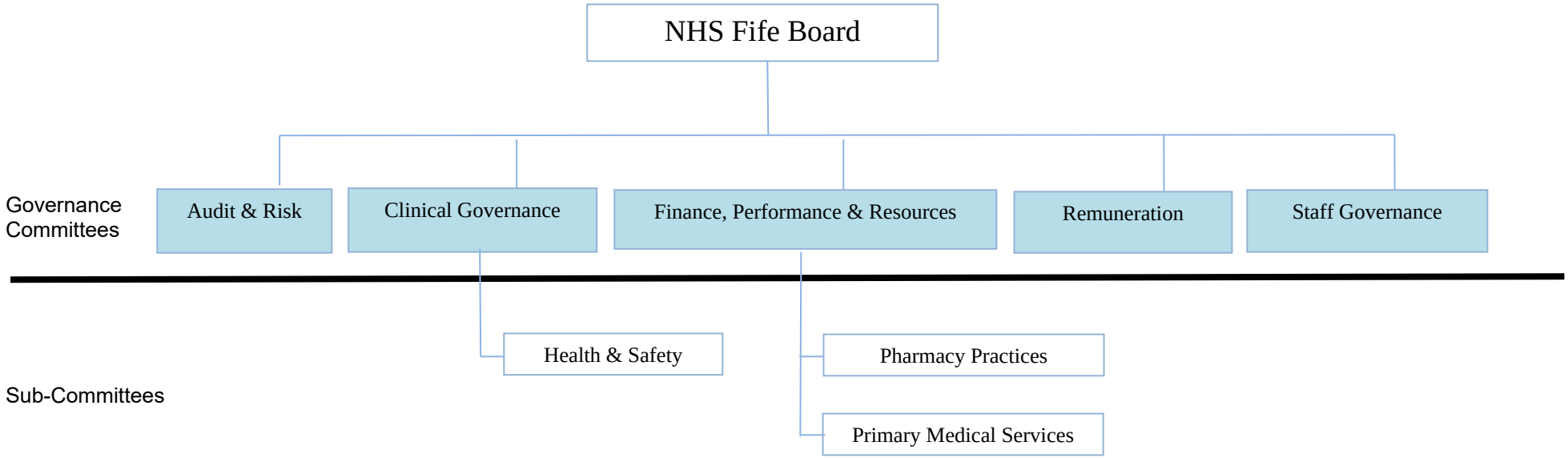
NHS Fife

NHS FIFE BOARD COMMITTEE STRUCTURE



TERMS OF REFERENCE FOR BOARD COMMITTEES

AUDIT AND RISK COMMITTEE
CONSTITUTION AND TERMS OF REFERENCE

Date of Board Approval: ***

1. PURPOSE

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

2. COMPOSITION

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

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

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

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

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

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

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

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

competently with financial management and reporting in the organisation, and associated assurances.

3. QUORUM

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

4. MEETINGS

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

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

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

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

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

5. REMIT

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

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

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

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

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

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

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

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

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

Internal Control and Corporate Governance

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

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

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

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

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

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

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

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

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

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

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

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

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

Internal Audit

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

5.10 To monitor audit progress and review audit reports.

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

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

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

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

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

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

External Audit

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

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

5.18 To consider all statutory audit material, in particular:

- Audit Reports;
- Annual Reports;
- Management Letters

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

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

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

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

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

Risk Management

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Standing Orders and Standing Financial Instructions

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

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

Annual Accounts

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

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

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

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

Other Matters

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

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

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

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

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

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

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

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

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

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

6. AUTHORITY

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

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

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

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

7. REPORTING ARRANGEMENTS

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

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

CLINICAL GOVERNANCE COMMITTEE
CONSTITUTION AND TERMS OF REFERENCE

Date of Board Approval: ***

1. PURPOSE

1.1 To oversee clinical governance mechanisms in NHS Fife.

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

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

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

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

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

2. COMPOSITION

2.1 The membership of the Clinical Governance Committee will be:

- Six Non-Executive or Stakeholder members of the Board (one of whom will be the Chair). (A Stakeholder member is appointed to the Board from Fife Council or by virtue of holding the Chair of the Area Partnership Forum or the Area Clinical Forum)
- Chief Executive
- Medical Director
- Nurse Director
- Director of Public Health
- One Staff Side representative of NHS Fife Area Partnership Forum
- One Representative from Area Clinical Forum
- One Patient Representative

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

- Director of Acute Services
- Director of Health & Social Care
- Director of Pharmacy & Medicines
- Associate Medical Director, Acute Services Division
- Associate Medical Director, Fife Health & Social Care Partnership
- Associate Medical Director, Women & Children's Services
- Head of Quality & Clinical Governance
- Board Secretary

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

3. QUORUM

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

4. MEETINGS

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

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

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

5. REMIT

5.1 The remit of the Clinical Governance Committee is to:

- monitor progress on the health status targets set by the Board.

- provide oversight of the implementation of the Clinical Strategy in line with the NHS Fife Strategic Framework and the Care and Clinical Governance Strategy.

- receive the minutes of meetings of:
  - Acute Services Division Clinical Governance Committee
  - Area Clinical Forum
  - Area Drug & Therapeutics Committee
  - Area Radiation Protection Committee
  - Digital & Information~~eHealth~~ Board
  - Fife Research Committee
  - Health & Safety Sub Committee

- H&SCP Clinical & Care Governance Committee
- H&SCP Integration Joint Board
- Infection Control Committee
- Information Governance & Security Group
- Integrated Transformation Board Public Health Assurance Committee
- NHS Fife Clinical Governance Steering Group
- NHS Fife Resilience Forum

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

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

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

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

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

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

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

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

6. AUTHORITY

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

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

7. REPORTING ARRANGEMENTS

7.1 The Clinical Governance Committee reports directly to Fife NHS Board. Minutes of the Committee are presented to the Board by the Committee Chair, who provides a report, on an exception basis, on any particular issues which the Committee wishes to draw to the Board's attention.

7.2 Each Committee of the Board will scrutinise relevant risks on the Corporate Risk Register on a bi-monthly basis.

7.3 Each Committee of the Board will scrutinise the Board Assurance Framework risk(s) aligned to it on a bi-monthly basis.

FINANCE, PERFORMANCE AND RESOURCES COMMITTEE
CONSTITUTION AND TERMS OF REFERENCE

Date of Board Approval: ***

1. PURPOSE

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

2. COMPOSITION

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

- Six Non-Executive or Stakeholder members of the Board (one of whom will be the Chair). (A Stakeholder member is appointed to the Board from Fife Council or by virtue of holding the Chair of the Area Partnership Forum or the Area Clinical Forum)
- Chief Executive
- Director of Finance
- Medical Director
- Director of Public Health
- Director of Nursing

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

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

- Director of Acute Services
- Director of Property & Asset Management~~Estates & Facilities~~
- Director of Health & Social Care
- Director of Pharmacy & Medicines
- Board Secretary

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

3. QUORUM

3.1 No business shall be transacted at a meeting of the Committee unless at least three Non-Executive members or Stakeholder members are present. There

may be occasions when due to the unavailability of the above Non-Executive members, the Chair will ask other Non-Executive members to act as members of the committee so that quorum is achieved. This will be drawn to the attention of the Board.

4. MEETINGS

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

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

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

5. REMIT

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

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

Arrangements for Securing Value for Money

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

Allocation and Use of Resources

5.3 The Committee has key responsibilities for:

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

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

5.5 The Committee will receive minutes from the Pharmacy Practices Committee and the Primary Medical Services Committee. Issues arising from these Committees will be brought to the attention of the Chair of the Finance, Performance and Resources Committee for further consideration as required.

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

5.7 The Annual Report will include the Committee's assessment and conclusions on its effectiveness over the financial year in question.

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

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

6. AUTHORITY

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

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

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

7. REPORTING ARRANGEMENTS

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

7.2 Each Committee of the Board will scrutinise relevant risks on the Corporate Risk Register on a bi-monthly basis.

7.3 Each Committee of the Board will scrutinise the Board Assurance Framework risk(s) aligned to it on a bi-monthly basis.

REMUNERATION COMMITTEE
CONSTITUTION AND TERMS OF REFERENCE

Date of Board Approval: ***

1. PURPOSE

1.1 To consider and agree performance objectives and performance appraisals for staff in the Executive cohort and to oversee performance arrangements for designated senior managers.

1.2 To direct the appointment process for the Chief Executive and Executive Members of the Board.

2. COMPOSITION

2.1 The membership of the Remuneration Committee will be:

- Fife NHS Board Chairperson
- Two Non-Executive Board members
- Chief Executive
- Employee Director

2.2 The Director of Workforce shall act as Lead Officer for the Committee.

2.3 The NHS Fife Chief Executive will leave the meeting when there is any discussion with regard to their own performance. The Director of Workforce will leave the meeting when there is any discussion with regard to their own performance.

3. QUORUM

3.1 Meetings will be quorate when at least three members are present, at least two of whom are Non-Executive members.

4 MEETINGS

4.1 The Committee shall meet as necessary, but not less than three times a year.

4.2 The Fife NHS Board Chairperson will chair the Committee. If the Chairperson is absent from the meeting, one of the other Non-Executive members will chair the meeting.

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

4.4 The full minutes will be circulated to all Committee members. Minutes edited to remove all personal details will be circulated to the Board.

5 REMIT

5.1 The remit of the Remuneration Committee is to consider:

- job descriptions for the Executive cohort;
- other terms of employment which are not under Ministerial direction;
- to hear and determine appeals against the decisions of the Consultant Discretionary Awards Panel. The Remuneration Committee can make decisions regarding Discretionary Points in exceptional circumstances;
- agree performance objectives and appraisals directly for the Executive cohort only, and oversee arrangements for designated senior managers;
- redundancy, early retiral or termination arrangement in respect of all staff in situations where there is a financial impact upon the Board (this excludes early retiral on grounds of ill health) and approve these or refer to the Board as it sees fit.

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

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

5.4 The Committee will undertake an annual self-assessment of its work and effectiveness.

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

6. AUTHORITY

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

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

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

7. REPORTING ARRANGEMENTS

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

STAFF GOVERNANCE COMMITTEE
CONSTITUTION AND TERMS OF REFERENCE

Date of Board Approval: ***

1. PURPOSE

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

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

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

2. COMPOSITION

2.1 The membership of the Staff Governance Committee will be:

- Four Non-Executive members, one of whom will be the Chair of the Committee.
- Employee Director (as a Stakeholder member of the Board by virtue of holding the Chair of the Area Partnership Forum)
- Chief Executive
- Director of Nursing
- Staff Side Chairs of the Local Partnership Forums, or their nominated deputy

2.2 Each member shall give notification if they are unable to attend a meeting. For Non-Executive members, they shall notify the Chair, who may ask other Non-Executive members to act as members of the Committee to achieve a quorum. For~~of the~~ Staff Side Chairs of the Local Partnership Forums, they will notify the Lead Officer, confirming their ~~shall, annually, notify the Lead Officer to the Committee of a specific~~ nominated deputy ~~who will attend meetings in their absence~~. This will be reported to the Chair.

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

- Director of Workforce
- Director of Acute Services
- Director of Health & Social Care
- Board Secretary

- Deputy Director of Workforce and Heads of Service, Workforce Directorate

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

3. QUORUM

3.1 No business shall be transacted at a meeting of the Committee unless:

- at least three members are present, at least two of whom should be Non-Executive members of the Board.
- at least ~~In addition, in order to be quorate, each meeting will require~~ one of the Staff Side Chairs of the Local Partnership Forums or their nominated deputy ~~to be~~is present.

There may be occasions when due to unavailability of the above Non-Executive members the Chair will ask other Non-Executive members to act as members of the Committee so that quorum is achieved. Similarly, there may be occasions due to unavailability a Staff Side Chair of the Local Partnership Forums shall confirm the nominated deputy who will attend meetings in their absence. This will be reported to the Chair. This information will be drawn to the attention of the Board.

4. MEETINGS

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

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

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

5. REMIT

5.1 The remit of the Staff Governance Committee is to:

- Consider NHS Fife's performance in relation to its achievements of effective Staff Governance and its compliance with the Staff Governance Standard;

- Review action taken on recommendations made by the Committee, NHS Boards, or the Scottish Ministers on Staff Governance matters;

- Give assurance to the Board on the operation of Staff Governance systems within NHS Fife, identifying progress, issues and actions being taken, where appropriate;

- Support the operation of the Area Partnership Forum and the Local Partnership Forums in their Staff Governance monitoring role and the appropriate flow of information to facilitate this;

- Encourage the further development of mechanisms for engaging effectively with all members of staff within the NHS in Fife;

- Contribute to the development of the Annual Operational Plan, in particular but not exclusively, around issues affecting staff;

- Support the continued development of personal appraisal professional learning and performance;

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

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

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

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

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

6. AUTHORITY

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

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

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

7. REPORTING ARRANGEMENTS

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

7.2 Each Committee of the Board will scrutinise relevant risks on the Corporate Risk Register on a bi-monthly basis.

7.3 Each Committee of the Board will scrutinise the Board Assurance Framework risk(s) aligned to it on a bi-monthly basis.

STANDING FINANCIAL INSTRUCTIONS

INDEX

1. INTRODUCTION

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

1.2 **Terminology**

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

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

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

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

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

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

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

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

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

2. KEY RESPONSIBILITIES FOR FINANCIAL GOVERNANCE

The Board and Audit and Risk Committee

2.1 The Board shall approve these SFIs and Scheme of Delegation

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

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

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

The Chief Executive (Accountable officer)

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

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

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

The Director of Finance

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

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

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

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

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

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

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

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

All Directors and Employees

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

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

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

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

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

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

- Avoiding loss;

- Securing Best Value in the use of resources; and

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

2.16 All budget holders shall ensure that:-

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

- Budgets are only used for their stated purpose; and

- Budgets are never exceeded.

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

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

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

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

Accountability

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

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

2.20 All employees shall:-

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

2.21 Furthermore all employees shall not:-

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

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

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

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

3. AUDIT

Audit and Risk Committee

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

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

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

Director of Finance

3.4 The Director of Finance is responsible for:

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

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

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

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

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

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

The report should include:

- A clear statement on the adequacy and effectiveness of internal control;
- Main internal control issues and audit findings during the year;

- Extent of audit cover achieved against the plan for the year.

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

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

Internal Audit

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

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

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

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

3.9 The Chief Internal Auditor (or Counter Fraud Services staff, acting on the Director of Finance's behalf on any matters related to the investigation of fraud) is entitled without necessarily giving prior notice to require and receive:

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

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

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

(d) Explanations concerning any matter under investigation.

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

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

External Audit

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

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

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

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

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

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

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

(b) The Board's main financial systems;

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

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

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

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

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

4. FINANCIAL MANAGEMENT

This section applies to both revenue and capital budgets.

Planning

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Budgetary Control

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

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

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

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

- the amount of the budget;

- the purpose(s) of each budget heading;

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

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

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

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

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

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

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

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

  c. capital project spend and projected outturn against plan;

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

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

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

- investigation and reporting of variances from agreed budgets;

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

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

Monitoring

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

5. ANNUAL ACCOUNTS AND REPORTS

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

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

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

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

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

6. BANKING AND CASH HANDLING

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

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

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

6.4 The Director of Finance shall:-

- Establish separate bank accounts for non-exchequer funds;
- Establish a separate bank account for all capital building projects where the budget is over £2m. This account will be used solely to process payments to Preferred Supply Chain Partners (PSCP);
- Ensure payments made from bank or GBS accounts do not exceed the amount credited to the account, except where arrangements have been made;

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

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

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

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

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

- Ensuring that the GBS account is used as the principal banker and that the amount of cleared funds held at any time within exchequer commercial bank accounts is limited to a maximum of £50,000 (of cleared funds). The bank account for capital building projects will only hold funds transferred from the GBS principal account to the value of the certified payment due at that time;

- The limit to be applied to any overdraft;

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

- The required controls for any system of electronic payment.

6.6 The Director of Finance shall:-

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

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

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

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

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

indemnities must be obtained from the organisation or individuals absolving the Board from responsibility for any loss.

7. SECURITY OF ASSETS

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

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

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

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

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

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

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

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

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

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

8. PAY

Remuneration Committee

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

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

Processes

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

8.4 All time records, payroll timesheets and other pay records and notifications shall be in a form approved by the Director of Finance and shall be authorised and submitted in accordance with his/her instructions. This also includes the payment of expenses and additions to pay whether via e-Expenses, SSTS or other arrangements, including manual systems.

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

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

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

8.6 Wherever possible, officers should not compile their own payroll input. Where it is unavoidable that the compiler of the payroll input is included on that input, then the entry in respect of the compiler must be supported by evidence that it has been checked and found to be appropriate by another officer holding a higher position.

8.7 Under no circumstance should officers authorise/approve their own payroll input or expenses.

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

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

9. NON PAY

Tendering, Contracting and Purchasing Procedures

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

9.2 The Chief Executive shall designate a senior officer as the lead senior officer for procurement, and this person shall oversee the procurement of goods and services, to ensure there is an adequate approval of suppliers and their supplies based on cost and quality.

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

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

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

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

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

9.8 The Director of Finance shall:-

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

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

9.9 The following basic principles shall be generally applied:-

- Procurement activity satisfies all legal requirements;

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

- Segregation of duties is applied throughout the process;

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

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

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

9.10 Limits of Authorisation of Orders

(a) Up to £100,000

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

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

(b) £100,000 to £1,000,000

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

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

All orders above £1,000,000 and less than £2,000,000 must be authorised by the Board Chief Executive and the Director of Finance, subject to the expenditure having been approved by the Board as part of a capital or revenue plan.

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

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

In the following exceptional circumstances, except in cases where EU Directives must be adhered to, the Director of Finance and Chief Executive, as specified in the Scheme of Delegation, can approve the waiving of the above requirements. Where goods and services are supplied on this basis and the value exceeds £2,500, a "Waiver of Competitive Tender/Quotation" may be granted by completing a Single Source Justification form for approval by the

appropriate director and the Head of Procurement. Where the purchase of equipment is valued in excess of £5,000 and where the purchase of other goods and services on this basis exceeds £10,000, the completed Single Source Justification Form shall be endorsed by the Director of Finance and Chief Executive and submitted to the Audit and Risk Committee.

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

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

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

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

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

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

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

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

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

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

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

9.15 The Board shall not make payments in advance of need. However payment in advance of the receipt of goods or services is permitted in accordance with the SPFM and where approved by the lead senior officer for procurement who shall be a member of the Finance Directorate Senior Team. Examples of such instances are:-

- Items such as conferences, courses and travel, foreign currency transactions, where payment is to be made at the time of booking.

- Where payment in advance of complete delivery is a legal or contractual requirement, e.g. maintenance contracts, utilities, rates.

- Where payment in advance is necessary to support the provision of services/delivery of a project by external providers (e.g. grants to local authorities or voluntary bodies.)

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

Commissioning of Patient Services

9.17 The Director of Finance, jointly with the Director of Acute Services or Director of Health & Social Care will ensure service agreements are in place with other healthcare providers for the delivery of patient services, ensuring the appropriate financial details are contained and clarity on reporting of performance, quality and safety issues.

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

Payment of Accounts and Expense Claims

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

9.20 The Director of Finance shall be responsible for designing and maintaining a system for the verification, recording and payment of all amounts payable by

the Board. The system shall provide for authorisation by agreed delegated officers, a timetable and system for the payment of accounts and instruction to staff regarding handling, checking and payment of accounts and claims.

9.21 The Director of Finance shall ensure that payments for goods and services are made only after goods and services are received. Prepayments will be permitted in exceptional circumstances and with the prior approval of the Director of Finance

Additional Matters for Capital Expenditure

Overall Arrangements for the Approval of the Capital Plan

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

9.23 The Chief Executive shall ensure that:-

- there is an adequate appraisal and approval process in place for determining capital expenditure priorities within the Property Strategy and the effect of each proposal upon business plans;
- all stages of capital schemes are managed, and are delivered on time and to cost;
- capital investment is not undertaken without confirmation that the necessary capital funding and approvals are in place; and
- all revenue consequences from the scheme, including capital charges, are recognised, and the source of funding is identified in financial plans.

Implementing the Capital Programme

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

- that a business case as required by the Scottish Capital Investment Manual (SCIM) is produced setting out:-
    a. an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs; and
    b. appropriate project management and control arrangements; and
- that the Director of Finance has assessed the costs and revenue consequences detailed in the business case.

9.25 The approval of a business case and inclusion in the Board's capital plan shall not constitute approval of the individual elements of expenditure on any

scheme. The Chief Executive shall issue to the manager responsible for any scheme:-

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

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

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

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

Public Private Partnerships and other Non-Exchequer Funding

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

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

Disposals of Assets

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

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

9.31 When it is decided to dispose of a Health Board asset, the head of department or authorised deputy will determine and advise the Director of Finance of the

estimated market value of the item, taking account of professional advice where appropriate.

9.32 All unserviceable articles shall be:-

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

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

Capital Accounting

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

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

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

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

10. PRIMARY CARE CONTRACTORS

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

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

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

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

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

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

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

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

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

11. INCOME AND SCOTTISH GOVERNMENT ALLOCATIONS

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

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

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

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

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

11.6 Scottish Government letters that change funding allocations must be signed by two members of the Finance Directorate Senior Team to evidence their review of the aggregate allocation received.

12. FINANCIAL MANAGEMENT SYSTEM

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

12.2 The Director of Finance shall ensure that contracts for computer services for financial applications with another Board or any other agency shall clearly

define the responsibility of all the parties for the security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage.

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

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

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

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

13. CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

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

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

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

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

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

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

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

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

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

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

14. RISK MANAGEMENT

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

14.2 The programme of risk management shall include:

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

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

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

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

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

5. Arrangements to review the risk management programme.

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

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

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

15. RETENTION OF DOCUMENTS

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

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

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

16. PATIENTS' PROPERTY AND FUNDS

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

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

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

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

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

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

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

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

17. STORES

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

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

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

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

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

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

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

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

18. AUTHORISATION LIMITS

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

18.2 Areas covered by the Scheme of Delegation include:

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

19. ENDOWMENT FUNDS

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

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

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

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

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

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

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

FIFE NHS BOARD SCHEME OF DELEGATION

1. Introduction

Board's Responsibility

The Standing Orders for the proceedings and Business of the Fife NHS Board include a section on Matters Reserved for the Board (Section 6). This section of the Standing Orders summarises all matters where decision making is reserved to the Board.

The subsequent section (Section 7) within the Standing Orders, identifies that other "matters" may be delegated to Committees or individuals to act on behalf of the Board.

The following appendix sets out:

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

2. Committees' Delegated Responsibility on behalf of the Board

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

Role and Remit	• Supporting the Accountable Officer and Fife NHS Board formulate their assurance needs with regard to risk management, governance and internal control;
	
	• Drawing attention to weaknesses in systems of risk management, governance and internal control;
	
	Internal Control and Corporate Governance
	
	• To evaluate the framework of internal control and corporate governance comprising the following components, as recommended by the Turnbull Report:
	
	  • control environment;
	  • risk management;
	  • information and communication;
	  • control procedures;
	  • monitoring and corrective action.
	
	• To review the system of internal financial control, which includes:
	
	  • the safeguarding of assets against unauthorised use and disposition;
	
	  • the maintenance of proper accounting records and the reliability of financial information used within the organisation or for publication.
	
	• To ensure that the activities of Fife NHS Board are within the law and regulations governing the NHS.
	
	• To review the disclosures included in the Governance Statement on behalf of the Board.
	
	• To present an annual statement of assurance on the above to the Board, to support the NHS Fife Chief Executive's Governance Statement.

	Internal Audit
	
	• To review and approve the Internal Audit Strategic and Annual Plans.
	
	• To monitor audit progress and review audit reports.
	
	• To monitor the management action taken in response to the audit recommendations through an appropriate follow-up mechanism.
	
	• To consider the Chief Internal Auditor's annual report and assurance statement.
	
	• To review the operational effectiveness of Internal Audit by considering the audit standards, resources, staffing, technical competency and performance measures.
	
	External Audit
	
	• To note the appointment of the Statutory Auditor and to approve the appointment and remuneration of the External Auditors for Patients' Funds and Endowment Funds.
	
	• To review the Audit Strategy and Plan, including the Best Value and Performance Audits programme.
	
	• To consider all statutory audit material, in particular:-
	
	  • Audit Reports;
	  • Annual Reports;
	  • Management Letters
	
	  relating to the certification of Fife NHS Boards Annual Accounts, Annual Patients' Funds Accounts.
	
	Risk Management
	
	The Committee shall seek assurance that**:**
	
	• There is a comprehensive risk management system in place to identify, assess, manage and monitor risks at all levels of the organisation.
	
	• There is appropriate ownership of risk in the organisation, and that there is an effective culture of risk management
	
	• The Board has clearly defined its risk appetite (i.e. the level of risk that the Board is prepared to accept, tolerate, or be exposed to at any time), and that the executive's approach to risk management is consistent with that appetite.

	• The Committee will also receive and review a report summarising any significant changes to the Board's Board Assurance Framework, and what plans are in place to manage them. The Committee may also elect to occasionally request information on significant risks held on any risk registers held in the organisation. • Assess whether the Board Assurance Framework is an appropriate reflection of the key risks to the Board, so as to advise the Board. • Receive an annual report on risk management, confirming whether or not there have been adequate and effective risk management arrangements throughout the year, and highlighting any material areas of risk. **Standing Orders and Standing Financial Instructions** • To review the model Standing Orders for Boards as issued by NHS Scotland, and associated appendices of Fife NHS Board, and advise the Board of any amendments required. • To examine the circumstances associated with any occasion when Standing Orders of Fife NHS Board have been waived or suspended. **Annual Accounts** • To review and recommend approval of draft Fife NHS Board Annual Accounts to the Board. • To review the draft Annual Report and Financial Review of Fife NHS Board as found within the Directors Report incorporated within the Annual Accounts. • To review annually (and approve any changes in) the accounting policies of Fife NHS Board. • To review schedules of losses and compensation payments where the amounts exceed the delegated authority of the Board prior to being referred to the Scottish Government for approval. **Other Matters** • The Committee shall review the arrangements for employees raising concerns, in confidence, about possible wrongdoing in financial reporting or other matters. The Committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow-up action.

	• The Committee shall review regular reports on Fraud and potential Frauds. • The Committee shall provide assurance to the Board on achievement and maintenance of Best Value standards, relevant to the Committee's area of governance as set out in Audit Scotland's baseline report "Developing Best Value Arrangements". • The Committee shall seek assurance that the Board has systems of control to ensure that it discharges its responsibilities under the Freedom of Information (Scotland) Act 2002. • The Committee shall review the Board's arrangements to prevent bribery and corruption within its activities. This includes the systems to support Board members' compliance with the NHS Fife Board Code of Conduct (Ethical Standards in Public Life Act 2000), the systems to promote the required standards of business conduct for all employees and the Boards procedure to prevent Bribery (Bribery Act 2000).

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

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

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

2.4 Remuneration Committee	
Responsible Director for this Section	Director of Workforce

Role and Remit	• The remit of the Remuneration Committee is to consider:
	  • job descriptions for the Executive cohort;
	  • other terms of employment which are not under Ministerial direction;
	  • to hear and determine appeals against the decisions of the Consultant Discretionary Awards Panel. The Remuneration Committee can make decisions regarding Discretionary Points in exceptional circumstances;
	  • agree performance objectives and appraisals directly for the Executive cohort only, and oversee arrangements for designated senior managers;
	  • redundancy, early retiral or termination arrangement in respect of all staff in situations where there is a financial impact upon the Board (this excludes early retiral on grounds of ill health) and approve these or refer to the Board as it sees fit; and
	  • undertake an annual self-assessment of the Committee's work and effectiveness.
	• The Committee will produce an Annual Report incorporating a Statement of Assurance for submission to the Board, via the Audit & Risk Committee. The proposed Annual Report will be presented to the first Committee meeting in the new financial year or agreed with the Chairperson of the Committee by the end of May each year for presentation to the Audit & Risk Committee in June.
	• The Committee shall provide assurance to the Board on achievement and maintenance of Best Value standards, relevant to the Committee's area of governance as set out in Audit Scotland's baseline report "Developing Best Value Arrangements".

2.5 Staff Governance Committee	
Responsible Director for this Section	Director of Workforce
Role and Remit	• The remit of the Staff Governance Committee is to: • consider NHS Fife's performance in relation to its achievements of effective Staff Governance and its compliance with the Staff Governance Standard; • review action taken on recommendations made by the Committee, NHS Boards, or the Scottish Ministers on Staff Governance matters; • give assurance to the Board on the operation of Staff Governance systems within NHS Fife, identifying progress, issues and actions being taken, where appropriate; • support the operation of the Area Partnership Forum and the Local Partnership Forums in their Staff Governance monitoring role and the appropriate flow of information to facilitate this; • encourage the further development of mechanisms for engaging effectively with all members of staff within the NHS in Fife; • contribute to the development of the Annual Operational Plan, in particular but not exclusively, around issues affecting staff; • support the continued development of personal appraisal professional learning and performance; • review regularly the sections of the NHS Fife Integrated Performance & Quality Report relevant to the Committee's responsibility; and • undertake an annual self-assessment of the Committee's work and effectiveness. • The Committee is also required to carry out a review of its function and activities and to provide an Annual Statement of Assurance. This will be submitted to the Board via the Audit and Risk Committee. The proposed Annual Statement will be presented to the first Committee meeting in the new financial year or agreed with the Chairperson of the

	respective Committee by the end of May each year for presentation to the Audit and Risk Committee in June. • The Committee shall provide assurance to the Board on achievement and maintenance of Best Value standards, relevant to the Committee's area of governance as set out in Audit Scotland's baseline report "Developing Best Value Arrangements".

3. Matters Delegated to Individuals

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

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

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

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

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

	• Developing and implementing strategies for the prevention and detection of fraud and irregularity; • Internal Audit. **Performance Management** The Director of Finance is authorised to assist the Chief Executive to ensure that suitable arrangements are in place to secure economy, efficiency, and effectiveness in the use of resources and that they are working effectively. These arrangements include procedures: • for planning, appraisal, authorisation and control, accountability and evaluation of the use of resources; • to ensure that performance targets and required outcomes are met and achieved. **Banking** The Director of Finance is authorised to oversee the Board's arrangements in respect of accounts held in the name of the Board with the Paymaster General Office and the commercial bankers duly appointed by the Board. The Director of Finance will be responsible for ensuring that the Paymaster General's Office and the commercial bankers are advised in writing of amendments to the panel of nominated authorised signatories. **Tax** The Director of Finance shall have delegated authority as lead officer for Tax matters, in relation to the management of taxes as they affect NHS Fife's financial affairs. This includes but is not limited to final determination in cases of off payroll working, application of the Construction Industry Scheme regulations, VAT etc. **Patients' Property** The Director of Finance shall have delegated authority to ensure that detailed operating procedures in relation to the management of the property of patients (including the opening of bank accounts where appropriate) are compiled for use by staff involved in the management of patients' property and financial affairs, in line with the terms of the Adults with Incapacity (Scotland) Act 2000.

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

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

	Patients' Property The Director of Acute Services and Director of Health and Social Care shall have overall responsibility for ensuring compliance with legislation in respect of patient's property and that effective and efficient management arrangements are in place.
	3.4 Champion Roles The following roles are filled by Non-Executive Board members. • Counter Fraud Services Champion • Digital Champion • Equality & Diversity Champion • Safety & Cleanliness Champion • Whistle Blowing Champion (appointed nationally)

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

1. STATUTORY DUTY

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

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

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

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

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

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

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

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

Appendix 5

APPENDIX A

SOUTH EAST AND TAYSIDE (SEAT) REGIONAL PLANNING GROUP

FRAMEWORK OF GOVERNANCE

Introduction

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

This Framework has four key sections:

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

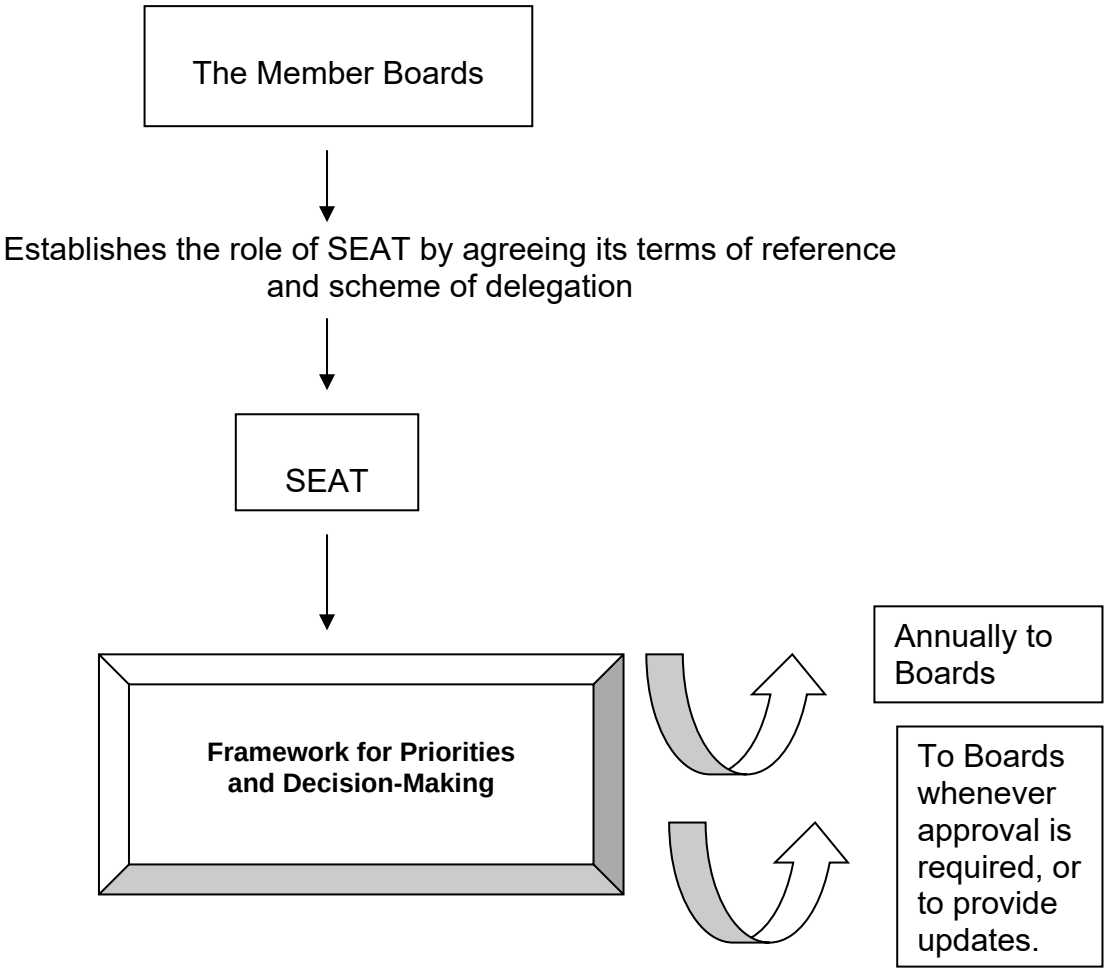
2. A **Terms of Reference**, describing the remit of the group, how it will make decisions, and how the different control elements of regional planning comes together to form the system of governance for SEAT.

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

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

1. THE SCHEME OF DELEGATION

1.1 – The Overall Process



1.2 – Schedule of Delegated Authority from Member Boards to SEAT

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

2. TERMS OF REFERENCE OF THE SEAT REGIONAL PLANNING GROUP

2.1 REMIT

2.1.1 The remit of the Group is to assist in the delivery of the following NHS Scotland objectives:

- To plan, fund and implement services across NHS Board boundaries;
- To harness and support the potential of Managed Clinical Networks;
- To develop integrated workforce planning for cross-board services;
- To facilitate the commissioning and monitoring of services which extend beyond NHS Board boundaries, services between members and out with the region on an inter-regional or national basis;
- To harmonise the NHS Board service plans at the regional level;
- To plan emergency response across NHS Board boundaries; and
- To support the delivery of NHS Boards' duty to co-operate for the benefit of the people of Scotland.

2.1.2 The above remit is to be delivered by the Group. However, the member boards remain accountable and responsible for the continued delivery of their statutory duties and general corporate governance requirements.

2.2 OUTCOMES FROM THE SEAT REGIONAL PLANNING GROUP ("THE GROUP")

2.2.1 The Group maintains and works to a Framework for Priorities and Decision-Making. The members must present this to their Boards for approval on an annual basis. This is the SEAT equivalent of the "Annual Regional Planning Agenda" referred to in HDL (2004) 46.

2.2.2 The Framework will include service, workforce, financial and other appropriate planning issues.

2.2.3 It is the responsibility of the member organisations to ensure congruence between their local plans and the Framework.

2.2.4 The Framework will contain all projects that have progressed beyond initial review stage, and require approval from member boards to progress to implementation. This document will also provide an analysis of the progress of projects that have previously been approved by the Boards for implementation, and is therefore key to effective performance management of the Group's agenda.

2.2.5 The Group will prepare an Annual Report of its activities, which will be sent to all members and partner organisations, and will be used as the focus for any public accountability processes. The Annual Report, prepared in accordance with this Framework of Governance, is submitted direct to Member Boards and, therefore, does not need to comply with the Audit Committee schedule and process for the production of Annual Reports.

2.2.6 The Group will support the retained accountability duties of member organisations, by making available any information to those organisations, which will support public reporting and the development of Local Delivery Plans.

2.2.7 The principal form of reporting by the Regional Group to the Board will be through the regular presentation of its minutes to the Board by the Board Chief Executive.

2.3 MEMBERSHIP OF THE SEAT REGIONAL PLANNING GROUP

2.3.1 The executive members of the SEAT Regional Planning Group are the Chief Executives of NHS Borders, NHS Fife, NHS Forth Valley, NHS Lothian and NHS Tayside.

2.3.2 Each member remains personally and legally accountable for their decisions both to their local Board and the Chief Executive of the NHS in Scotland. (This accountability incorporates the duty of regional planning as set out in SE guidance). All of the member Boards must formally recognise and approve the Scheme of Delegation in Section 1 of this Framework of Governance.

2.3.3 Once a decision is reached, each Board is bound by collective responsibility. The minutes of the meeting will reflect the decision of the Group.

2.3.4 The position of Chair of SEAT will rotate every three years as agreed by the executive members.

2.3.5 The Group will invite any other organisation or officers to attend meetings as it sees fit. Those who will be routinely invited to SEAT meetings will be:

- Directors of Planning for the member boards;
- Regional Planning Director;
- Regional Workforce Planning Director;
- Director (National Services Division);
- Representatives of:
  - the Chief Executive (NHS Scotland);
  - the Scottish Ambulance Service;
  - NHS Education Scotland;
  - Dumfries and Galloway NHS Board;
- The Postgraduate Dean for SE Scotland;
- Director of Pay Modernisation (SGHSCD);
- SEAT Workforce Champion; and
- the Lead Representative from each functional group, recognised by SEAT.

2.4 IMPLEMENTING THE WORK PLAN AND THE FRAMEWORK OF PRIORITIES AND DECISION MAKING

2.4.1 SEAT cannot progress any item on the Work Plan or implement any project on the Framework of Priorities and Decision Making without the prior approval of member boards. This would normally be via approval of the Annual Workplan.

2.4.2 Once all member board approvals are in place, SEAT is free to decide how to progress its workload. Each project will have a lead member assigned to it.

2.4.3 Once a member has been given lead responsibility for an item in the Work Plan or Framework of Priorities and Decision Making, he or she has complete authority from SEAT to progress the matter, as if the matter was an issue contained within his or her Board. The lead member will account to the SEAT Regional Planning Group by updating the Framework of Priorities and Decision Making.

2.4.4 All members are required to conduct SEAT business under the same standards of internal control and corporate governance as is generally expected of Chief Executives in NHS Scotland (Section 3). The lead member for a particular SEAT project will be primarily responsible for standards of internal control for activities within the scope of the project, on the understanding that all members have established adequate systems of internal control in their organisations.

2.4.5 For all items in the Framework of Priorities and Decision Making, a Project Agreement will be developed. This will describe the precise scope and objectives of the project, including timescales and accountability arrangements, as well as the associated resources required to deliver the project. This Project Agreement will define the parameters within which the member with lead responsibility for the project can operate.

2.4.6 In the event of the SEAT Regional Planning Group being in disagreement with the aspects of the delivery of the implementation of a project agreement, or if the Group wishes to amend or discontinue an agreed project, then a resolution to overrule the lead member responsible for the project (as stated in the project agreement) or alter the project terms of reference must be approved by the Group. An event of this nature should be reported back to the member boards.

2.5 SCOPE OF ACTIVITY TO BE ADDRESSED BY THE SEAT REGIONAL PLANNING GROUP

2.5.1 The national regional planning framework grants SEAT the authority to act on behalf of its members in the delivery of the following tasks:

- Develop and progress a co-ordinated approach to service delivery for and on behalf of constituent NHS Boards;
- Facilitate commissioning and monitoring of services which extend beyond NHS Board boundaries, services between members and out with the region on an inter-regional or national basis;
- Develop strategic workforce solutions which support service delivery models;

- Commit and monitor resources, within the agreed financial framework, for the purposes for which it was approved;
- Determine commissioning policy for those services within its workplan;
- Agree a prioritisation framework for the regional planning group, reflective of those within individual NHS Boards;
- Commission reviews or other research in order to inform decisions;
- Agree. Monitor and update action plans;
- Develop delivery plans (often in collaboration with other Regional Planning Groups) for highly specialised services;
- Performance manage regional Managed Clinical Networks.
- Establish sub-groups as appropriate.

2.6 EXCEPTIONAL MATTERS

2.6.1 There may exceptionally be decisions that require significant expenditure commitments (or controversial service changes), which would be beyond the scope of delegated authority conventionally awarded to Board Chief Executives. In these exceptional circumstances, the member NHS Boards can delegate the authority to act on their behalf to executive sub-committees of each Board as opposed to their Chief Executive. It would be for the member NHS Boards to determine the membership of this executive subcommittee. The five executive sub-committees would then meet together (as opposed to the five Chief Executives acting on their own delegated authority) to form the Regional Planning Group.

2.6.2 The undertaking of work not previously foreseen in the agreed Work Plan or Framework of Priorities and Decision Making can be classed as an exceptional matter. This may be because the issue relates to a matter that requires an emergency response.

2.6.3 In these exceptional circumstances, the Chair of each executive sub-committee will act on behalf of his or her Board.

2.6.4 The Chair of SEAT has the authority to make decisions in emergency situations on behalf of this group, following consultation with the other members. If the issue falls within the agreed Work Plan or Framework of Priorities and Decision Making, then it can be formally endorsed at the next meeting of the Group. If the issue is not within these documents, then it should be formally endorsed at the next meetings of the member boards.

2.6.5 It is intended that the members of the Regional Planning Groups will work together in order to reach consensus. In the event of a material dispute arising, a meeting will be convened between the Chief Executives and Chairs of the member boards in order to resolve the issue, recognising the back-up arrangements set out in Section 4 of Annex 3 of HDL (2004) 46.

3. THE EXPECTED STANDARDS OF CORPORATE GOVERNANCE AND INTERNAL CONTROL

Introduction

Paragraph 2.4.4 of the SEAT Regional Planning Group's Framework of Governance makes reference to the "standards of internal control and corporate governance as is generally expected of chief executives in NHS Scotland".

The standards of corporate governance and internal control which apply to NHS Boards will apply to the work of SEAT. In the event of a query arising about this, e.g. if wording differs between Boards' governance documents, the Chair for the time being of SEAT shall decide the issue.

Scope of Corporate Governance

Six key subjects make up Corporate Governance for the member boards:-

- **Clinical Governance** – How we deliver our clinical services;
- **Patient Focus and Public Accountability** – How we inform individual patients and involve them and other stakeholders in the manner by which we deliver our clinical services;
- **Staff Governance** – How we engage our employees and their representatives;
- **Financial Governance** – How we manage our financial resources;
- **Research Governance** – How we conduct research and development;
- **Educational Governance** – How we teach and train healthcare professionals.

The principles of corporate governance are covered at slightly greater length in Annex A.

4. REPOSITORY OF CONTROL DOCUMENTS

SEAT has developed standardised templates to implement the above terms of reference. The templates are maintained centrally and made widely available for use. These are then elements of the overall Framework of Governance.

Items included:

- Template for the Work Plan;

- Template for the Framework of Priorities and Decision Making.

These are designed in a way that allows new projects and existing commitments to be presented efficiently, providing high level information to the member boards. They can be used to seek approval of new items, and present updates on progress. The detail will be in the individual Project Agreements.

- Template for the Project Agreement

Appendix 5

This is the key control document to be presented to SEAT for approval. This should contain everything you need to know about the project, e.g. SMART objectives, funding requirements, service implications, lead Chief Executive, project staff, monitoring arrangements, etc.

ANNEX A

THE EXPECTED STANDARDS OF CORPORATE GOVERNANCE AND INTERNAL CONTROL

The Principles of Corporate Governance

In the following, the "organisation" is taken to be both the member boards individually and when they come together as the Regional Planning Group. All of the organisation's activities, policies and procedures should be consistent with these principles. In the absence of a specific procedure, employees should comply with the requirements of these principles.

General

1. The organisation will discharge its responsibilities in accordance with the relevant legislative requirements of European Parliament, and the United Kingdom and Scottish Parliaments. The organisation will also comply with any directions or guidance issued by the Scottish Ministers.

2. No person will receive less favourable treatment regardless or individual differences or be disadvantaged by conditions or requirements which cannot be shown to be justifiable.

Clinical Governance

3. The organisation will plan for, and monitor the provision of a range of services consistent with the overall strategy of NHS Scotland, as established by Scottish Ministers.

4. The organisation will provide care in accordance with relevant and nationally recognised standards and with all due care and attention.

5. The organisation will work in partnership with others in the development of healthcare and the general well-being of the public.

6. The organisation will provide undergraduate and postgraduate education to the standards required by the relevant funding authorities.

Patient Focus and Public Accountability

7. The organisation will conduct its activities in an open and accountable manner. Its activities and organisational performance will be auditable.

8. The organisation will give patients the knowledge to make it possible for them to become active partners, with professionals, in making informed decisions and choices about their own treatment and care.

9. The organisation will establish mechanisms to inform, engage and consult patients and members of the public to inform its decision making appropriately.

Staff Governance

10. The organisation recognises the important of working in partnership with its staff.

11. The organisation will ensure that its employees are well informed, appropriately trained, involved in decisions that affect them, treated fairly and consistently and provided with a safe working environment.

Financial Governance

12. The organisation will perform its activities within the available financial resources at its disposal.

13. The organisation will conduct its activities in a manner that is cost-effective and demonstrably secures value for money.

Research Governance

14. The organisation will conduct research and development activity in accordance with the Research Governance Framework.

Educational Governance

15. This is taken forward through the applications of principles 1, 2, 6, 9 and 10.

CODE of CONDUCT

for

MEMBERS

of

The NHS Fife Public Board

CODE OF CONDUCT for MEMBERS of the NHS Fife Public Board

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SECTION 1: INTRODUCTION TO THE CODE OF CONDUCT

1.1 The Scottish public has a high expectation of those who serve on the boards of public bodies and the way in which they should conduct themselves in undertaking their duties. You must meet those expectations by ensuring that your conduct is above reproach.

1.2 The Ethical Standards in Public Life etc. (Scotland) Act 2000, "the Act", provides for Codes of Conduct for local authority councillors and members of relevant public bodies; imposes on councils and relevant public bodies a duty to help their members to comply with the relevant code; and establishes a Standards Commission for Scotland, "The Standards Commission" to oversee the new framework and deal with alleged breaches of the codes.

1.3 The Act requires the Scottish Ministers to lay before Parliament a Code of Conduct for Councillors and a Model Code for Members of Devolved Public Bodies. The Model Code for members was first introduced in 2002 and has now been revised in December 2013 following consultation and the approval of the Scottish Parliament. These revisions will make it consistent with the relevant parts of the Code of Conduct for Councillors, which was revised in 2010 following the approval of the Scottish Parliament.

1.4 As a member of The NHS Fife PUBLIC BOARD, "the Board", it is your responsibility to make sure that you are familiar with, and that your actions comply with, the provisions of this Code of Conduct which has now been made by the Board.

Appointments to the Boards of Public Bodies

1.5 Public bodies in Scotland are required to deliver effective services to meet the needs of an increasingly diverse population. In addition, the Scottish Government's equality outcome on public appointments is to ensure that Ministerial appointments are more diverse than at present**.** In order to meet both of these aims, a board should ideally be drawn from varied backgrounds with a wide spectrum of characteristics, knowledge and experience. It is crucial to the success of public bodies that they attract the best people for the job and therefore it is essential that a board's appointments process should encourage as many suitable people to apply for positions and be free from unnecessary barriers. You should therefore be aware of the varied roles and functions of the public body on which you serve and of wider diversity and equality issues. You should also take steps to familiarise yourself with the appointment process that your board will have agreed with the Scottish Government's Public Appointment Centre of Expertise.

1.6 You should also familiarise yourself with how the public body's policy operates in relation to succession planning, which should ensure public bodies have a strategy to make sure they have the staff in place with the skills, knowledge and experience necessary to fulfil their role economically, efficiently and effectively.

Guidance on the Code of Conduct

1.7 You must observe the rules of conduct contained in this Code. It is your personal responsibility to comply with these and review regularly, and at least annually, your personal circumstances with this in mind, particularly when your circumstances change. You must not at any time advocate or encourage any action contrary to the Code of Conduct.

1.8 The Code has been developed in line with the key principles listed in Section 2 and provides additional information on how the principles should be interpreted and applied in practice. The Standards Commission may also issue guidance. No Code can provide for all circumstances and if you are uncertain about how the rules apply, you should seek advice from the public body. You may also choose to consult your own legal advisers and, on detailed financial and commercial matters, seek advice from other relevant professionals.

1.9 You should familiarise yourself with the Scottish Government publication "On Board – a guide for board members of public bodies in Scotland". This publication will provide you with information to help you in your role as a member of a public body in Scotland and can be viewed on the Scottish Government website.

Enforcement

1.10 Part 2 of the Ethical Standards in Public Life etc. (Scotland) Act 2000 sets out the provisions for dealing with alleged breaches of this Code of Conduct and where appropriate the sanctions that will be applied if the Standards Commission finds that there has been a breach of the Code. Those sanctions are outlined in **Annex 6.1**.

SECTION 2: KEY PRINCIPLES OF THE CODE OF CONDUCT

2.1 The general principles upon which this Code is based should be used for guidance and interpretation only. These general principles are:

Duty
You have a duty to uphold the law and act in accordance with the law and the public trust placed in you. You have a duty to act in the interests of the public body of which you are a member and in accordance with the core functions and duties of that body.

Selflessness
You have a duty to take decisions solely in terms of public interest. You must not act in order to gain financial or other material benefit for yourself, family or friends.

Integrity
You must not place yourself under any financial, or other, obligation to any individual or organisation that might reasonably be thought to influence you in the performance of your duties.

Objectivity

You must make decisions solely on merit and in a way that is consistent with the functions of the public body when carrying out public business including making appointments, awarding contracts or recommending individuals for rewards and benefits.

Accountability and Stewardship
You are accountable for your decisions and actions to the public. You have a duty to consider issues on their merits, taking account of the views of others and must ensure that the public body uses its resources prudently and in accordance with the law.

Openness
You have a duty to be as open as possible about your decisions and actions, giving reasons for your decisions and restricting information only when the wider public interest clearly demands.

Honesty
You have a duty to act honestly. You must declare any private interests relating to your public duties and take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership
You have a duty to promote and support these principles by leadership and example, and to maintain and strengthen the public's trust and confidence in the integrity of the public body and its members in conducting public business.

Respect
You must respect fellow members of your public body and employees of the body and the role they play, treating them with courtesy at all times. Similarly you must respect members of the public when performing duties as a member of your public body.

2.2 You should apply the principles of this Code to your dealings with fellow members of the public body, its employees and other stakeholders. Similarly you should also observe the principles of this Code in dealings with the public when performing duties as a member of the public body.

SECTION 3: GENERAL CONDUCT

3.1 The rules of good conduct in this section must be observed in all situations where you act as a member of the public body.

Conduct at Meetings

3.2 You must respect the chair, your colleagues and employees of the public body in meetings. You must comply with rulings from the chair in the conduct of the business of these meetings.

Relationship with Board Members and Employees of the Public Body (including those employed by contractors providing services)

3.3 You will treat your fellow board members and any staff employed by the body with courtesy and respect. It is expected that fellow board members and employees will show you the same consideration in return. It is good practice for employers to provide examples of what is unacceptable behaviour in their organisation. Public bodies should promote a safe, healthy and fair working environment for all. As a board member you should be familiar with the policies of the public body in relation to bullying and harassment in the workplace and also lead by exemplar behaviour.

Remuneration, Allowances and Expenses

3.4 You must comply with any rules of the public body regarding remuneration, allowances and expenses.

Gifts and Hospitality

3.5 You must not accept any offer by way of gift or hospitality which could give rise to real or substantive personal gain or a reasonable suspicion of influence on your part to show favour, or disadvantage, to any individual or organisation. You should also consider whether there may be any reasonable perception that any gift received by your spouse or cohabitee or by any company in which you have a controlling interest, or by a partnership of which you are a partner, can or would influence your judgement. The term “gift” includes benefits such as relief from indebtedness, loan concessions or provision of services at a cost below that generally charged to members of the public.

3.6 You must never ask for gifts or hospitality.

3.7 You are personally responsible for all decisions connected with the offer or acceptance of gifts or hospitality offered to you and for avoiding the risk of damage to public confidence in your public body. As a general guide, it is usually appropriate to refuse offers except:

(a) isolated gifts of a trivial character, the value of which must not exceed £50;
(b) normal hospitality associated with your duties and which would reasonably be regarded as appropriate; or
(c) gifts received on behalf of the public body.

3.8 You must not accept any offer of a gift or hospitality from any individual or organisation which stands to gain or benefit from a decision your body may be involved in determining, or who is seeking to do business with your organisation, and which a person might reasonably consider could have a bearing on your judgement. If you are making a visit in your capacity as a member of your public body then, as a general rule, you should ensure that your body pays for the cost of the visit.

3.9 You must not accept repeated hospitality or repeated gifts from the same source.

3.10 Members of devolved public bodies should familiarise themselves with the terms of the Bribery Act 2010 which provides for offences of bribing another person and offences relating to being bribed.

Confidentiality Requirements

3.11 There may be times when you will be required to treat discussions, documents or other information relating to the work of the body in a confidential manner. You will often receive information of a private nature which is not yet public, or which perhaps would not be intended to be public. You must always respect the confidential nature of such information and comply with the requirement to keep such information private.

3.12 It is unacceptable to disclose any information to which you have privileged access, for example derived from a confidential document, either orally or in writing. In the case of other documents and information, you are requested to exercise your judgement as to what should or should not be made available to outside bodies or individuals. In any event, such information should never be used for the purposes of personal or financial gain or for political purposes or used in such a way as to bring the public body into disrepute.

Use of Public Body Facilities

3.13 Members of public bodies must not misuse facilities, equipment, stationery, telephony, computer, information technology equipment and services, or use them for party political or campaigning activities. Use of such equipment and services etc. must be in accordance with the public body's policy and rules on their usage. Care must also be exercised when using social media networks not to compromise your position as a member of the public body.

Appointment to Partner Organisations

3.14 You may be appointed, or nominated by your public body, as a member of another body or organisation. If so, you are bound by the rules of conduct of these organisations and should observe the rules of this Code in carrying out the duties of that body.

3.15 As a member of the Board, you are appointed, ex officio, as a Trustee of the Endowment Fund. You do not need to declare an interest in the Endowment Fund when participating in Board meetings or vice versa in the Board of Trustees but you must act in only the discrete interests of each.

3.16 Members who become directors of companies as nominees of their public body will assume personal responsibilities under the Companies Acts. It is possible that conflicts of interest can arise for such members between the company and the public body. It is your responsibility to take advice on your responsibilities to the public body and to the company. This will include questions of declarations of interest.

SECTION 4: REGISTRATION OF INTERESTS

4.1 The following paragraphs set out the kinds of interests, financial and otherwise which you have to register. These are called "Registerable Interests". You must, at all times, ensure that these interests are registered, when you are appointed and whenever your circumstances change in such a way as to require change or an addition to your entry in the body's Register. It is your duty to ensure any changes in circumstances are reported within one month of them changing.

4.2 The Regulations[1] as amended describe the detail and timescale for registering interests. It is your personal responsibility to comply with these regulations and you should review regularly and at least once a year your personal circumstances. **Annex 6.2** contains key definitions and explanatory notes to help you decide what is required when registering your interests under any particular category. The interests which require to be registered are those set out in the following paragraphs and relate to you. It is not necessary to register the interests of your spouse or cohabitee.

Category One: Remuneration

4.3 You have a Registerable Interest where you receive remuneration by virtue of being:

- employed;
- self-employed;
- the holder of an office;
- a director of an undertaking;
- a partner in a firm; or
- undertaking a trade, profession or vocation or any other work.

4.4 In relation to 4.3 above, the amount of remuneration does not require to be registered and remuneration received as a member does not have to be registered.

4.5 If a position is not remunerated it does not need to be registered under this category. However, unremunerated directorships may need to be registered under category two, "Related Undertakings".

4.6 If you receive any allowances in relation to membership of any organisation, the fact that you receive such an allowance must be registered.

4.7 When registering employment, you must give the name of the employer, the nature of its business, and the nature of the post held in the organisation.

4.8 When registering self-employment, you must provide the name and give details of the nature of the business. When registering an interest in a partnership, you must give the name of the partnership and the nature of its business.

4.9 Where you undertake a trade, profession or vocation, or any other work, the detail to be given is the nature of the work and its regularity. For example, if you

[1] SSI - The Ethical Standards in Public Life etc. (Scotland) Act 2000 (Register of Interests) Regulations 2003 Number 135, as amended.

write for a newspaper, you must give the name of the publication, and the frequency of articles for which you are paid.

4.10 When registering a directorship, it is necessary to provide the registered name of the undertaking in which the directorship is held and the nature of its business.

4.11 Registration of a pension is not required as this falls outside the scope of the category.

Category Two: Related Undertakings

4.12 You must register any directorships held which are themselves not remunerated but where the company (or other undertaking) in question is a subsidiary of, or a parent of, a company (or other undertaking) in which you hold a remunerated directorship.

4.13 You must register the name of the subsidiary or parent company or other undertaking and the nature of its business, and its relationship to the company or other undertaking in which you are a director and from which you receive remuneration.

4.14 The situations to which the above paragraphs apply are as follows:

- you are a director of a board of an undertaking and receive remuneration declared under category one – and
- you are a director of a parent or subsidiary undertaking but do not receive remuneration in that capacity.

Category Three: Contracts

4.15 You have a registerable interest where you (or a firm in which you are a partner, or an undertaking in which you are a director or in which you have shares of a value as described in paragraph 4.19 below) have made a contract with the public body of which you are a member:

(i) under which goods or services are to be provided, or works are to be executed; and
(ii) which has not been fully discharged.

4.16 You must register a description of the contract, including its duration, but excluding the consideration.

Category Four: Houses, Land and Buildings

4.17 You have a registerable interest where you own or have any other right or interest in houses, land and buildings, which may be significant to, of relevance to, or bear upon, the work and operation of the body to which you are appointed.

4.18 The test to be applied when considering appropriateness of registration is to ask whether a member of the public acting reasonably might consider any

interests in houses, land and buildings could potentially affect your responsibilities to the organisation to which you are appointed and to the public, or could influence your actions, speeches or decision making.

Category Five: Interest in Shares and Securities

4.19 You have a registerable interest where you have an interest in shares comprised in the share capital of a company or other body which may be significant to, of relevance to, or bear upon, the work and operation of (a) the body to which you are appointed and (b) the **nominal value** of the shares is:

(i) greater than 1% of the issued share capital of the company or other body; or
(ii) greater than £25,000.

Where you are required to register the interest, you should provide the registered name of the company in which you hold shares; the amount or value of the shares does not have to be registered.

Category Six: Gifts and Hospitality

4.20 You must register the details of any gifts or hospitality received within your current term of office. This record will be available for public inspection. It is not however necessary to record any gifts or hospitality as described in paragraph 3.7 (a) to (c) of this Model Code.

Category Seven: Non–Financial Interests

4.21 You may also have a registerable interest if you have non-financial interests which may be significant to, of relevance to, or bear upon, the work and operation of the body to which you are appointed. It is important that relevant interests such as membership or holding office in other public bodies, clubs, societies and organisations such as trades unions and voluntary organisations, are registered and described.

4.22 In the context of non-financial interests, the test to be applied when considering appropriateness of registration is to ask whether a member of the public might reasonably think that any non-financial interest could potentially affect your responsibilities to the organisation to which you are appointed and to the public, or could influence your actions, speeches or decision-making.

SECTION 5: DECLARATION OF INTERESTS

General

5.1 The key principles of the Code, especially those in relation to integrity, honesty and openness, are given further practical effect by the requirement for you to declare certain interests in proceedings of the public body. Together with the rules on registration of interests, this ensures transparency of your interests which might influence, or be thought to influence, your actions.

5.2 Public bodies inevitably have dealings with a wide variety of organisations and individuals and this Code indicates the circumstances in which a business or personal interest must be declared. Public confidence in the public body and its members depends on it being clearly understood that decisions are taken in the public interest and not for any other reason.

5.3 In considering whether to make a declaration in any proceedings, you must consider not only whether you will be influenced but whether anybody else would think that you might be influenced by the interest. You must, however, always comply with the **objective test** ("the objective test") which is whether a member of the public, with knowledge of the relevant facts, would reasonably regard the interest as so significant that it is likely to prejudice your discussion or decision making in your role as a member of a public body.

5.4 If you feel that, in the context of the matter being considered, your involvement is neither capable of being viewed as more significant than that of an ordinary member of the public, nor likely to be perceived by the public as wrong, you may continue to attend the meeting and participate in both discussion and voting. The relevant interest must however be declared. It is your responsibility to judge whether an interest is sufficiently relevant to particular proceedings to require a declaration and you are advised to err on the side of caution. If a board member is unsure as to whether a conflict of interest exits, they should seek advice from the board chair.

5.5 As a member of a public body you might serve on other bodies. In relation to service on the boards and management committees of limited liability companies, public bodies, societies and other organisations, you must decide, in the particular circumstances surrounding any matter, whether to declare an interest. Only if you believe that, in the particular circumstances, the nature of the interest is so remote or without significance, should it not be declared. You must always remember the public interest points towards transparency and, in particular, a possible divergence of interest between your public body and another body. Keep particularly in mind the advice in paragraph 3.15 of this Model Code about your legal responsibilities to any limited company of which you are a director.

Interests which Require Declaration

5.6 Interests which require to be declared if known to you may be financial or non-financial. They may or may not cover interests which are registerable under the terms of this Code. Most of the interests to be declared will be your personal interests but, on occasion, you will have to consider whether the interests of other persons require you to make a declaration. The paragraphs which follow deal with (a) your financial interests (b) your non-financial interests and (c) the interests, financial and non-financial, of other persons.

5.7 You will also have other private and personal interests and may serve, or be associated with, bodies, societies and organisations as a result of your private and personal interests and not because of your role as a member of a public body. In the context of any particular matter you will need to decide whether to declare an interest. You should declare an interest unless you believe that, in

the particular circumstances, the interest is too remote or without significance. In reaching a view on whether the objective test applies to the interest, you should consider whether your interest (whether taking the form of association or the holding of office) would be seen by a member of the public acting reasonably in a different light because it is the interest of a person who is a member of a public body as opposed to the interest of an ordinary member of the public.

Your Financial Interests

5.8 You must declare, if it is known to you, any financial interest (including any financial interest which is registerable under any of the categories prescribed in Section 4 of this Code). If, under category one (or category seven in respect of non-financial interests) of section 4 of this Code, you have registered an interest

(a) as an employee of the Board; or
(b) as a Councillor or a Member of another Devolved Public Body where the Council or other Devolved Public Body, as the case may be, has nominated or appointed you as a Member of the Board;

you do not, for that reason alone, have to declare that interest.

There is no need to declare an interest which is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

You must withdraw from the meeting room until discussion of the relevant item where you have a declarable interest is concluded. There is no need to withdraw in the case of an interest which is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

Your Non-Financial Interests

5.9 You must declare, if it is known to you, any non-financial interest if:

(i) that interest has been registered under category seven (Non- Financial Interests) of Section 4 of the Code; or
(ii) that interest would fall within the terms of the objective test.

There is no need to declare an interest which is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

You must withdraw from the meeting room until discussion of the relevant item where you have a declarable interest is concluded. There is no need to withdraw in the case of an interest which is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

The Financial Interests of Other Persons

5.10 The Code requires only your financial interests to be registered. You also, however, have to consider whether you should declare any financial interest of certain other persons.

You must declare if it is known to you any financial interest of:-

(i) a spouse, a civil partner or a co-habitee;
(ii) a close relative, close friend or close associate;
(iii) an employer or a partner in a firm;
(iv) a body (or subsidiary or parent of a body) of which you are a remunerated member or director;
(iv) a person from whom you have received a registerable gift or registerable hospitality;
(v) a person from whom you have received registerable expenses.

There is no need to declare an interest if it is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

You must withdraw from the meeting room until discussion of and voting on the relevant item where you have a declarable interest is concluded. There is no need to withdraw in the case of an interest which is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

5.11 This Code does not attempt the task of defining “relative” or “friend” or “associate”. Not only is such a task fraught with difficulty but is also unlikely that such definitions would reflect the intention of this part of the Code. The key principle is the need for transparency in regard to any interest which might (regardless of the precise description of relationship) be objectively regarded by a member of the public, acting reasonably, as potentially affecting your responsibilities as a member of the public body and, as such, would be covered by the objective test.

The Non-Financial Interests of Other Persons

5.12 You must declare if it is known to you any non-financial interest of:-

(i) a spouse, a civil partner or a co-habitee;
(ii) a close relative, close friend or close associate;
(iii) an employer or a partner in a firm;
(iv) a body (or subsidiary or parent of a body) of which you are a remunerated member or director;
(v) a person from whom you have received a registerable gift or registerable hospitality;
(vi) a person from whom you have received registerable election expenses.

There is no need to declare the interest if it is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

There is only a need to withdraw from the meeting if the interest is clear and substantial.

Making a Declaration

5.13 You must consider at the earliest stage possible whether you have an interest to declare in relation to any matter which is to be considered. You should consider whether agendas for meetings raise any issue of declaration of interest. Your declaration of interest must be made as soon as practicable at a meeting where that interest arises. If you do identify the need for a declaration of interest only when a particular matter is being discussed you must declare the interest as soon as you realise it is necessary.

5.14 The oral statement of declaration of interest should identify the item or items of business to which it relates. The statement should begin with the words "I declare an interest". The statement must be sufficiently informative to enable those at the meeting to understand the nature of your interest but need not give a detailed description of the interest.

Frequent Declarations of Interest

5.15 Public confidence in a public body is damaged by perception that decisions taken by that body are substantially influenced by factors other than the public interest. If you would have to declare interests frequently at meetings in respect of your role as a board member you should not accept a role or appointment with that attendant consequence. If members are frequently declaring interests at meetings then they should consider whether they can carry out their role effectively and discuss with their chair. Similarly, if any appointment or nomination to another body would give rise to objective concern because of your existing personal involvement or affiliations, you should not accept the appointment or nomination.

Dispensations

5.16 In some very limited circumstances dispensations can be granted by the Standards Commission in relation to the existence of financial and non-financial interests which would otherwise prohibit you from taking part and voting on matters coming before your public body and its committees.

5.17 Applications for dispensations will be considered by the Standards Commission and should be made as soon as possible in order to allow proper consideration of the application in advance of meetings where dispensation is sought. You should not take part in the consideration of the matter in question until the application has been granted.

SECTION 6: LOBBYING AND ACCESS TO MEMBERS OF PUBLIC BODIES

Introduction

6.1 In order for the public body to fulfil its commitment to being open and accessible, it needs to encourage participation by organisations and individuals in the decision-making process. Clearly however, the desire to involve the public and other interest groups in the decision-making process must take account of the need to ensure transparency and probity in the way in which the public body conducts its business.

6.2 You will need to be able to consider evidence and arguments advanced by a wide range of organisations and individuals in order to perform your duties effectively. Some of these organisations and individuals will make their views known directly to individual members. The rules in this Code set out how you should conduct yourself in your contacts with those who would seek to influence you. They are designed to encourage proper interaction between members of public bodies, those they represent and interest groups.

Rules and Guidance

6.3 You must not, in relation to contact with any person or organisation that lobbies do anything which contravenes this Code or any other relevant rule of the public body or any statutory provision.

6.4 You must not, in relation to contact with any person or organisation who lobbies, act in any way which could bring discredit upon the public body.

6.5 The public must be assured that no person or organisation will gain better access to or treatment by, you as a result of employing a company or individual to lobby on a fee basis on their behalf. You must not, therefore, offer or accord any preferential access or treatment to those lobbying on a fee basis on behalf of clients compared with that which you accord any other person or organisation who lobbies or approaches you. Nor should those lobbying on a fee basis on behalf of clients be given to understand that preferential access or treatment, compared to that accorded to any other person or organisation, might be forthcoming from another member of the public body.

6.6 Before taking any action as a result of being lobbied, you should seek to satisfy yourself about the identity of the person or organisation that is lobbying and the motive for lobbying. You may choose to act in response to a person or organisation lobbying on a fee basis on behalf of clients but it is important that you know the basis on which you are being lobbied in order to ensure that any action taken in connection with the lobbyist complies with the standards set out in this Code.

6.7 You should not accept any paid work:-

(a) which would involve you lobbying on behalf of any person or organisation or any clients of a person or organisation.
(b) to provide services as a strategist, adviser or consultant, for example, advising on how to influence the public body and its members. This does not prohibit you from being remunerated for activity which may arise because of, or relate to, membership of the public body, such as journalism

or broadcasting, or involvement in representative or presentational work, such as participation in delegations, conferences or other events.

6.8 If you have concerns about the approach or methods used by any person or organisation in their contacts with you, you must seek the guidance of the public body.

ANNEX 6.1

SANCTIONS AVAILABLE TO THE STANDARDS COMMISSION FOR BREACH OF THE CODE

(a) Censure – the Commission may reprimand the member but otherwise take no action against them;

(b) Suspension – of the member for a maximum period of one year from attending one or more, but not all, of the following:

i) all meetings of the public body;
ii) all meetings of one or more committees or sub-committees of the public body;
(iii) all meetings of any other public body on which that member is a representative or nominee of the public body of which they are a member.

(c) Suspension – for a period not exceeding one year, of the member's entitlement to attend all of the meetings referred to in (b) above;

(d) Disqualification – removing the member from membership of that public body for a period of no more than five years.

Where a member has been suspended, the Standards Commission may direct that any remuneration or allowance received from membership of that public body be reduced, or not paid.

Where the Standards Commission disqualifies a member of a public body, it may go on to impose the following further sanctions:

(a) Where the member of a public body is also a councillor, the Standards Commission may disqualify that member (for a period of no more than five years) from being nominated for election as, or from being elected, a councillor. Disqualification of a councillor has the effect of disqualifying that member from their public body and terminating membership of any committee, sub-committee, joint committee, joint board or any other body on which that member sits as a representative of their local authority.
(b) Direct that the member be removed from membership, and disqualified in respect of membership, of any other devolved public body (provided the members' code applicable to that body is then in force) and may disqualify that person from office as the Water Industry Commissioner.

In some cases the Standards Commission do not have the legislative powers to deal with sanctions, for example if the respondent is an executive member of the board or appointed by the Queen. Sections 23 and 24 of the Ethical Standards in Public Life etc. (Scotland) Act 2000 refer.

Full details of the sanctions are set out in Section 19 of the Act.

ANNEX 6.2

DEFINITIONS

"Chair" includes Board Convener or any person discharging similar functions under alternative decision making structures.

"Code" code of conduct for members of devolved public bodies

"Cohabitee" includes a person, whether of the opposite sex or not, who is living with you in a relationship similar to that of husband and wife.

"Group of companies" has the same meaning as "group" in section 262(1) of the Companies Act 1985. A "group", within s262 (1) of the Companies Act 1985, means a parent undertaking and its subsidiary undertakings.

"Parent Undertaking" is an undertaking in relation to another undertaking, a subsidiary undertaking, if a) it holds a majority of the rights in the undertaking; or b) it is a member of the undertaking and has the right to appoint or remove a majority of its board of directors; or c) it has the right to exercise a dominant influence over the undertaking (i) by virtue of provisions contained in the undertaking's memorandum or articles or (ii) by virtue of a control contract; or d) it is a councillor of the undertaking and controls alone, pursuant to an agreement with other shareholders or councillors, a majority of the rights in the undertaking**.**

"A person" means a single individual or legal person and includes a group of companies.

"Any person" includes individuals, incorporated and unincorporated bodies, trade unions, charities and voluntary organisations.

"**Public body"** means a devolved public body listed in Schedule 3 of the Ethical Standards in Public Life etc. (Scotland) Act 2000, as amended.

"Related Undertaking" is a parent or subsidiary company of a principal undertaking of which you are also a director. You will receive remuneration for the principal undertaking though you will not receive remuneration as director of the related undertaking.

"Remuneration" includes any salary, wage, share of profits, fee, expenses, other monetary benefit or benefit in kind. This would include, for example, the provision of a company car or travelling expenses by an employer.

“Spouse” does not include a former spouse or a spouse who is living separately and apart from you.

“Undertaking” means:
a) a body corporate or partnership; or
b) an unincorporated association carrying on a trade or business, with or without a view to a profit.

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**13 May 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.

2.2 Background

The Internal Audit year runs from May to April. The Internal Audit team continues to deliver the remaining reviews from the 2020/21 plan under the supervision of the Chief Internal Auditor. We have experienced some delays in progressing audits but all work will be completed to allow consideration as part of the Annual Report for 2020/21. Audit work completed allows the Chief Internal Auditor to provide the necessary assurances prior to the signing of the accounts.

A large element of our year-end assurance work has been delivered through the Internal Control Evaluation and Sustainability audit; final assurance will be derived from the 2020/21 Annual Internal Audit Report.

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.

Due to IT difficulties, we are unable to provide KPIs around the time budget.

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
- 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.

Appendix B shows:

- The revised recommendation priorities and assurance definitions for use in all future internal audit reports.

Advice and input

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

- Assurance mapping and risk advice, in particular Digital and Information risks
- Advice on the revised Terms of Reference for the Digital Information Board, Information Governance and Security Steering and Operational Groups and attendance at their meetings.

Improvement Activities

Further work since the March 2021 Audit and Risk Committee meeting includes:

- Following discussion with Directors, we have reviewed our recommendation priorities to include an additional category 'Moderate'. This enhancement is to address feedback that there was a significant gap between the 'Significant' and 'Merits Attention' prioritisations. We have also slightly amended the definitions for clarity. We have also updated our assurance definitions in line with the CIPFA guidance 'Setting common definitions' (https://www.cipfa.org/policy-and-guidance/reports/setting-common-definitions), issued in April 2020. The new definitions will be introduced for audits within the 2021/22 Annual Internal Audit Plan and are at Appendix B.

- The FTF self assessment against the Public Sector Internal Audit Standards has been completed, to be circulated to the FTF Partnership Board before presentation to the September 2021 Audit and Risk Committee.

- FTF have assumed responsibility for the provision of the Chief Interal Auditor Service to Fife IJB; initial planning discussions have commended. The Chief Internal Auditor was also asked to provide comment on the draft revised Integration Scheme

- Development of the FTF website is ongoing.

2.3.1 Quality/ Patient Care

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

2.3.2 Workforce

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

2.3.3 Financial

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

2.3.4 Risk Assessment/Management

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

2.3.5 Equality and Diversity, including health inequalities

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

2.3.6 Other impacts

N/A

2.3.7 Communication, involvement, engagement and consultation

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

2.3.8 Route to the Meeting

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

2.4 Recommendation

The Audit and Risk Committee is asked to:

- **DISCUSS** and **NOTE** the progress on the delivery of the Internal Audit Plans.
- **APPROVE** the revised recommendation priorities and assurance definitions for use in all future internal audit reports as set out in Appendix B.

3 List of appendices

The following appendices are included with this report:

- Appendix A – Internal Audit Progress Report

- Appendix B – Revised internal audit reporting definitions

Internal Audit Progress Report

Introduction

This report presents the progress of internal audit activity up to 4 May 2021.

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 19 January 2021. 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				
B09/21 – Audit Follow Up	N/A	N/A	N/A	Report provided to each Audit and Risk Committee and year end summary to May 2021 Audit and Risk Committee
B11/21 – Attendance at meetings/ Ad-hoc Advice provided by Chief Internal Auditor, Audit Manager and Principal Auditors	N/A	N/A	4 May 2021	4 May 2021 – Year end summary
B12/21 – Assurance Framework	N/A	None	30 April 2021	4 May 2021
B18/21 – Health and Social Care Integration	N/A	N/A	4 May 2021	4 May 2021 – Year end summary
B20/21 – Adverse Event Management	N/A	1 – Merits Attention	17 February 2021	22 March 2021

NHS Fife Draft Reports Issued

Audit 2020/21	Draft issued
B22/21 - Workforce - Review of Manual Handling Arrangements	4 May 2021
B23/21 - Information Technology Infrastructure Library (ITIL) Processes	4 May 2021
B26/21 – Financial Process Compliance	23 April 2021
B28/21 - Digital and Information Governance Arrangements	4 May 2021

NHS Fife Work in Progress and Planned:

Audit 2020/21		Status	Target Audit and Risk Committee
B10/21	Code of Corporate Governance – COVID Checklist	Fieldwork	Each of these reviews had a target Audit and Committee of 13 May 2021 but we experienced delays in progressing these reviews due to the following factors: • Client staff availability due to COVID commitments. • Staff from the FTF Fife team assisting in other FTF clients due to long term sickness (Covid) and staff vacancies in other FTF Client Boards. These reviews are progressing and will be completed in time to be considered as part of the Internal Audit Annual Report. Draft reports will be issued for these by the end of May 2021.
B13/21	Risk Management	Fieldwork	
B15/21	NHS Resilience	Planning	
B19/21	Clinical Governance Strategy and Assurance including Scottish Patient Safety Programme	Fieldwork	
B21/21	Medical Equipment and Devices	Fieldwork	

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 March 2021 where a progress report was considered.

1. B09/21 Audit Follow Up (AFU)

Full report included on the agenda for the May 2021 Audit and Risk Committee.

Throughout 2020/21, Internal Audit have provided a comprehensive Audit Follow Up (AFU) report to each Audit and Risk Committee and updated the AFU protocol. Enhancements to the reporting have been made during the year and the Executive Directors Group has monitored the action taken in year for the outstanding recommendations. Following a review by Internal Audit of historical audit recommendations, many have been updated within "current" audit reports or been removed as they are no longer applicable. The outcomes from this exercise are reported within the AFU report to the May 2021 Audit and Risk Committee.

2. B11/21 – Attendance at meetings/ Ad-hoc Advice provided by Chief Internal Auditor, Audit Manager and Principal Auditors

The Chief Internal Auditor/Regional Audit Manager/Principal Auditors, as and when requested, have attended NHS Fife committees and groups to provide advice or support. When requested have provided input, for example draft policies or changes in the control environment:

- Assurance mapping and risk advice, in particular Digital and Information risks
- Advice on the revised Terms of Reference for the Digital Information Board, Information Governance and Security Steering and Operational Groups and attendance at their meetings.
- Suggested amendments to the draft Integration Scheme
- 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.

3. B12/21 – Assurance Framework

The December 2018 Audit and Risk Committee received a report on the requirements of the revised Scottish Public Finance Manual (SPFM) Audit Committee Handbook which reported that '*Consideration should also be given to developing an assurance map for NHS Fife*' which in itself would substantially assist in the work to ensure risk management arrangements are sufficiently robust. Subsequently, it was agreed that the approach adopted would be to trial an assurance mapping process on specific key risks and that the Digital and Information Governance BAF would be the most appropriate,

being both high risk and subject to diffuse assurance arrangements.

Digital and Information Board Assurance Framework (BAF) - Work with General Manager for eHealth and IM&T identified a number of improvements required to the Digital and Information BAF before our work on assisting with mapping assurances could progress in earnest. These improvements were being taken forward by the General Manager for eHealth and IM&T and the Risk Manager but have not yet been concluded. The General Manager for eHealth and IM&T retired in early 2021 and since this time we have discussed the BAF with the Associate Director – Digital and Information who has made initial changes to the BAF (presented to NHS Fife Clinical Governance Committee on 30 April 2021) and is now undertaking a full risk review within his directorate the outcome of which will inform further revisions to the BAF. These revisions are anticipated to be made in 2021/22 therefore our work in assisting with the related assurance mapping process will be completed following this.

Assurance Mapping Group - During the year, the Assurance Mapping group, consisting of Board Secretaries and Risk Managers from NHS Fife, Forth Valley, Tayside and Lanarkshire, continued to agree the way forward for assurance mapping, taking into account the implication of Covid 19 on timetables. The group agreed a set of Committee Assurance and Risk principles, which are presented to this Committee separately. The Assurance Mapping group along with considerable input from the NHS Fife Board Secretary, agreed an approach to the SGHSCD Directors' Assurance requirements and developed a detailed questionnaire, to be considered for adoption in NHS Fife in 2021/22, which will align with assurance mapping across the organisation and be integrated with other assurance processes within Standing Committees, in order to avoid unnecessary duplication.

4. B18/21 – Health and Social Care Integration

The Chief Internal Auditor has continued to provide advice to NHS Fife officers and members on Integration issues. For 2021/22 onwards, FTF will be leading and providing the input to the IJB Audit Plan.

5. B20/21 – Adverse Event Management

This audit was an extension of the Adverse Event Management review - B19/20, and was a specific request from the Medical Director. The primary focus of that review was to consider the procedures in place to implement actions to address issues identified from adverse event reviews.

From a sample of 29 SAERs/LAERs actions originating in 2018 and 2019, identified as overdue completion in B19/20, we evaluated through responses to a questionnaire sent to the responsible officers, whether these actions had been implemented without being updated on DATIX and whether evidence had been retained to enable instances where this has occurred to be verified. The questionnaire also asked for an explanation of the reason for actions not being implemented and whether there were any issues in using the DATIX Action Module.

From the sample of 29 outstanding actions selected, the following was noted from the 23 responses received (6 not responding):

- Actions implemented but not updated on the DATIX Action Module (11) – **48%**
- Actions not implemented (12) – **52%**

These results indicate that although not recorded as such, actions are being implemented. This provides evidence that the overall number of actions outstanding is not as significant as indicated in the DATIX Action Module. Sufficient evidence was obtained from officers to provide assurance that these actions were completed. The above testing highlights a data quality issue within the DATIX Action Module, and also raises a further risk that a considerable

number do still remain outstanding. This testing reflects the previous finding within B19/20, that officers are not implementing all actions by the set due dates and also that the officers responsible for monitoring there implementation are not confirming such.

Management have produced a comprehensive action plan to progress with the following extract summarising the approach – "*The findings of this audit will be shared with relevant Clinical Governance Committees and management teams across the organisation. The anonymised raw data from this audit has been shared with the NHS Fife Quality and Clinical Governance team and this will be used to support a review and establish actions required. The inherent risks associated with the number of actions not implemented are noted and the importance of a multifaceted action plan to improve this is recognised.*"

Key Performance Indicators

2020/21

Performance against service specification as at 4 May 2020:

	Planning	Target	19 January 2021	13 May 2021
1	Audit assignment plans for planned audits issued to the responsible Director at least 2 weeks before commencement of audit	75%	67%	73%
2	Draft reports issued by target date	75%	60%	56%
3	Responses received from client within timescale defined in reporting protocol	75%	75%	80%
4	Final reports presented to target Audit Committee	75%	75%	73%
5	Number of days delivered against plan	100% at year-end	System Issue – not provided	System Issue – not provided

Internal Audit Definition of Assurance and Recommendation Priorities

Introduction

Following discussion with a number of client Directors, we have reviewed our Recommendation Priorities to include an additional category 'Moderate'. This follows feedback that there was a significant gap between 'Significant' and 'Merits Attention' which was resulting in needless additional discussion for recommendations which fell between those categories. We have also slightly amended the definitions for clarity, again following discussions with Directors. In addition, we have also updated our assurance definitions slightly to be in line with recently issued CIPFA guidance: https://www.cipfa.org/policy-and-guidance/reports/setting-common-definitions.

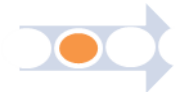
This change has been considered and approved by the Partnership Board.

Previous position

The previous definitions were as follows:

Definition of Assurance

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

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

Recommendation Priorities

The priorities relating to Internal Audit recommendations are currently defined as follows:

Risk Assessment		Definition	Total
Fundamental		Non Compliance with key controls or evidence of material loss or error. **Action is imperative to ensure that the objectives for the area under review are met.**	
Significant		Weaknesses in control or design in some areas of established controls. **Requires action to avoid exposure to significant risks in achieving the objectives for area under review.**	
Merits attention		There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**	

Approved change

Definition of Assurance

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

Level of Assurance		System Adequacy	Controls
Substantial Assurance		A sound system of governance, risk management and control exists, with internal controls operating effectively and being consistently applied to support the achievement of objectives in the area audited.	Controls are applied continuously or with only minor lapses.
Reasonable Assurance		There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified which may put at risk the achievement of objectives in the area audited.	Controls are applied frequently but with evidence of non-compliance.
Limited Assurance		Significant gaps, weaknesses or non-compliance were identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the area audited.	Controls are applied but with some significant lapses.
No Assurance		Immediate action is required to address fundamental gaps, weaknesses or non-compliance identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the area audited.	Significant breakdown in the application of controls.

Approved change

We have now included a moderate recommendation within the Assessment of Risk as follows:

Assessment of Risk

To assist management in assessing each audit finding and recommendation, we have assessed the risk of each of the weaknesses identified and categorised each finding according to the following criteria:

Fundamental		Non Compliance with key controls or evidence of material loss or error. **Action is imperative to ensure that the objectives for the area under review are met.**	
Significant		Weaknesses in design or implementation of key controls i.e. those which individually reduce the risk scores. **Requires action to avoid exposure to significant risks to achieving the objectives for area under review.**	
Moderate		Weaknesses in design or implementation of controls which contribute to risk mitigation. **Requires action to avoid exposure to moderate risks to achieving the objectives for area under review.**	
Merits attention		There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**	

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**13 May 2021**
Title:	**Internal Audit Operational Plan – 2021/22**
Responsible Executive:	**Margo McGurk – Director of Finance and Strategy**
Report Author:	**Tony Gaskin – Chief Internal Auditor**

1 Purpose

This is presented to the Audit and Risk Committee for:

- Discussion
- Approval

This report relates to a:

- Legal requirement

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

Public Sector Internal Audit Standards (PSIAS) require the Chief Internal Auditor to produce a risk based plan, which takes into account NHS Fife's risk management framework, strategic objectives and priorities, and the views of senior managers, Standing Committee lead officers, and the Audit & Risk Committee Chair and members.

As part of the annual planning process we have engaged initially with the Director of Finance and Strategy and then with the wider Executive Directors Group to ensure the plan reflects current risks and any other areas where a review would be beneficial and add value to NHS Fife.

NHS Fife is in the process of revisiting the risk profile and introducing a Corporate Risk Register, with the Director of Finance and Strategy the executive lead for risk management from 1 April 2021. The draft Internal Audit Operational Plan 2021/22 has been mapped to the extant BAFs and the highest risks from the COVID 19 Risk Register, also taking into account issues identified in recent Internal Audit reports.

During 2021/22 we will actively reflect on the operational plan in place to ensure it continues to meet the needs of the service, reflects the current risk profile and incorporates the outputs from the ongoing assurance mapping work. Any consequent changes to the plan will be reported to the Audit and Risk Committee for approval.

2.2 Background

> ***"Internal auditing is an independent, objective assurance and consulting activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, internal control and governance processes."***
>
> Public Sector Internal Audit Standards (PSIAS) – Section 3, Definition of Internal Auditing

The Operational Plan 2021/22 has been developed in accordance with Public Sector Internal Audit Standard 2010 – Planning, to enable the Chief Internal Auditor to meet the following key objectives:

- The need to establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organisation's goals;
- Provision to the Accountable Officer of an overall independent and objective annual opinion on the organisation's governance, risk management, and control, which will in turn support the preparation of the Annual Governance Statement;
- Audits of the organisation's governance, risk management, and control arrangements which afford suitable priority to the organisation's objectives and risks;
- Improvement of the organisation's governance, risk management, and control arrangements by providing line management with recommendations arising from audit work;
- Effective co-operation with external auditors and other review bodies functioning in the organisation.

The internal audit service will be delivered in accordance with the Internal Audit Charter. The plan is driven by NHS Fife's organisational objectives and priorities, and maps directly to the BAF and COVID risks that may prevent NHSF from meeting those objectives.

Our Strategic Internal Audit Plan is designed to provide NHS Fife, through the Audit and Risk Committee, with the assurance it needs to prepare an annual Governance Statement that complies with best practice in corporate governance. We also support the continuous improvement of governance, risk management and internal control processes by using a systematic and disciplined evaluation approach.

The objective of audit planning is to direct audit resources in the most efficient manner to provide sufficient assurance that key risks are being managed effectively.

2.3 Assessment

Standard process – Previous Years

Our Strategic Internal Audit planning process is normally structured around an audit universe based on a 5 year cycle which links to the BAF Risk Register and objectives. The process overtly demonstrates cyclical coverage of all corporate risks and is designed to allow greater potential for Executive Directors and the Audit and Risk Committee to contribute their views on areas for inclusion. The resultant operational plan is, again overtly linked to the BAF risk, which will still be the focus of our work, together with any key governance or assurance elements required in order to provide a view on the overall adequacy and effectiveness of internal controls.

If required further background information can be provided on the standard process, which will resume for 2022/23 onwards when the organisation will have a new overarching strategy and a revised risk register.

Current year process – 2021/22

Due to the significant and emergent impact of Covid-19 on the risk profile of the organisation, a planning process which relied on a relatively static risk environment and change generally occurring in the medium to long term was no longer viable. As such, our view is very much that the plan will need to be flexible, responsive to the requirements of senior management and non executive directors and, to a certain extent, emergent as the risk profile changes and new information becomes available.

In order to provide a starting point for discussion, we have obtained the views of the Director of Finance and Strategy and the wider Executive Directors Group with greater emphasis on the organisations current rather than cyclical needs, focusing on emergent risks and those with most immediacy, as the basis for a first draft plan which we will adapt to the views of the Audit and Risk Committee, if required, or obtain approval.

However, we know that the organisational risk profile is changing rapidly, as is organisational understanding of those risks and we will continuously review the plan and update as required, with approval sought from the Audit and Risk Committee for any changes required.

Environmental and change risks

We actively take into account ongoing projects, forthcoming changes and our wider knowledge of the NHS to ensure we provide an appropriate level of audit coverage across all key areas and risks. This includes consideration of the following key sources of information:

- Corporate Strategy & Plans/local plans/annual operational plans
- Previous internal audit reports, in particular the Internal Control Evaluation
- External audit reports and plans
- Board website, internal policies and procedures
- Our knowledge and experience at other client Health Boards
- Discussions with the EDG and the Audit and Risk Committee
- Changes to the risk profile due to Covid 19

Assurance mapping

Internal Audit are working with the Board to develop a process and timetable for the development of a holistic Assurance Mapping process to identify key sources of assurance and any gaps in independent assurance, which will then be taken into account in the formation of future Internal Audit plans and audit scopes.

Other stakeholders

There is congruence between Health Board internal audit plans and those of the Integrated Joint Board (IJB) Partners. The NHS Fife Internal Audit Plan currently includes days for Internal Audit of the IJBs, with IJB Plans agreed with the IJB Chief Officers and Chief Finance Officers and approved by the IJB Audit Committee. The IJB Chief Officer will have the opportunity to influence the Health Board Plan as a member of the EDG and there is a sharing protocol that allows for Health Board and Council Internal Audit Plans to be shared with the IJB and vice-versa.

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. It is likely that the Board's workforce strategy, along with all key strategies will require fundamental review later in the year and this will be reflected in any later revisions to the Internal Audit plan.

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

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 impact

N/A

2.3.7 Communication, involvement, engagement and consultation

See timetable above.

2.3.8 Route to the Meeting

See timetable above.

2.4 Recommendation

The Audit and Risk Committee are asked to:

- **Discuss** the draft Internal Audit Operational Plan for 2021/22 **and,**
- **Approve** the Internal Audit Operational Plan for 2021/22 if no changes are required. (If the plan needs to be updated it will be tabled at June 2021 meeting of the Audit and Risk Committee for approval).

3 List of appendices

The following appendices are included with this report:

- **Appendix 1** – Internal Audit Operational Plan 2021/22 including mapping to BAF/COVID 19 risks.

Report Contact
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Appendix 1

Ref		Audit Process	Scope	Days	BAF Risk Link
		AUDIT MANAGEMENT		***55***	
B 01	22	Audit Risk Assessment & Planning	Audit Risk Assessment & Operational Planning	8	-
B 02	22	Audit Management & Liaison with Directors	Audit Management, liaison with Director of Finance and other officers	15	-
B 03	22	Liaison with External Auditors	Liaison and co-ordination with External Audit	4	-
B 04	22	Audit Committee	Briefing, preparation of papers, attendance and action points	18	-
B 05	22	Clearance of Prior Year	Provision for clearance and reporting of 2020/21 audit reports	10	-
		CORPORATE GOVERNANCE			
		Accountability and Assurance		***110***	
B 06	22	Annual Internal Audit Report	CIA annual assurance to Audit Committee	15	-
B 07	22	Governance Statement	Preparation of portfolio of evidence to support	20	-
B 08	22	Interim Control Evaluation	Mid-year assurance for Audit and Risk Committee on specific agreed governance areas	35	-
B 09	22	Audit Follow Up	Undertaking the follow up of audit action points and provision of related reports to the Audit and Risk Committee	40	-
		Control Environment		***15***	
B 10	22	Board, Operational Committees and Accountable Officer	Attendance and input / provision of advice at Standing Committees and other Groups.	5	-
B11	22	Assurance Framework	Review of assurance structures, including Audit and Risk Committee; relevance, reliability, timeliness and quality of evidence. Continuation of assurance mapping work.	10	-

Ref		Audit Process	Scope	Days	BAF Risk Link
		Risk Management		***20***	
B12	22	Risk Management Strategy, Standards and Operations	Review of strategy and supporting structures in order to conclude on risk maturity as required of the Public Sector Internal Audit Standards. Review of revised Risk Register.	20	-
		Health Planning		***105***	
B 13	22	Strategic Planning	Provide advice and input at key stages of the development of Clinical and related Strategies	15	Strategic Planning
B14	22	Operational Planning	Review of the Strategic Planning and Resource Allocation process, including savings and related risks.	20	Strategic Planning
B15	22	Health & Social Care Integration	Delivery of Fife IJB Internal Audit Plans. Note : first year of FTF CIA role - days will reduce in future years	70	IJB
		CLINICAL GOVERNANCE		***15***	
B16	22	Medicines Management	Review of Secured Stationary as requested by the Safer Use Medicine Group.	15	Quality and Safety
		STAFF GOVERNANCE		***25***	
B17	22	Workforce Planning	Specific review to ensure safe staffing levels are being maintained	25	Workforce Sustainability
		FINANCIAL GOVERNANCE		***50***	
		Financial Management		***25***	
B18	22	Procurement	Review of procurement arrangements including governance.	25	Financial Sustainability
		Capital Investment		***10***	
B 19	22	Property Transaction Monitoring	Post transaction monitoring	10	-
		Transaction Systems		***15***	

Ref		Audit Process	Scope	Days	BAF Risk Link
B20	22	Financial Process Compliance	To be selected from: Central, payroll, travel, accounts payable, accounts receivable, banking arrangements.	15	Financial Sustainability
		INFORMATION GOVERNANCE		***25***	
B21	22	Digital and Information (eHealth) governance		25	Digital and Information
		CONTINGENCY and DEPARTMENTAL REVIEWS		***35***	
B 22	22	Contingency		15	-
B23	22	Departmental Review	Compliance with policies & procedures & risk management arrangements – Department TBC	20	-
Total Days Allocated				***455***	
Contingency and discretionary				***8***	
Total Days for 2021/22 Internal Audit Plan				***463***	

Review of COVID Risk Register

There are 96 COVID risks within the COVID risk register, of which 13 high level risks are monitored by the Executive Directors Group. These risks relate to the following and have been mapped to audit reviews to be undertaken during 2021/22:

	High Level COVID Risks	Internal Audit	Link to Audit Review
1	As a result of the current global COVID-19 pandemic, there is a risk of significant morbidity and mortality in the Fife population due to a lack of immunity to this novel disease. This could result in mild-to-moderate illness in the majority of the population, but complications requiring hospital care and severe disease (including death) in a minority of the population, particularly among the elderly and those with underlying health risk conditions. The potential impacts for NHS Fife include increased deaths, increased pressure on healthcare and support services affecting service delivery, reduced capacity for non-urgent services, disruption to supply chains	This has links to the development of the Clinical Strategy and other related strategies and delivery of services both now and in the future	B13/22 – Strategic Planning B14/22 – Operational Planning

	and high levels of employee absence due to personal illness and caring responsibilities.		
2	Unavailability of AlphaSolway S-3v FFP3 mask (specially designed for smaller fit) and low pass rates for fit testing for AlphaSolway Hx Series masks (17%) and 3M 1863+ (50%) [These being the only disposable FFP3 masks currently with sustainable supply in NHS Scotland] has resulted in increasing number of staff who do not have access to a disposable FFP3 mask which fits correctly.	Internal Audit will be reviewing the Procurement Governance Board and will consider as part of this review how related risks are being monitored.	B18/22 - Procurement
3	The area that NHS Fife has available to serve as a PPE distribution hub is limited in its capacity, with items being received in bulk by the pallet and items moving unexpectedly slower. There is a risk that the space available in the hub is quickly reaching capacity which limits what items we can stock and hold locally and slow throughput could indicate areas not ordering PPE products.	Internal Audit will be reviewing the Procurement Governance Board and will consider as part of this review how related risks are being monitored.	B18/22 - Procurement
4	There is a risk that due to the focus on managing the coronavirus outbreak and impact on the transformation programme and budget savings, the IJB's budget deficit will increase going forward.	This risk will be considered as part of both our year end work and Internal Control Evaluation (ICE).	B06/22 – Annual Report B08/22 – ICE
5	As services remobilise, the impact on the Procurement function and its resources is unknown and currently unquantified. Anticipate pressures on product demand, requirements for PPE and cleaning products, and Procurement BAU functions. Risk for the Procurement function handling the competing demands of the operational requirements (post-COVID PPE/stock management/mass vaccination clinics requiring a trial of a pull model (agreed at bronze group) to help deliver the stock to each independent location- involving a lot of planning) versus strategic requirements (remobilisation, return to pre-COVID BAU, longer-term procurement activity).	Internal Audit will be reviewing the Procurement Governance Board and will consider as part of this review how related risks are being monitored.	B18/22 - Procurement
6	COVID-19 is highly transmissible from person to person. Contact tracing is a well-established public health measure to reduce transmission in the population by rapid identification and self-isolation of cases and their contacts. At an earlier stage in the pandemic (containment phase), it was accepted nationally that contact tracing all cases was not possible due to the scale and	A review of Workforce Planning will be scoped for 2021/22 and this risk considered as part of that review.	B17/22 – Workforce Planning

	resources available. Now the virus has been suppressed to lower levels, there is a requirement to undertake contact tracing for all confirmed cases of COVID-19. There is a risk that we are not able to undertake contact tracing at a larger scale in Fife due to limited specialist workforce and the rate of transmission of COVID-19. An inability to maintain low levels of transmission risks increasing illness, increasing pressure on NHS services and extended lockdown measures impacting the economy and health outcomes of the population in Fife.		
7	There is a risk that medicines expenditure rises during COVID, and that medicines efficiency targets are missed. This is because pharmacy teams are unable to focus on delivery of efficiencies, shortages cause switches to more expensive alternatives, and patients may change their ordering behaviour Against Pharmacy priorities and key Pharmacy risk categories, this impacts: Governance	This risk will be considered as part of both our year end work and Internal Control Evaluation (ICE) on Financial Governance.	B06/22 – Annual Report B08/22 - ICE
8	There is a risk that, due to competing demands for nursing resource to support urgent programmes such as test and protect and vaccination roll-out, combined with staff absences due to illness, fatigue, child care issues and the need to self-isolate, the HSCP may be unable to maintain safe staffing levels and this may impact on provision of critical services.	This risk will be considered within Workforce Planning, with a specific review included on maintaining safe staff levels.	B17/22 – Workforce Planning
9	As a result of the current global COVID-19 pandemic, there is a risk of significant morbidity and mortality. It is recognised that adults living in care homes often have multiple health and care needs and many are frail with varying levels of dependence. Many are inevitably at greater risk of poorer outcomes if they were to contract COVID-19 due to conditions such as frailty, multiple co-morbidity, pre-existing cardio-respiratory conditions or neurological conditions. Care homes are environments that have proved to be particularly susceptible to Coronavirus and require whole system support to protect residents and staff. The potential impacts for care home include increased morbidity and mortality, increased pressure on care home	Noted.	-

	staff, high levels of employee absence due to personal illness and caring responsibilities		
10	The supply of non-PPE goods and services continues to fluctuate following global supply chain pressures or goods that have been impacted by an increased uptake following the COVID-19 outbreak (e.g. gloves, soap, cleaning products, airway consumables). There is a risk that supply shortages on specific items could have an adverse impact on NHS Fife's ability to meet its objectives and provide the expected level of care	Internal Audit will be reviewing the Procurement Governance Board and will consider as part of this review how related risks are being monitored.	B18/22 - Procurement
11	There is a risk that NHS Fife will be unable to deliver and sustain Cancer Waiting Times Access Standards which will result in delays to patient appointments, investigations and treatment.	This has links to the development of the Clinical Strategy and other related strategies and delivery of services both now and in the future	B13/22 – Strategic Planning B14/22 – Operational Planning
12	As a result of amendments to the Resuscitation Guidance in response to Covid 19, requiring full AGP PPE to be worn during chest compressions/airway interventions as part of a cardiac arrest call, there is a risk that we will be unable to respond to a "resus" incident in a timely fashion which could lead to a poor clinical outcome for patients and stress and anxieties for staff.	Noted.	-
13	Number of staff shielding within ECD directly impacts on staffing of services and poses increased risk to staff members affected.	This risk will be considered within Workforce Planning, with a specific review included on maintaining safe staff levels.	B17/22 – Workforce Planning

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**13 May 2021**
Title:	**Audit follow up position at 28 April 2021**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Report Author:	**Barry Hudson, Regional Audit Manager**

1 Purpose

This is presented to the Audit & Risk Committee for:

- Assurance
- Discussion

This report relates to the:

- Audit Follow up Protocol

This aligns to the following NHSScotland quality ambition:

- Effective

2 Report summary

2.1 Situation

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

2.2 Background

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

A revised Audit Follow-Up Protocol is included as Appendix G at the end of this report to reflect the change in focus to address outstanding recommendations and improve Client response times.

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

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

2.3 Assessment

We are only including reports which have actions with a status of Extended, Outstanding or Not Yet Due. All reports that had completed actions or had been superseded by

subsequent reports have been removed from the tables and figures below. This is to promote focus on addressing the remaining recommendations.

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

	March 2021	**May 2021**
Remaining Recommendations	**59**	**53**
Extended with revised dates (agreed by Responding Officer)	29	40
Outstanding – Date passed	19	2
Not yet due	11	11

Progress has not been as expected, even when taking into account the impact of COVID-19. This issue was discussed at the March 2021 Audit & Risk Committee where it was agreed all outstanding recommendations would be reviewed and reprioritised. This one-off exercise, out with the scope of the Audit Follow-Up Protocol, was necessary to improve progression of actions and provide assurance that the risks and consequences of non-completion of recommendations has been appropriately considered and reported.

The outcome of this exercise has led to the following internal audit reports and related actions being removed from the AFU report, with rationale provided as below:

Assignment	**Rationale**	**Outcome**
B26/18 Brookson Locum Invoice Approval Process (3 recommendations (2b, 4 & 5) – status – Extended)	This review was completed in 2017/18. Recently a working group has been tasked with taking forward the Locum approval process and will consider the relevance of the recommendations within the new process.	Recommendations removed from AFU system.
B31& B32/19 IS Assurance & eHealth Strategic Planning (1 recommendation – (2) status - for validation)	A consolidated review of all prior year recommendations is underway under B28/21. Any further recommendations required will be included under B28/21.	Recommendations removed from AFU system.
B08/20 Internal Control Evaluation (1 recommendation (3) - status - Extended)	Recommendation related to a previous review of Clinical Governance Strategy and Assurance from 2018. Superseded by a recommendation in B08/21 ICE and work ongoing in B19/21 - Clinical Governance Strategy and Assurance.	Recommendations removed from AFU system.
B08/20 Internal Control Evaluation (5 recommendations (10, 11, 12, 14 & 15)	A consolidated review of all prior year recommendations for Information Governance and eHealth is underway under B28/21 which will consolidate any	Recommendations removed from AFU system.

- status - Extended)	outstanding recommendations.	
B15/20 Follow Up of Transformation Programme Governance (B10-18)	The findings and principles from B15/20 remain extant going forward. However, as agreed with the Director of Finance and Strategy, the most efficient approach will be for this to be reviewed as a key component of part of the Internal Audit review of Strategy proposed for 2021/22.	Recommendations removed from AFU system.
B31/20 eHealth Strategic Planning & Governance (6 recommendations (1, 2, 4, 5 & 6 - status – Outstanding and (3)- status – Not Yet Due)	A consolidated review of all prior year recommendations for Information Governance and eHealth is underway under B28/21 which will consolidate any outstanding recommendations.	Recommendations removed from AFU system.

Removing the above recommendations from the follow-up process allows focus on the remaining 53 recommendations which are either not yet due, have had their target implementation dates extended (*Appendix C*) or have lapsed target implementation dates with no communication of status having been provided by management (*Appendix D*).

The role of Internal Audit in the follow-up process is to maintain a record of responses received by management and to assess and validate responses. Appendix F records where we have concluded evidence provided was insufficient to allow us to validate that action as complete, and where further information has been requested.

Appendix D to this report highlights those actions where responding officers have reported delays in progressing actions due to prioritisation of COVID-19 duties.

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

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

Updated Audit Follow Up Protocol

The Audit Follow-Up Protocol has been amended to reflect a change in focus to address outstanding recommendations and improve Client response times. Specifically, the Protocol has been enhanced to now have an approval process for extensions with the first extension to be approved by Internal Audit, second extensions to be approved by the relevant Executive Director and any subsequent requests to be approved by the Director of Finance and Strategy or the Chief Executive.

2.3.1 Quality/ Patient Care

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

2.3.2 Workforce

There are no workforce implications arising from this report.

2.3.2 Financial

There are no direct financial implications arising from this report.

2.3.3 Risk Assessment/Management

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

2.3.4 Equality and Diversity, including health inequalities

Not applicable

2.3.5 Other impacts

Not applicable

2.3.6 Communication, involvement, engagement and consultation

The content of the report was discussed with the Chief Internal Auditor and the Director of Finance and Strategy ahead of submission to the Audit and Risk Committee.

2.3.7 Route to the Meeting

Not applicable

2.4 Recommendation

The Audit and Risk Committee is asked to:-

- **note** and consider the current status of Internal Audit recommendations recorded within the AFU system.
- **note** the exercise undertaken to rationalise outstanding recommendations**.**
- **approve** the revised Audit Follow-Up Protocol (appendix G)

3. List of appendices

The following appendices are included with this report:

Report Contact

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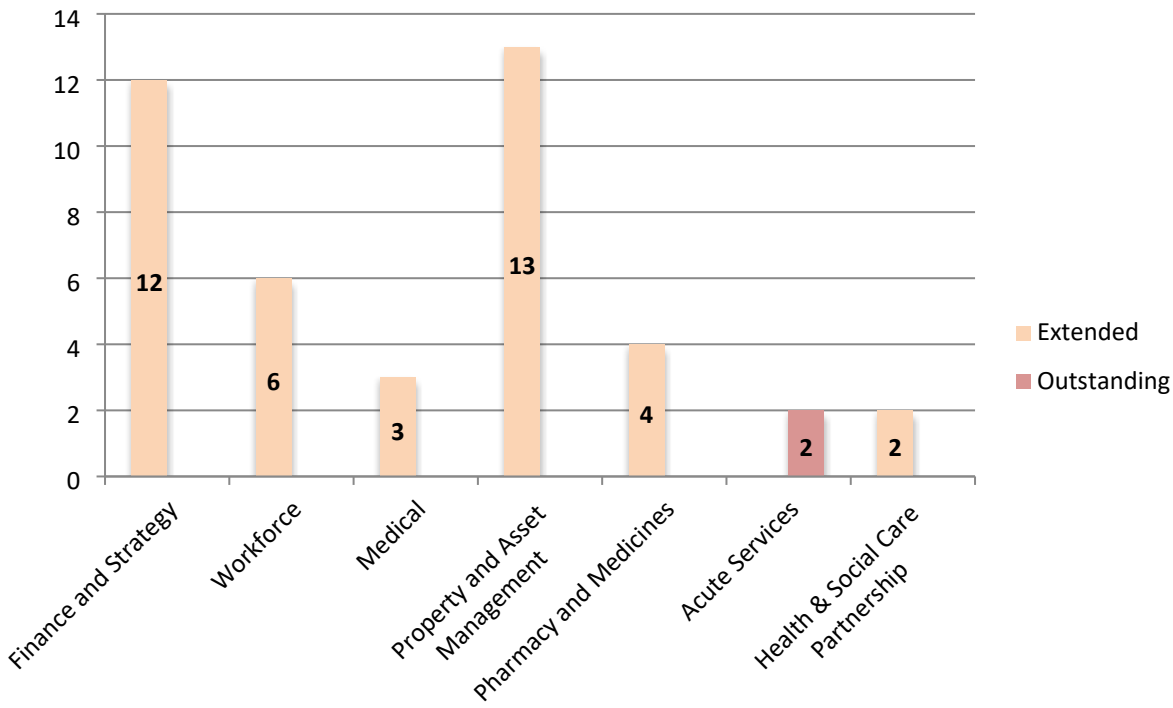
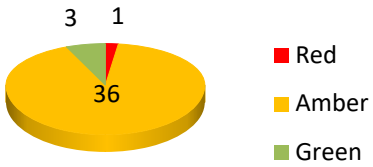
Outstanding and Extended by Directorate

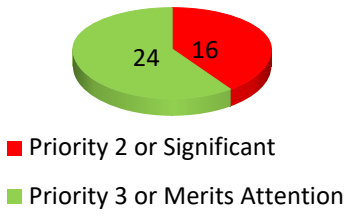


Extended Recommendations RAG Status and Priority

RAG Status



Priority



Outstanding Recommendations (No response) Priority

Priority

	Date of Issue	Total Recs.	Complete	Superseded	Remaining		Extended	Outstanding	Not Yet Due		Not Validated
Appendix							*C*	*D*			*E*
2017/18											
B28/18 Service Contract Income	Oct-17	2	2	0	0		0	0	0		1
2017/18 Totals		**2**	**2**	**0**	**0**		**0**	**0**	**0**		**1**
2018/19											
B11/19 Mandatory Training	Aug-19	3	0	0	3		3	0	0		-
B22/19 Losses & Comps	Apr-19	8	3	0	5		5	0	0		-
B23&24/19 Savings & Financial Planning	Sep-19	2	1	0	1		1	0	0		-
B25/19 Financial Management	Mar-20	2	0	0	2		2	0	0		-
2018/19 Totals		**15**	**4**	**0**	**11**		**11**	**0**	**0**		**0**
2019/20											
B08/20 Internal Control Evaluation	Jan-20	15	6	6	3		3	0	0		-
B13/20 Risk Management Staging	Jun-20	3	0	0	3		3	0	0		-
B14/20 Staff & Patient Environment	Dec-19	3	0	0	3		3	0	0		-
B17/20 Organisational Performance Management	Oct-20	6	1	0	5		0	0	5		-
B19/20 Adverse Events Management	Mar-20	4	2	0	2		2	0	0		1
B21/20 Medicines Management	Dec-19	23	19	0	4		4	0	0		3
B23A/20 Workforce Planning	Jan -20	4	2	0	2		2	0	0		-
B27/20 Financial Process Compliance	Jan-20	2	1	0	1		1	0	0		-
B32/20 Waiting Times Methodology	Mar-20	13	10	0	3		0	2	1		1
2019/20 Totals		**73**	**41**	**6**	**26**		**18**	**2**	**6**		**5**
2020/21											
B14/21 Sharps Management	Dec-21	14	0	0	14		11	0	3		-
B26/21 Property Transaction Monitoring	Sep-20	4	2	0	2		0	0	2		-
2020/21 Totals		**18**	**2**	**0**	**16**		**11**	**0**	**5**		**0**
Overall Totals (Actions from reports where recommendations remain unaddressed)		**108**	**49**	**6**	**53**		**40**	**2**	**11**		**6**

	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
2018/19							
B11/19 Mandatory Training	1	3	A central record of course updates and reviews should be maintained and provided to the SGC at least annually.	Head of Workforce Development **Director of Workforce**	31-Mar-20 30 Apr 21		The Director of Workforce will undertake a project to address this.
	2	3	A policy on mandatory training requirements to be followed by staff should be introduced.	Director of Workforce **Chief Executive**	31-Mar-20 30 Apr 21		The needs are different across the organisation so writing a policy on mandatory training requirements would be challenging e.g. not all core topics including in mandatory skills is applicable to all roles
	3	3	The SGC should receive assurance regarding NHS Fife addressing its mandatory training obligations.	Head of Workforce Development **Director of Workforce**	31-Mar-20 30 Apr 21		NHS Fife 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 & 6	3 & 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.	Head of Financial Services & Procurement **Director of Finance and Strategy**	31-Jul-19 30 Apr 21		The previous responsible officer has now left and a new responsible officer has been identified to take this action forward to completion.
	2b & 5	3 & 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 **Director of Finance and Strategy**	31-Jul-19 30 Apr 21		FOP Update on going
			• a section regarding the prevention of recurrence of losses.	Head of Financial Services & Procurement **Director of Finance and Strategy**	31-Jul-19 30 Apr 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	Director of Finance and Strategy **Chief Executive**	31-Mar-20 30 Apr 21		Work on this has commenced, however has been delayed due to the mobilisation of the local response to COVID 19.

	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
			savings opportunities to mitigate risks of adverse consequences up or down stream from where an efficiency project is being implemented.				
B25/19 Financial Management	1	S	Section 5 of the FOP Appendix A should be updated to include appropriate designations and authorisation levels and the reporting method for virements which are not fully delegated.	Deputy Director of Finance **Director of Finance and Strategy**	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 Accounts process the responses to the audit recommendations remain a work in progress.
	2	M A	Virement approval should be In line with Section 5 of the FOP 9.2 and 9.3, which requires 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 **Director of Finance and Strategy**	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**						
2019/20							
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.	Director of Health & Social Care **Chief Executive**	31-Apr-20 30 Apr 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. *[Internal Audit comment - In Progress, a draft revised integration scheme has been developed albeit financial risk share is unresolved]*
	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	Medical Director **Chief Executive**	31-Mar-20 30 Apr 21		Covid-19 Responsibilities. Indication that work will be ongoing. Extended date is for an update on these actions.

	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
			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 included as a disclosure in the Board's Governance Statement. 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 **Chief Executive**	30-Jun-20 30 Apr 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.
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 **Director of Finance and Strategy**	31-Jul-20 30-Jun21		Work on this has commenced. The new Head of Quality & Clinical Governance took up post in late February 2021. Undertaking this work will be a key priority for Q1 2021.
	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 **Director of Finance and Strategy**	31-Jul-20 30-Jun21		Work on this has commenced. The new Head of Quality & Clinical Governance took up post in late February 2021. Undertaking this work will be a key priority for Q1 2021.

	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
	3	S	The IJB risk management arrangements should be 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 Fife NHS Board. The governance arrangements regarding risk management with the Fife IJB, and the Fife Health Care Partnership should be recorded in the Risk Register and Risk Assessment policy GP/R7.	Risk Manager **Director of Finance and Strategy**	31-Jul-20 30-Jun21		Work on this has commenced. The new Head of Quality & Clinical Governance took up post in late February 2021. Undertaking this work will be a key priority for Q1 2021.
B14/20 Staff & Patient Environment	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 Safety Training so that these areas/departments/wards can be supported to improve attendance.	Learning & Development Officer **Director of Workforce**	31-Mar-20 31-May-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 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 **Director of Property and Asset Management**	On-going 31-May-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 **Director of Property and Asset Management**	31-Mar-20 31-May-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.

	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
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 **Medical Director**	30-Jun-20 30 Apr 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	Sufficient explanation is not being provided within DATIX on the steps taken to implement the actions for SAERs and LAERs. Staff should be reminded to fully note on DATIX what steps have been taken to implement actions; including what shared learning has actually taken place. Additionally, a review of the fields on DATIX for recording details of the steps taken to implement actions should be completed, so that staff can be more readily directed to note the final outcome.	Head of Quality & Clinical Governance **Medical Director**	30-Jun-20 30 Apr 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.
B21/20 Medicines Management	4 a-c	S	Training of Pharmacy, Transport and clinical staff to be reviewed.	Senior Pharmacy Technician **Director of Pharmacy & Medicines**	31-Mar-20 31-May-21		Responsible officer is currently a Covid Vaccinator
	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	Lead Pharmacy Technician **Director of Pharmacy &**	31-Mar-20 30 Apr 21		Work is ongoing.

	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
			explored.	**Medicines**			
B23a/20 Workforce Planning - Attendance Management	2	M A	A communication to be disseminated to all Managers to raise awareness of the importance of the timeliness of the return to work discussion.	Head of HR **Director of Workforce**	31-Dec-19 31-May-21		Covid-19 responsibilities – this will tie in with services moving out of an emergency footing and back to normal.
	4	M A	A review should be undertaken to identify any gaps or duplication with the Attendance Management groups and ensure that there is a clear framework of all the groups, their purpose (strategic or operational) and how they interrelate to ensure that themes, reporting and escalation are defined and reported.	Director of Workforce **Chief Executive**	31-Mar-20 31-May-21		Covid-19 responsibilities – this will tie in with services moving out of an emergency footing and back to normal
B27/20 Financial Process Compliance	2	M A	Financial Operating Procedures to be updated.	Head of Financial Services & Procurement **Director of Finance and Strategy**	31-Jul-20 30 Apr 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	**18**						
2020/21							
B14/21 Sharps Management	1a 1b 1c	M A	Corporate risk to be discussed and recorded regarding non-compliance with the Health & Safety (Sharp Instruments in Healthcare) Regulations 2013. Corporate risks to be recorded regarding all HSE reports/improvement notices that require rollout across the organisation.	H&S Manager **Director of Estates, Facilities and Capital Planning**	a 29-Jan-21 b 12 Feb 21 c 31 Dec 20 30-Jun-21		Work is ongoing

	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
	2a 2b 2c 2g	M A	Sharps Management and Use Policy and procedures to be updated to address issues raised in report and to update 'intranet' to 'stafflink' and to update email addresses to '...nhs.scot'. Pharmacy management to be contacted to ensure patients being discharged with injectable medicines are also prescribed with a sharps bin.	H&S Manager **Director of Estates, Facilities and Capital Planning**	a 31 Dec 20 b 22 Jan 21 c 12 Feb 21 g 29 Jan 21 30-Jun-21		Work is ongoing
	3a 3b 3c 3d	S	Action plan to address issues raised in report (section 3 - Control 2) and appendix 1 to be developed and implementation progress to be reported to the Sharps Strategy Group and the Health and Safety Sub-Committee. The Health and Safety Sub-Committee to be reminded of their responsibility to escalate issues to the Clinical Governance Committee when required.	H&S Manager **Director of Estates, Facilities and Capital Planning**	a. 3-Feb-21 b. 3-Feb-21 c. 10-Feb-21 d. 30-Dec-20 30-Jun-21		Work is ongoing
20/21 Sub Total	**11**						
Total	**40**						

Report	Issue Date	Rec Ref.	Audit Finding & Recommendation	Responsible Officer & Executive Director	Original Management Response	Priority	Original Due Date
2019/20							
B32/20 NHS Scotland Waiting Times Methodology	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 on the patient journey (in terms of extra time waiting) not being calculated and recorded.	Secretarial Services & Waiting Times Team Manager **Director of Acute Services**	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 collate the results so that this can be included in reporting.	Merits attention	30-Apr-20
		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.	Secretarial Services & Waiting Times Team Manager **Director of Acute Services**	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		**2**					
Total		**2**					

Audit Year/Report	Rec. Ref.	Finding & Recommendation	Priority	Responsible Officer, Executive Director & Action by Date	Follow-up Response	Internal Audit Opinion on Further Evidence Required to Allow Action to be Recorded as Complete [*This further evidence will be requested from the Responsible Officers through the Follow-up Process*]
2017/18						
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 place to review charges on an annual basis and it should be confirmed that this exercise is being completed.	3	Head of Management Accounting & Performance **Director of Finance and Strategy** 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.
2017/18 Sub Total	**1**					
2018/19						
-	-	-	-	-	-	-
2018/19 Sub Total	**0**					
2019/20						
B19/20 Adverse Event Management	1	**Finding** There is currently no regular reporting to relevant committees on the SAER and LAER actions implemented and those still outstanding. **Recommendation**	MA	Head of Quality and Clinical Governance **Medical Director** 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	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, Executive Director & Action by Date	Follow-up Response	Internal Audit Opinion on Further Evidence Required to Allow Action to be Recorded as Complete [*This further evidence will be requested from the Responsible Officers through the Follow-up Process*]
		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.			which included the status of all actions associated with SAER or LAER 2017- to date 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.	
B21/20 Medicines Management	3b	**Finding** White copies of the Medicines Uplift and Delivery Forms are not being returned to Pharmacy stores and no follow-up action is being taken to chase these up. **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	S	Pharmacy Technician **Director of Pharmacy & Medicines** 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, Executive Director & Action by Date	Follow-up Response	Internal Audit Opinion on Further Evidence Required to Allow Action to be Recorded as Complete [*This further evidence will be requested from the Responsible Officers through the Follow-up Process*]
		time.				
B21/20 Medicines Management	6a&b	**Finding** SECURITY/HEALTH AND SAFETY A number of issues were identified from Questionnaires: **Recommendation** 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 above. 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.	Merits Attention	Lead Pharmacy Technician **Director of Pharmacy & Medicines** 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.
B32/20 NHSScotland Waiting Times Methodology	7	**Finding** Appendix 1 of Patient Access Policy does not specifically refer to the NHS Scotland Waiting Times Monthly Audit Methodology. **Recommendation**	Merits Attention	Head of Information Management **Director of Acute Services** 30-Apr-2020	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

Audit Year/Report	Rec. Ref.	Finding & Recommendation	Priority	Responsible Officer, Executive Director & Action by Date	Follow-up Response	Internal Audit Opinion on Further Evidence Required to Allow Action to be Recorded as Complete [*This further evidence will be requested from the Responsible Officers through the Follow-up Process*]
		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.				
2019/20 Sub Total	**5**					
Total	**6**					

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

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.

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

NHS FIFE AUDIT FOLLOW-UP PROTOCOL

INTERNAL AND EXTERNAL AUDIT REPORT ACTION PLANS AND RECOMMENDATIONS

1. INTRODUCTION

As Accountable Officer, the Chief Executive is ultimately responsible for ensuring that the organisation has effective management systems in place to safeguard public funds.

The Audit and Assurance Committee Handbook (March 2018) includes the following good practice requirements for the audit follow up of recommendations:

- ***'holding managers within the organisation to account for the implementation of audit recommendations***
- ***to advise the Board and Accountable Officer on the adequacy of management response to audit recommendations***
- ***key lines of enquiry include obtaining assurance that:***
    - ***Internal Audit recommendations that have been agreed by management are timeously implemented***
    - ***any issues arising from line management not accepting Internal Audit recommendations are appropriately escalated for consideration***
    - ***the implementation of recommendations is monitored and followed up***
- ***outputs from follow-up audits by Internal Audit are monitored by the committee and the committee considers the adequacy of implementation of recommendations'.***

2. FOLLOW-UP ON INTERNAL AUDIT REPORTS

Status Notification Process

- Internal Audit send a Proactive Notification Form (see Appendix) to the Responsible Officer two weeks prior to the due date for the relevant actions requesting a response confirming, by no later than the due date, the completion or otherwise of the actions.
- If the action is reported by the Responsible Officer as completed, appropriate evidence to demonstrate that the required action has been taken and has been effective must be provided to support this.
- If the action is reported by the Responsible Officer as no longer relevant or superseded a valid reason supporting this status must be provided.
- Internal Audit will highlight 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. In such situations further evidence will be requested from the Responsible Officer.
- If the action is reported by the Responsible Officer as delayed, an extension to the original due date must be requested along with provision of a valid reason for the delay. The approval of extensions will be subject to consideration based on the context of the impact of risk as follows:
    - 1st Extension – Internal Audit

- 2nd Extension – Executive Director
- Subsequent extensions - Chief Executive/Director of Finance and Strategy

If approval is not granted it is expected that the action will be addressed promptly.

Reminder Process

- If no response is received from the Responsible Officer by the due date, Internal Audit will issue a reminder to the Responsible Officer.
- Where significant inaction or no response is provided by a Responsible Officer, Internal Audit will discuss this initially with the relevant Director/Senior Manager. Where the matter remains unresolved, it will be escalated to the Director of Finance and Strategy and, ultimately, the Chief Executive.

Validation

- All actions notified as completed are checked by Internal Audit to confirm that the evidence supplied is sufficient. Internal Audit will highlight 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. In these situations further evidence will be requested from the Responsible Officer.

Monitoring

A spreadsheet will be maintained by Internal Audit of agreed management actions 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.

Reporting

- Internal Audit will be responsible for presenting regular reports on Audit Follow-Up to each Audit and Risk Committee. The report will detail the most recent position on progress in addressing remaining actions from internal audit reports, detailed action status by report, reasons for extensions granted, outstanding recommendations and internal audit validation. For extended actions a RAG status is recorded giving an indication of how much still needs to be done to fully address the recommendation to aid prioritisation.
- Prior to each Audit and Risk Committee meeting, the report will be presented to the Executive Directors Group. This is for 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. The expectation being to have these actions addressed before the next Audit and Risk Committee meeting.

- The information from Responsible Officers recorded within the appendices to the report are verbatim updates as provided by officers of NHS Fife. Internal Audit will validate updates **only** at the stated completion of an action.

3. FOLLOW-UP OF EXTERNAL AUDIT REPORTS

3.1 The follow up of External Audit reports remains the responsibility of the Director of Finance and Strategy. Audit Scotland reports are far fewer in number and generally speaking will identify a Director as being responsible for the action to be taken. Internal Audit will only review progress against external audit recommendations where relevant to internal audit fieldwork

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.

3.3 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 and Strategy 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 and Strategy will present an annual update on progress to the Audit & Risk Committee in accordance with the Audit and Risk Committee's Work Plan.

BARRY HUDSON

Regional Audit Manager

DATE OF ISSUE: May 2021

REVIEW DATE: May 2022

NHS FIFE AUDIT FOLLOW UP

Internal Audit Action Plans - Proactive Notification to Internal Audit

The protocol for the follow up of actions within Internal Audit Reports requires the Responsible Officer to confirm to the Internal Audit Office Manager and Audit Follow-Up Coordinator, by no later than the due date, the completion or otherwise of all actions identified within the Audit Report.

The Responsible Officer for the actions should therefore submit this form, along with evidence required to confirm that all actions identified within the report have been completed. In the event that any action has not been implemented, please supply a progress report and a request for the due date to be extended.

Audit Report: **BXX/XX– Action by: XX, XX**				
Action Reference	**Recommendation**	**Due Date**	**Date of Completion**	**Action taken and Evidence thereof**
1				**Management Response**:
	Evidence Required/ Suggested Evidence for audit validation process: •			**Evidence of completion**:

NHS FIFE AUDIT FOLLOW UP
Internal Audit Action Plans - Proactive Notification to Internal Audit

In the event this action has not been completed, please supply a progress report and the request for extension below:

Progress Report:

Formal request for the due date to be extended

Action Reference	Reason for request	Length of extension required	Granted extension	Revised completion date

Signed: _____ (Job title)
Date: _____

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**13 May 2021**
Title:	**Patients' Private Funds – Audit Planning Memorandum**
Responsible Executive:	**Margo McGurk, Director of Finance**
Report Author:	**Kevin Booth, Head of Financial Services**

1 Purpose

This is presented to the Board for:

- Discussion
- Decision

This report relates to a:

- Legal requirement for the annual statutory audit

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

- Safe

2 Report summary

2.1 Situation

The Committee is asked to consider the Audit Planning Memorandum in respect of the external audit of the Patients' Private Funds Abstract of Receipts and Payments for 2020/21.

2.2 Background

International Standard on Auditing 260 requires auditors to communicate by effective means, matters concerning an entity's audit to those charged with the governance of that organisation. The purpose of the report is to provide the Committee (as those charged with the governance of Fife NHS Board Endowment Fund) with information regarding:

- the planned audit approach to be adopted by Thomson Cooper
- the proposed means and modes of communication throughout the audit assignment; and
- to provide the Trustees with the opportunity to discuss the assignment and the audit approach, agreeing any changes as necessary.

2.3 Assessment

As part of the audit planning process the auditors have provided their Audit Planning Memorandum for the statutory audit of Patients' Private Funds Abstract of receipts and Payments and this is attached at the Appendix.

Although this is part of the Exchequer Annual Accounts process, it relates to private funds held on trust and is therefore audited separately by Thomson Cooper at the same time as they carry out the Endowment Fund audit. The main issue for the auditors in carrying out this audit during the ongoing COVID-19 pandemic is the restrictions that are currently in place regarding access to wards in NHS Hospitals which may result in a limitation of scope*.

* A limitation of scope may result in the auditor not being in a position to give an opinion on the validity of the financial statements or the controls operating within an organisation or it may mean that they can only give an opinion on part. It is likely to mean that the Committee cannot be comprehensively assured in respect of the subject of the audit.

2.4 Recommendation

Trustee members of the Committee are asked to note the Audit Planning Memorandum attached at the Appendix and to agree any requirements they may have with regard to this audit.

2 List of appendices

The following appendices are included with this report:

- Fife NHS Board Patients' Private Funds Audit Planning Memorandum 2020/21.

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

30th April 2021

Fife Health Board Patients' Private Funds Audit Planning Memorandum

To the Board

Audit of Accounts

Year Ended 31 March 2021

Introduction

Purpose and Scope

International Standard on Auditing 260 requires auditors to communicate by effective means, matters concerning an entity's audit to those charged with the governance of that organisation.

The purpose of this report is to provide the Board (as those charged with the governance of Fife Health Board Patients Private Funds) with information regarding:

- the planned audit approach;
- the proposed means and modes of communication throughout the audit assignment; and
- to provide the Board with the opportunity to discuss the assignment and the audit approach prior to the commencement of audit field work.

Over recent years there have been a number of developments in the auditing and financial reporting framework. We have provided details of these developments in the Audit Planning Memorandum for the Fife Health Charity.

This report is addressed to the Board of Fife Health Board Patients' Private Funds and is intended for internal use only for the purpose of planning and discussing the audit of the financial statements for the year ended 31 March 2021. This report may not be reproduced in whole or in part without the prior, written consent of Thomson Cooper.

Background to Appointment

General

As part of our quality control procedures, we review and update our Letters of Engagement on a regular basis. As there has been a change of the Director of Finance, we have issued an updated Engagement Letter. An electronic copy of this Engagement Letter is shown at Appendix 1. As detailed in our Engagement Letter, it remains effective until it is replaced.

Independence

We can confirm that Thomson Cooper are independent within the context of relevant regulatory and professional requirements and that there are no circumstances of which the firm is aware which might lead to impairment in the objectivity of either the audit engagement partners or audit staff.

Staff Independence

All our Staff must adhere to strict regulatory, professional and internal independence requirements related to investments or business relationships with clients. All staff and partners must certify their compliance with independence rules on an annual basis. Thomson Cooper is authorised by ICAS to carry out statutory audits. Members of ICAS and other Accounting Bodies are bound by the Ethical Code which covers, objectivity, independence, confidentiality and integrity.

Money Laundering Regulations

All our staff are briefed in the current Money Laundering Regulations. As part of these regulations, and determining the risk to our audit, we consider the nature of your business, where you operate, your products and services and the appropriateness of your internal controls.

Quality

Independent quality reviews of our audit work are performed throughout the year. The reviews include testing of the effectiveness and quality of our audit work and we maintain a continuous improvement programme to ensure that our standards are maintained and improved. In addition, external reviews are also carried out periodically by the Institute of Chartered Accountants of Scotland (ICAS).

We are members of Accelerate, a community of relationship-focused, technology-driven, value-based accounting firms. Accelerate is a Business Associate of Crowe Global, meaning we can access accounting firms in more than 130 countries throughout the world. As part of that membership we receive visits every two years to review our audit approach and to discuss current auditing issues. Accelerate also provides technical courses and material on auditing throughout the year.

All Audit Staff undertake ongoing Continuous Professional Development via attendance at internal and external training courses and seminars.

Background to Appointment (continued)

Ethical Standards

Part 5 of the Ethical Standard issued by the Financial Reporting Council limits the range of services auditors can provide. At present, we assist in the preparation of the Statutory Accounts as required. There is no need to disclose this in the financial statements if the company has "informed management". Based on the knowledge and experience of the Trustees, we are satisfied that Fife Health Board Patients' Private Funds has "informed management" and therefore no disclosures will be required in the financial statements.

Thomson Cooper Audit Approach

General

Thomson Cooper adopts a risk-based approach to audit assignments.

The starting point for each assignment is to identify the key issues and risks facing the organisation including a review of internal control strengths and weaknesses. This involves close liaison with clients in order to obtain a good understanding of the client's business before detailed audit work commences.

Following this initial assessment, the audit work to be undertaken can be fully planned.

Effective planning facilitates:

- concentration of audit effort in areas of high risk;
- maximisation of overall efficiencies in audit work; and
- the drawing of suitable conclusions concerning the truth and fairness of the financial statements.

Detailed Audit Procedures

The extent of testing undertaken on the detailed records depends upon the continued adequacy of key internal accounting and operational controls, the materiality of the item involved, and the information and support provided by management.

Detailed audit testing will be performed to test the reliability of the accounting system in operation and to provide additional audit assurance.

Relationship with Internal Audit

Introduction

NHS Fife has an internal audit service which conducts periodic reviews of the Patients' Private Funds.

International Standard on Auditing 610 (ISA 610) entitled "Considering the Work of Internal Audit" establishes standards and provides guidance to external auditors in considering the work of internal audit. The standard requires external auditors to "consider the activities of internal auditing and their affect, if any, on external audit procedures".

The following sets out our audit approach for the current year and our relationship with NHS Fife internal audit function.

International Standard on Auditing 610

As stated above, the standard requires the auditor to consider the activities of internal audit. Section 5 of the standard indicates that internal audit normally has specific regard to the following:-

1. Monitoring of internal control.
2. Examination of financial and operating information.
3. Review of the efficiency and effectiveness of operations including non financial controls.
4. Review of compliance with laws and regulations.

The role of internal audit is set by management and clearly its objectives will differ from the external auditor whose appointment is to report independently on the annual financial statements. The standard recognises, however, that some of the means of achieving the respective objectives are similar and therefore certain aspect of internal audit work may be useful in determining the nature, timing and extent of external audit procedures. It follows therefore that we are obliged to obtain a sufficient understanding of the work carried out by internal audit to enable us to identify and assess the risks of material misstatements of the financial statements and accordingly to design and perform further audit procedures.

Based on our review of the work carried out by NHS Internal Audit Service in previous years, the principal area upon which we can place reliance on the work of internal audit function, has been in relation to the overall control environment within which the Patients' Private Funds operates.

The process of communication between external and internal auditors is two way and we will ensure that any instances of non compliance with the Financial Operating Procedures detected during our external audit work are brought to the attention of internal audit. The Board are asked to note and confirm their approval with the way in which we intend working with internal audit.

Staffing

Partner in Charge of Assignment

The current lead partner is Alan Mitchell. The audit of the financial statements for the year ended 31 March 2021 will be Alan's eighth year as lead partner following the rotation of the audit engagement partner from Andrew Croxford to Alan Mitchell.

Support Partners

Andrew Croxford will be called upon to undertake concurring reviews where required and will be available to discuss any issues which may arise throughout the audit.

Other Staff

In order to maximise efficiency and minimise disruption to the company, the firm, as far as possible will try to maintain continuity in the other staff deployed on the assignment.

Staff members involved in the audit have previous experience of the assignment and are suitably qualified and trained.

The senior staff member this year is Billy Leitch, a qualified Accountant. He will be assisted by Kara Coalter who is also a qualified Accountant.

Audit Risks

Introduction

Audit risk comprises three elements:

- Inherent risk
- Control risk
- Detection risk

Thomson Cooper aim to plan and perform sufficient audit work so as to ensure that detection risk is minimised, and that the conclusion drawn regarding the truth and fairness of Fife Health Board Patients Private Fund's accounts is valid.

This involves Thomson Cooper in a wide evaluation of risk areas (per ISA 300 - Planning, ISA 250A – Consideration of Laws and Regulations and ISA 330 - Auditor's Response to Assessed Risks) and also a detailed evaluation, at the level of account class, of the risk of material misstatement.

The areas detailed below have been limited to those, based on previous audit experience, which carry the highest risk of material misstatement either because the balances are so significant in the overall context of Fife Health Board Patients Private Fund's accounts or the account class is subject to a degree of estimation or relies upon the work of an expert.

The list is not exhaustive and has been prepared based upon our previous experience prior to the commencement of the detailed planning work for the audit for the year ended 31 March 2021.

The Board remain ultimately responsible for the integrity of the financial statements and risk management in the widest context. Thomson Cooper, as external auditor, are responsible for providing the Board of Fife Health Board Patients' Private Funds reasonable assurance that the accounts are free from material misstatement and that the accounts give a true and fair view of the state of the affairs of Fife Health Board Patients' Private Funds at 31 March 2021. While the audit work performed may involve consideration of such issues as the impact of failure of IT equipment for example, the work performed will be limited to considering the extent to which the breach might impact upon the financial statements. Hence risks of this nature have been excluded from those listed below.

Audit Risks (continued)

Security of Patients Funds

Due to the nature of the fund's assets i.e. cash, there is an increased susceptibility of the assets to loss through theft or misappropriation. A key focus of our audit will be the testing of the adequacy of the controls in place governing the security of patient funds on the wards.

Compliance with Agreed Operating Procedures

The Board has in place a series of control and authorisation procedures for patient funds which are documented in the Board's Financial Operating Procedure. This report details the various forms which should be used by staff in order to adequately record and control patient funds on the wards and is a key source of internal control. Our audit will include tests to assess the extent to which members of staff have adhered to the documented procedures, including visiting various hospital wards on a rotational basis (see Appendix 2).

We shall also consider any areas of potential non-compliance with procedures that were identified and communicated to the Board in the previous year's audit and follow up with regard to how each item has been subsequently dealt with. In addition, where considered relevant, we will seek to re-visit any wards attended in the previous year where issues were identified to perform updated tests to re-assess the extent to which staff have been advised of the issues and have acted upon the recommendations.

Management Override

In every organisation, senior management may be in a position to override the routine day-to-day financial controls. For all of our audits, we consider this risk and adapt our audit procedures accordingly.

Fraud

The auditor's responsibility to consider the audit risk of fraud is laid down in ISA 240 "The auditor's responsibility to consider fraud in an audit of financial statements".

In accordance with ISA 200, 'the auditor shall maintain professional scepticism throughout the audit, recognising the possibility that a material misstatement due to fraud could exist, notwithstanding the auditor's past experience of the honesty and integrity of the entity's management and those charged with governance'.

Audit Risks (continued)

Fraud (continued)

As part of the planning process, we are obliged to make enquiries of management and those charged with governance regarding:

a) Management's assessment of the risk that the financial statements may be materially misstated due to fraud, including the nature, extent and frequency of such assessments;
b) Management's process for identifying and responding to the risks of fraud in the entity, including any specific risks of fraud that management has identified or that have been brought to its attention, or classes of transactions, account balances, or disclosures for which a risk of fraud is likely to exist;
c) Management's communication, if any, to those charged with governance regarding its processes for identifying and responding to the risks of fraud in the entity;
d) Management's communication, if any, to employees regarding its views on business practices and ethical behaviour; and
e) Whether Management have knowledge of any actual, suspected or alleged fraud affecting the entity.

We can confirm that if we identify any fraud or obtain information that indicates that a fraud may exist, we will communicate this to the appropriate level of management as soon as practicable. If the fraud involves management, employees who have significant roles in internal control or where the fraud results in a material misstatement in the financial statements, we will communicate these matters to the Board as soon as practicable.

At the conclusion of our audit work, we will request written confirmation in our letter of representation that the Board acknowledge their responsibility for the design and implementation of internal control to prevent and detect fraud and that it has disclosed to ourselves the results of its risk assessment and disclosed any instances or allegations of fraud which have arisen.

Materiality

Concept and definition

The concept of materiality is fundamental to the preparation of the financial statements and the audit process and applies not only to monetary misstatements but also to disclosure requirements and adherence to appropriate accounting principles and statutory requirements.

- According to International Standard on Auditing 320 Audit Materiality, 'misstatements, including omissions, are considered to be material if they, individually or in aggregate, could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements; and judgements about materiality are made in light of surrounding circumstances, and are affected by the size or nature of a misstatement, or a combination of both'.

  The Clarified ISA 320 on Audit Materiality establishes the concept of 'performance materiality'. Performance materiality means the amounts set by the auditor at less than materiality for the financial statements as a whole to reduce to an appropriately low level the probability that the aggregate of uncorrected and undetected misstatements exceeds materiality for the financial statements as a whole.

An item may also be considered material for reasons other than size, if for example, it had an impact on:

- trends;
- compliance with loan covenants; or
- instances when greater precision is required.

Calculation and determination

We have determined materiality based on professional judgement in the context of our knowledge of Fife Health Board Patients' Private Funds, including consideration of factors such as member expectations, industry developments, financial stability and reporting requirements for the financial statements.

We determine materiality in order to:

- estimate the tolerable level of misstatement in the financial statements;
- assist in establishing the scope of our audit engagement and audit tests;
- calculate sample sizes; and
- assist in evaluating the effect of known and likely misstatements on the financial statements.

We will finalise our materiality figure prior to the commencement of our audit.

Materiality (continued)

If, in the specific circumstances of Fife Health Board Patients' Private Funds, we believe there are particular transactions, account balances or disclosures where misstatement of less than materiality for the financial statements as a whole could be expected to influence the decisions of the users, we shall also determine the performance materiality level to be applied to those particular transactions.

Reassessment of materiality

We will reconsider materiality if, during the course of our audit engagement, we become aware of facts and circumstances that would have caused us to make a different determination of planning materiality if we had been aware of those facts and circumstances when we made our initial determination.

Further, when we have performed all our substantive tests and are ready to evaluate the results of those tests, including any misstatements we detected, we will reconsider whether materiality, in combination with the nature, timing and extent of our auditing procedures, provided a sufficient audit scope. If we conclude that our audit scope was sufficient, we will use materiality to evaluate whether uncorrected misstatements, individually or in aggregate, are material.

Unadjusted errors

In accordance with auditing standards, we will communicate to the Board all unadjusted items identified during our audit, other than those which we believe are "clearly trivial".

Clearly trivial is defined as matters which will be of a wholly different (smaller) order of magnitude than the materiality thresholds used in the audit, and will be matters that are clearly inconsequential, whether taken individually or in aggregate.

Auditing standards do not place numeric limits on the meaning of 'clearly trivial', however, we consider the 'clearly trivial' limit to be less than 1% of materiality.

We will obtain written representations from the Board confirming that after considering all these unadjusted items, both individually and in aggregate, no adjustments are required.

There are a number of areas where we would strongly recommend or request any misstatements identified during the audit process being adjusted. These include:

- misstatements that we believe were intentionally made to achieve targeted earnings or similar goals;
- clear cut-off errors whose correction would cause non-compliance with loan covenants, management compensation agreements, other contractual obligations or governmental regulations that we consider are significant; and
- other misstatements that we believe are material or clearly wrong.

Reporting of Audit Findings

Communication

As external auditor, we have direct access to the Board should the need arise. Audit findings will be communicated orally at the meeting of the Board at which the annual accounts are reviewed.

In addition, on completion of the audit field work an Audit Completion Memorandum will be prepared summarising the main audit findings which will be addressed to the Board for their responses.

Audit Adjustments

Any misstatements identified as a result of the audit work performed, which have not already been adjusted, will be reported to the Board. If, after discussion, there remain any material unadjusted misstatements written representation from the Board may be sought setting out the reasons for non-adjustment.

Misstatements which have been found, but adjusted, will only be brought to the attention of the Board where it is believed that an awareness is required for the Board to be able to fulfil their governance responsibilities or where adjustments indicate significant weaknesses in the system of internal controls.

Potential Limitation of Scope

As discussed at the planning meeting, due to the ongoing COVID-19 pandemic, there is currently limited access to the hospitals and wards. If Thomson Cooper is unable to attend the sites and perform on-site work there may be a potential limitation in the scope of our audit work which, if arises, will impact on our final audit report.

If limitations in the scope of our audit arise we will seek to bring these to the attentions of management and the Board at the earliest convenience.

Timetable

	Date
Issue Bank Confirmation Letter	3 March 2021
Audit Planning Meeting with Client	16 March 2021
Issue Audit Planning Memorandum	24 March 2021
Audit Staff Planning Meeting	30 April 2021
Audit Fieldwork Commences	4 May 2021
Audit Clearance Meeting	24 May 2021
Provide Completion Documents	1 June 2021
Board Papers Issued	1 June 2021
Audit Committee Meeting	8 June 2021
Board Meeting	29 June 2021

Proposed Fees

	Proposed 2021	Actual 2020
	£	£
On completion of audit fieldwork	1,650	1,600
On signing of accounts	900	900
	2,550	2,500

Should we anticipate that our costs will exceed our budget due to additional work that we may require to undertake, we shall notify you immediately in order that we may agree what action, if any, is required by you and to agree the basis for any additional charges.

The above fees are exclusive of VAT and expenses.

Appendix 1 – Engagement Letter

An electronic copy of our newly issued Engagement Letter is as follows:

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-

24 March 2021

The Trustees
Fife Health Board Patients' Private Fund
Evans Business Centre
Mitchelston Industrial Estate
Mitchelston Drive
Kirkcaldy
Fife
KY1 3NB

Dear Trustees

We are pleased to continue the instruction to act as your advisers and are writing to confirm the terms of our appointment.

The purpose of this letter together with the attached terms and conditions is to set out our terms for carrying out the work and to clarify our respective responsibilities.

We are bound by the ethical guidelines of the Institute of Chartered Accountants Scotland and accept instructions to act for you on the basis that we will act in accordance with those guidelines.

1. Engagement letter

1.1 Thank you for engaging us as your advisers. Alan Mitchell will be your main point of contact and will have primary responsibility for this assignment. This letter and the attached schedule(s) of services together with this firm's standard terms and conditions set out the basis on which we will act.

2. Who we are acting for

2.1 For the avoidance of doubt Margo McGurk is acting as nominated first point of contact. Any change to the nominated person should be notified to us in writing and will not be effective until acknowledged by us in writing.

3. Period of engagement

3.1 This engagement will start from the date this letter is signed. It replaces all previous engagements that we have had with you.

4. Our responsibility to you

4.1 We have set out the agreed scope and objectives of your instructions within this letter of engagement. Any subsequent changes will be discussed with you and where appropriate a new letter of engagement will be agreed. We shall proceed on the basis of the instructions we have received from you and will rely on you to tell us as soon as possible if anything occurs which renders any information previously given to us as incorrect or inaccurate. We shall not be responsible for any failure to advise or comment on any matter which falls outside the specific scope of your instructions. We cannot accept any responsibility for any event, loss or situation unless it is one against which it is the expressed purpose of these instructions to provide protection.

5. Your responsibility to us

5.1 The advice that we give can only be as good as the information upon which it is based. Insofar as that information is provided by you, or by third parties with your permission, your responsibility arises as soon as possible if any circumstances or facts alter as any alteration may have a significant impact on the advice given. If the circumstances change therefore or your needs alter, advise us of the alteration as soon as possible in writing.

6. Services

6.1 Attached is the schedule of services listed below which records the work we are instructed to carry out. This also states your and our responsibilities in relation to the work to be carried out.

Schedules

Unincorporated Charity Audit (April 2015 version 2)

6.2 You may request that we provide other services from time to time. We will issue a separate schedule of service or, if necessary, a new letter of engagement and scope of work to be performed accordingly.

6.3 Because rules and regulations frequently change you must ask us to confirm any advice already given if a transaction is delayed or a similar transaction is to be undertaken.

7. Fees

7.1 Our fees will be charged in accordance with our standard terms and conditions. Please review these to ensure you understand the basis of our charges and our payment terms.

8. Limitation of liability

8.1 You have agreed that our liability as auditors to the company will be limited in accordance with sections 532 to 538 of the Companies Act 2006. The terms of this agreement are in our standard terms and conditions which are attached to this engagement letter.

8.2 We specifically draw your attention to paragraph 23 of our standard terms and conditions which sets out the basis on which we limit our liability to you and to others. You should read this in conjunction with paragraph 11 of our standard terms and conditions which excludes liability to third parties.

8.3 There are no Third Parties that we have agreed should be entitled to rely on the work done pursuant to this engagement letter.

9. Your agreement

9.1 Once it has been agreed, this letter will remain effective until it is replaced.

9.2 We shall be grateful if you could confirm your agreement to the terms of this letter, the schedule of services and the standard terms and conditions by signing the enclosed copy and returning it to us immediately.

9.3 If this letter and schedule of services is not in accordance with your understanding of the scope of our engagement or your circumstances have changed, please let us know.

Yours sincerely

Thomson Cooper

Acceptance

We confirm that we have read and understood the contents of this letter, schedules and related terms and conditions and agree that it accurately reflects our fair understanding of the services that we require you to undertake.

Signed ..... Date .....

For and on behalf of
Fife Health Board Patients' Private Fund

SCHEDULE OF SERVICES

This schedule should be read in conjunction with the engagement letter and the standard terms and conditions.

UNINCORPORATED CHARITY AUDIT

1. Your responsibilities as trustees of the charity

1.1 In agreeing to these engagement terms, you acknowledge your responsibilities and confirm that you understand them.

1.2 As trustees of the charity you are responsible for:

a) ensuring that adequate accounting records are maintained which disclose the charity's financial position with reasonable accuracy at any time;

b) preparing financial statements for each financial year that:

i) give a true and fair view of the charity's state of affairs at the end of the financial year and of its incoming resources and application of resources for that year; and

ii) are in accordance with the Charities and Trustee Investment (Scotland) Act 2005 and regulations thereunder;

c) preparing an annual report on the activities of the charity during the year that complies with the requirements of the relevant regulations.

1.3 In preparing the financial statements (or arranging for them to be prepared) you are required to:

a) select suitable accounting policies and then apply them consistently;

b) make judgements and estimates that are reasonable and prudent;

c) prepare the financial statements on the going concern basis unless it is inappropriate to assume that the charity will continue in business; and

d) have regard to applicable accounting standards and the relevant statement of recommended practice.

1.4 You are responsible for such internal controls as you consider necessary to enable the preparation of the financial statements that are free from material misstatement, whether due to fraud or error.

1.5 Under the Charities Accounts (Scotland) Regulations 2006 (as amended) and the Charities SORP you are required to report as to whether you have given consideration to the major risks to which the charity is exposed, and to the systems designed to manage those risks. We are not required to audit this statement, or to form an opinion on the effectiveness of the risk management and control procedures.

1.6 You are responsible for safeguarding the assets of the charity and to ensure their proper application, and hence for taking reasonable steps to prevent and detect fraud and other irregularities.

1.7 You are responsible for ensuring that the charity complies with laws and regulations that apply to its activities, and for preventing non-compliance and detecting any that occurs.

1.8 You undertake to make available to us, as and when required, all the charity's accounting records and related financial information, including minutes of management and members' meetings that we need to do our work. You will disclose to us all relevant information in full. In particular, you agree to provide:

a) access to all information of which management is aware that is relevant to the preparation of the financial statements such as records, documentation and other matters;

b) additional information that we may request from management for the purpose of the audit; and

c) unrestricted access to persons within the entity from whom we determine it necessary to obtain audit evidence.

1.9 If audited financial information is published, which includes a report by us or is otherwise connected to us, on the charity's website or by other electronic means, you must inform us of the electronic publication and obtain our consent before it occurs and ensure that it presents the financial information and auditor's report properly. We have the right to withhold consent to the electronic publication of our report or the financial statements if they are to be published in an inappropriate manner.

1.10 You must set up controls to prevent or detect quickly any changes to electronically published information. We are not responsible for reviewing these controls nor for keeping the information under review after it is first published. You are responsible for the maintenance and integrity of electronically published information and we accept no responsibility for changes made to audited information after it is first posted.

1.11 You are responsible for establishing and controlling any process for electronically distributing Annual Reports and other financial information to members and/or supporters of the charity and to the Office of the Scottish Charity Regulator (OSCR).

1.12 You are responsible for filing the charity's financial statements and an annual report for the financial year complying in its form and content, as well as other relevant documentation, with OSCR in accordance with their requirements, unless otherwise agreed.

1.13 The audited financial statements and annual report are required to be delivered to OSCR within nine months of the end of the charity's financial year end and it is the trustees' responsibility to ensure that this deadline is met.

2. Our responsibilities as auditor

2.1 We have a statutory responsibility to report to you whether, in our opinion, the financial statements give a true and fair view of the state of affairs of the charity at the end of the financial year and of its incoming resources and application of resources in that year and whether they have been properly prepared in accordance with the Charities and Trustee Investment (Scotland) Act 2005 and regulations thereunder. In deciding this, we must consider the following matters, and report on any that we are not satisfied with:

a) whether the charity has kept proper accounting records;

b) whether the charity's balance sheet and statement of financial activities are in agreement with the accounting records and returns;

c) whether we have obtained all the information and explanations which we consider necessary for the purposes of our audit; and

d) whether the information given in the annual report of the charity trustees is not consistent with that contained in the audited financial statements.

2.2 We may also need to deal with certain other matters, according to the circumstances, in our report such as any material concerns we may have relating to the financial effects of any non-compliance with relevant laws and regulations.

2.3 We have a professional responsibility to report if the financial statements do not significantly comply with applicable financial reporting standards or the relevant statement of recommended practice unless, in our opinion, the departure is justified in the circumstances. In deciding whether or not this is the case we consider:

a) whether the non-compliance is necessary for the financial statements to give a true and fair view; and

b) whether the non-compliance has been clearly disclosed.

2.4 Our professional responsibilities also include:

a) describing in our audit report the trustees' responsibilities for the financial statements if the financial statements or accompanying information do not include this information; and

b) considering whether other information in documents containing the audited financial statements is consistent with those financial statements.

2.5 In respect of the expected form and content of our report, we refer you to the most recent bulletin on auditor's reports published by the Auditing Practices Board at http://www.frc.org.uk/apb. The form and content of our report may need to be amended in the light of our findings.

2.6 We have a statutory duty to report to OSCR such matters (concerning the activities or affairs of the charity or any connected institution or body corporate) of which we become aware during the course of our audit which are (or are likely to be) of material significance to OSCR in the exercise of the powers of inquiry into, or acting for the protection of, charities. It is envisaged that the need to make such a report will arise only very rarely, in accordance with the guidance set out in International Standards on Auditing (UK & Ireland) 250 Section B "The Auditor's Right and Duty to Report to Regulators in the Financial Sector".

2.7 We will report solely to the charity's trustees, as a body. Our audit work will be undertaken so that we might state to the trustees those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the trustees, as a body, for our audit work, for this report, or for the opinion we have formed.

2.8 You should be aware that the charity's annual financial statements are for the specific purpose of reporting to the trustees [as well as to the members] at a particular point in time. They may therefore not be suitable for other purposes such as such as making decisions regarding borrowing or investing by you as trustees or by any other party.

3. Scope of audit

3.1 We will carry out our audit in accordance with the International Standards on Auditing (UK and Ireland) issued by the Auditing Practices Board. The audit will include such tests of transactions and of the existence, ownership and valuation of assets and liabilities as we consider necessary.

3.2 We shall obtain an understanding of the accounting and internal control systems to ensure they are adequate as a basis for the preparation of the financial statements and to establish whether the charity has kept proper accounting records. We will gather enough evidence to enable us to reach a reasonable conclusion.

3.3 You are responsible for safeguarding the charity's assets and for preventing and detecting fraud, error and non-compliance with law or regulations. We will plan our audit so that we can reasonably expect to detect significant misstatements in the financial statements or accounting records (including those resulting from fraud, error or non-compliance with law or regulations), but you cannot rely on us finding all such errors.

3.4 We shall not be treated as having notice, for the purposes of our audit responsibilities, of information provided to members of our firm other than those engaged on the audit.

3.5 Once we have issued our audit report we have no further responsibility in relation to the financial statements for that financial year.

3.6 We would appreciate receiving notice of and invitations to attend the meeting of the trustees at which the annual report and financial statements are to be approved.

3.7 To ensure that there is effective two-way communication between us and to comply with the requirements of Auditing Standards we will:

a) contact you prior to the audit to discuss any relevant matters and to agree any required action; and

b) contact you to discuss any matters arising from the audit and to confirm any agreed action.

4. Reporting to the Trustees and Management

4.1 The nature and extent of our procedures will vary according to our assessment of the charity's accounting system and, where we wish to place reliance on it, the internal control system, and may cover any aspect of the charity's operations that we consider appropriate. Our audit is not designed to identify all significant weaknesses in the charity's systems but, if such weaknesses come to our notice during the course of our audit which we think should be brought to your attention, we shall report them to you. Any such report may not be provided to third parties without our prior written consent. Such consent will be granted only on the basis that such reports are not prepared with the interests of anyone other than the charity in mind and that we accept no duty or responsibility to any other party as concerns the reports.

5. Representations by management/trustees

5.1 As part of our normal audit procedures, we may request written confirmation of oral representations which we have received during the course of the audit on matters having a material effect on the financial statements.

6. Documents issued with the financial statements

6.1 In order to assist us with the examination of your financial statements, we shall request sight of all documents or statements, including the trustees' report, which are due to be issued with the financial statements. If it is proposed that any documents or statement which refer to our name, other than the audited financial statements, are to be circulated to third parties, please consult us before they are issued.

7. Irregularities, including fraud

7.1 The responsibility for the prevention and detection of fraud, error and non-compliance with law or regulations rests with yourselves. However, we shall endeavour to plan our audit so that we have a reasonable expectation of detecting material misstatements in the financial statements or accounting records (including those resulting from fraud, error or non-compliance with law or regulations), but our examination should not be relied upon to disclose all such material misstatements or frauds, errors or instances of non-compliance as may exist.

8. Provision of Service Regulations

8.1 Details of our audit registration can be viewed at www.auditregister.org.uk under reference number 0538.

24 March 2021

Thomson Cooper

Appendix 2 – Hospitals Visited

Hospital	Gross Receipts	2015	2016	2017	2018	2019	2020	Proposed 2021
Adamson	4							
Levenmouth	4,571	✓				✓	✓	
Lynebank	132,136		✓		✓	✓		✓
Queen Margaret *	12,866		✓					✓
St Andrews	8							
Stratheden	132,075	✓		✓	✓		✓	
Whyteman's Brae	13,523			✓				

* Excludes "QM Acute" of £17,047

Gross Receipts are based on the figures from the accounts for the year ended 31 March 2020.

Note : Queen Margaret will also be visited to review and test the art catalogue

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**13 May 2021**
Title:	**External Audit Planning Memorandum**
Responsible Executive:	**Margo McGurk, Director of Finance**
Report Author:	**Julie Farr, Charity Manager**

1 Purpose

This is presented to the Committee for:

- Awareness

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

- Effective

2 Report summary

2.1 Situation

The annual External Audit of the Charity will take place after the financial year end. It will be carried out by Thomson Cooper again who have submitted the Planning Memorandum for the Trustees' awareness.

2.2 Background

As required under the Charities Accounts (Scotland) Regulations 2006 all charities with an income over £500,000 are required to have an external audit conducted.

2.3 Assessment

The Planning Memorandum for the audit is contained in Appendix 1. The auditors have asked for it to be highlighted that due to the ongoing COVID-19 pandemic and there currently being limited access to the hospitals and wards there is potential limitation of scope of the process. If Thomson Cooper are unable to attend the sites and perform on-site work it may impact on the final audit report. If limitations in the scope of the audit arise they will seek to bring these to the attentions of management and the Trustees at the earliest opportunity.

2.3.1 Patient Care/Quality

N/A

2.3.2 Workforce

Some staff may be involved in the scrutiny process.

2.3.3 Financial

The external audit provides assurance that charitable funds are being recorded and accounted for in line with agreed accounting standards and charity legislation. The cost of the Audit to the Charity will be £8,300.

2.3.4 Risk Assessment/Management

The external audit plan will make an assessment of any audit risks and use that to inform their approach and testing plans.

2.3.5 Equality and Diversity, including health inequalities

N/A.

2.3.6 Other impact

N/A.

2.3.7 Communication, involvement, engagement and consultation

N/A.

2.3.8 Route to the Meeting

This paper has been considered by the Fife Health Charity Sub Committee.

2.4 Recommendation

The Committee are asked to **note** the External audit Planning Memorandum.

3 List of appendices

The following appendices are included with this report:

- Appendix 1 – External Audit Planning Memorandum

Report Contact
Margo McGurk
Director of Finance and Strategy
Margo.McGurk@nhs.scot

Fife Health Charity
Audit Planning Memorandum

To the Trustees

Audit of Accounts

Year Ended 31 March 2021

Introduction

Purpose and Scope

International Standard on Auditing 260 requires auditors to communicate by effective means, matters concerning an entity's audit to those charged with the governance of that organisation.

The purpose of this report is to provide the Trustees (as those charged with the governance of Fife Health Charity) with information regarding:

- the planned audit approach;
- the proposed means and modes of communication throughout the audit assignment; and
- to provide the Trustees with the opportunity to discuss the assignment and the audit approach prior to the commencement of audit field work.

Over recent years there have been a number of developments in the auditing and financial reporting framework. These are set out in Appendix 1. If you wish to discuss further the impact of these developments, we would be pleased to do so.

We are aware that during the financial year the charity has changed its name from Fife Health Board Endowment Fund to Fife Health Charity. For the purposes of the audit planning memorandum, we will refer to Fife Health Charity.

This report is addressed to the Trustees of Fife Health Charity and is intended for internal use only for the purpose of planning and discussing the audit of the financial statements for the year ended 31 March 2021. This report may not be reproduced in whole or in part without the prior, written consent of Thomson Cooper.

Background to Appointment

General

As part of our quality control procedures, we review and update our Letters of Engagement on a regular basis. As there has been a change of name and Director of Finance, we have issued an updated Engagement Letter. An electronic copy of this Engagement Letter is shown at Appendix 2. As detailed in our Engagement Letter, it remains effective until it is replaced.

Independence

We can confirm that Thomson Cooper are independent within the context of relevant regulatory and professional requirements and that there are no circumstances of which the firm is aware which might lead to impairment in the objectivity of either the audit engagement partners or audit staff.

Staff Independence

All our Staff must adhere to strict regulatory, professional and internal independence requirements related to investments or business relationships with clients. All staff and partners must certify their compliance with independence rules on an annual basis.

Thomson Cooper is authorised by ICAS to carry out statutory audits. Members of ICAS and other Accounting Bodies are bound by the Ethical Code which covers, objectivity, independence, confidentiality and integrity.

Money Laundering Regulations

All our staff are briefed in the current Money Laundering Regulations. As part of these regulations, and determining the risk to our audit, we consider the nature of your business, where you operate, your products and services and the appropriateness of your internal controls.

Quality

Independent quality reviews of our audit work are performed throughout the year. The reviews include testing of the effectiveness and quality of our audit work and we maintain a continuous improvement programme to ensure that our standards are maintained and improved. In addition, external reviews are also carried out periodically by the Institute of Chartered Accountants of Scotland (ICAS).

We are members of Accelerate, a community of relationship-focused, technology-driven, value-based accounting firms. Accelerate is a Business Associate of Crowe Global, meaning we can access accounting firms in more than 130 countries throughout the world. As part of that membership we receive visits every two years to review our audit approach and to discuss current auditing issues. Accelerate also provides technical courses and material on auditing throughout the year.

All Audit Staff undertake ongoing Continuous Professional Development via attendance at internal and external training courses and seminars.

Background to Appointment (continued)

Ethical Standards

Part 5 of the Ethical Standard issued by the Financial Reporting Council limits the range of services auditors can provide.

There is no need to disclose this in the financial statements if the company has "informed management". Based on the knowledge and experience of the Trustees, we are satisfied that Fife Health Charity has "informed management" and therefore no disclosures will be required in the financial statements.

Reliance upon the work of an expert

In accordance with International Standard on Auditing 620, when relying upon the work performed by an expert the auditor should obtain sufficient appropriate audit evidence that the scope of such work is adequate for the purposes of the audit. "Expert" means a person or firm possessing special skills, knowledge and experience in a particular field other than accounting and auditing.

Fife Health Charity maintains an investment portfolio as the asset base for the future growth of the Charity. The investments held include a portfolio of stocks and securities, which are managed by third party fund managers. This involves some reliance upon the work of experts during the audit process. The investments are stated in the financial statements at market value and our audit will include reviewing the effects of fluctuations in market values from the date of the balance sheet until the signing of the financial statements to ensure material differences in the market value of investments are appropriately disclosed in the financial statements.

Whistleblowing

We are required to report certain matters to The Office of the Scottish Charity Regulator (OSCR) as part of our statutory reporting duties. Relevant matters should be reported to OSCR as soon as they become apparent. Within section 46 of the Charities and Trustees Investment (Scotland) Act 2005 auditors responsibility fall into two categories:

- Matters that must be reported on the basis that the auditor has reasonable cause to believe that the matter is likely to be of material significance for the purpose of OSCR exercising its statutory reporting duty.
- Matters that the auditor may report as they have reasonable cause to believe they are relevant to OSCR in exercising its statutory duties but are not captured by the mandatory reporting duty.

Thomson Cooper Audit Approach

General

Thomson Cooper adopts a risk-based approach to audit assignments.

The starting point for each assignment is to identify the key issues and risks facing the organisation including a review of internal control strengths and weaknesses. This involves close liaison with clients in order to obtain a good understanding of the client's business before detailed audit work commences.

Following this initial assessment, the audit work to be undertaken can be fully planned.

Effective planning facilitates:

- concentration of audit effort in areas of high risk;
- maximisation of overall efficiencies in audit work; and
- the drawing of suitable conclusions concerning the truth and fairness of the financial statements.

Detailed Audit Procedures

The extent of testing undertaken on the detailed records depends upon the continued adequacy of key internal accounting and operational controls, the materiality of the item involved, and the information and support provided by management.

Detailed audit testing will be performed to test the reliability of the accounting system in operation and to provide additional audit assurance.

Relationship with Internal Audit

Introduction

NHS Fife has an internal audit service which conducts periodic reviews of Fife Health Charity.

International Standard on Auditing 610 (ISA 610) entitled "Considering the Work of Internal Audit" establishes standards and provides guidance to external auditors in considering the work of internal audit. The standard requires external auditors to "consider the activities of internal auditing and their affect, if any, on external audit procedures".

The following sets out our audit approach for the current year and our relationship with NHS Fife internal audit function.

International Standard on Auditing 610

As stated above, the standard requires the auditor to consider the activities of internal audit. Section 5 of the standard indicates that internal audit normally has specific regard to the following:-

1. Monitoring of internal control.
2. Examination of financial and operating information.
3. Review of the efficiency and effectiveness of operations including non financial controls.
4. Review of compliance with laws and regulations.

The role of internal audit is set by management and clearly its objectives will differ from the external auditor whose appointment is to report independently on the annual financial statements. The standard recognises, however, that some of the means of achieving the respective objectives are similar and therefore certain aspect of internal audit work may be useful in determining the nature, timing and extent of external audit procedures. It follows therefore that we are obliged to obtain a sufficient understanding of the work carried out by internal audit to enable us to identify and assess the risks of material misstatements of the financial statements and accordingly to design and perform further audit procedures.

Based on our review of the work carried out by NHS Internal Audit Service in previous years, the principal area upon which we can place reliance on the work of internal audit function, has been in relation to the overall control environment within which Fife Health Charity operates.

The process of communication between external and internal auditors is two way and we will ensure that any instances of non compliance with the Financial Operating Procedures detected during our external audit work are brought to the attention of internal audit. The Trustees are asked to note and confirm their approval with the way in which we intend working with internal audit.

Staffing

Partner in Charge of Assignment

The current lead partner is Alan Mitchell. The audit of the financial statements for the year ended 31 March 2021 will be Alan's eighth year as lead partner following the rotation of the audit engagement partner from Andrew Croxford to Alan Mitchell.

Support Partners

Andrew Croxford will be called upon to undertake concurring reviews where required and will be available to discuss any issues which may arise throughout the audit.

Other Staff

In order to maximise efficiency and minimise disruption to the company, the firm, as far as possible will try to maintain continuity in the other staff deployed on the assignment.

Staff members involved in the audit have previous experience of the assignment, and are suitably qualified and trained.

The senior staff member this year is Billy Leitch, a qualified Accountant. He will be assisted by Kara Coalter who is also a qualified Accountant.

Audit Risks

Introduction

Audit risk comprises three elements:

- Inherent risk
- Control risk
- Detection risk

Thomson Cooper aim to plan and perform sufficient audit work so as to ensure that detection risk is minimised, and that the conclusion drawn regarding the truth and fairness of Fife Health Charity's accounts is valid.

This involves Thomson Cooper in a wide evaluation of risk areas (per ISA 300 - Planning, ISA 250A – Consideration of Laws and Regulations and ISA 330 - Auditor's Response to Assessed Risks) and also a detailed evaluation, at the level of account class, of the risk of material misstatement.

The areas detailed below have been limited to those, based on previous audit experience, which carry the highest risk of material misstatement either because the balances are so significant in the overall context of Fife Health Charity's accounts or the account class is subject to a degree of estimation or relies upon the work of an expert.

The list is not exhaustive and has been prepared based upon our previous experience prior to the commencement of the detailed planning work for the audit for the year ended 31 March 2021.

The Trustees remain ultimately responsible for the integrity of the financial statements and risk management in the widest context. Thomson Cooper, as external auditor, are responsible for providing the Trustees of Fife Health Charity reasonable assurance that the accounts are free from material misstatement and that the accounts give a true and fair view of the state of the affairs of Fife Health Charity at 31 March 2021. While the audit work performed may involve consideration of such issues as the impact of failure of IT equipment for example, the work performed will be limited to considering the extent to which the breach might impact upon the financial statements. Hence risks of this nature have been excluded from those listed below.

Audit Risks (continued)

Security of Investments

The investments are by far the Charity's largest asset and by virtue of size, therefore, constitute a specific audit risk. Our audit procedures will involve assessing the adequacy of the security arrangements operated by Standard Life in relation to the Charity's investments as well as considering whether it is appropriate for us to rely upon their work as directed by International Standard on Auditing 620 – Using the Work of an Expert.

Accounting for Restricted Funds

The Trustees must ensure that the accounts are prepared in accordance with the Charities SORP 2015 (FRS 102) which requires that funds received with specific conditions attaching are accounted for as restricted funds and disclosed in the financial statements accordingly. We will look for evidence during our audit that all sources of income have been properly identified and recorded in the accounting records and financial statements of the Charity.

Income Recognition and Cut-off

Specific audit work will be performed to ensure that income has been recognised in the correct accounting period and the accounting policy for the recognition of income has been consistently applied, particularly with regard to income from legacies.

Management Override

In every organisation, senior management may be in a position to override the routine day-to-day financial controls. For all of our audits, we consider this risk and adapt our audit procedures accordingly.

Fraud

The auditor's responsibility to consider the audit risk of fraud is laid down in ISA 240 "The auditor's responsibility to consider fraud in an audit of financial statements".

In accordance with ISA 200, 'the auditor shall maintain professional scepticism throughout the audit, recognising the possibility that a material misstatement due to fraud could exist, notwithstanding the auditor's past experience of the honesty and integrity of the entity's management and those charged with governance'.

Audit Risks (continued)

Fraud (continued)

As part of the planning process, we are obliged to make enquiries of management and those charged with governance regarding:

a) Management's assessment of the risk that the financial statements may be materially misstated due to fraud, including the nature, extent and frequency of such assessments;
b) Management's process for identifying and responding to the risks of fraud in the entity, including any specific risks of fraud that management has identified or that have been brought to its attention, or classes of transactions, account balances, or disclosures for which a risk of fraud is likely to exist;
c) Management's communication, if any, to those charged with governance regarding its processes for identifying and responding to the risks of fraud in the entity;
d) Management's communication, if any, to employees regarding its views on business practices and ethical behaviour; and
e) Whether Management have knowledge of any actual, suspected or alleged fraud affecting the entity.

We can confirm that if we identify any fraud or obtain information that indicates that a fraud may exist, we will communicate this to the appropriate level of management as soon as practicable. If the fraud involves management, employees who have significant roles in internal control or where the fraud results in a material misstatement in the financial statements, we will communicate these matters to the Trustees as soon as practicable.

At the conclusion of our audit work, we will request written confirmation in our letter of representation that the Trustees acknowledge their responsibility for the design and implementation of internal control to prevent and detect fraud and that it has disclosed to ourselves the results of its risk assessment and disclosed any instances or allegations of fraud which have arisen.

Materiality

Concept and definition

The concept of materiality is fundamental to the preparation of the financial statements and the audit process and applies not only to monetary misstatements but also to disclosure requirements and adherence to appropriate accounting principles and statutory requirements.

- According to International Standard on Auditing 320 Audit Materiality, 'misstatements, including omissions, are considered to be material if they, individually or in aggregate, could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements; and judgements about materiality are made in light of surrounding circumstances, and are affected by the size or nature of a misstatement, or a combination of both'.

  The Clarified ISA 320 on Audit Materiality establishes the concept of 'performance materiality'. Performance materiality means the amounts set by the auditor at less than materiality for the financial statements as a whole to reduce to an appropriately low level the probability that the aggregate of uncorrected and undetected misstatements exceeds materiality for the financial statements as a whole.

An item may also be considered material for reasons other than size, if for example, it had an impact on:

- trends;
- compliance with loan covenants; or
- instances when greater precision is required.

Calculation and determination

We have determined materiality based on professional judgement in the context of our knowledge of Fife Health Charity, including consideration of factors such as member expectations, industry developments, financial stability and reporting requirements for the financial statements.

We determine materiality in order to:

- estimate the tolerable level of misstatement in the financial statements;
- assist in establishing the scope of our audit engagement and audit tests;
- calculate sample sizes; and
- assist in evaluating the effect of known and likely misstatements on the financial statements.

We will finalise our materiality figure prior to the commencement of our audit.

Materiality (continued)

If, in the specific circumstances of Fife Health Charity, we believe there are particular transactions, account balances or disclosures where misstatement of less than materiality for the financial statements as a whole could be expected to influence the decisions of the users, we shall also determine the performance materiality level to be applied to those particular transactions.

Reassessment of materiality

We will reconsider materiality if, during the course of our audit engagement, we become aware of facts and circumstances that would have caused us to make a different determination of planning materiality if we had been aware of those facts and circumstances when we made our initial determination.

Further, when we have performed all our substantive tests and are ready to evaluate the results of those tests, including any misstatements we detected, we will reconsider whether materiality, in combination with the nature, timing and extent of our auditing procedures, provided a sufficient audit scope. If we conclude that our audit scope was sufficient, we will use materiality to evaluate whether uncorrected misstatements, individually or in aggregate, are material.

Unadjusted errors

In accordance with auditing standards, we will communicate to the Trustees all unadjusted items identified during our audit, other than those which we believe are “clearly trivial”.

Clearly trivial is defined as matters which will be of a wholly different (smaller) order of magnitude than the materiality thresholds used in the audit, and will be matters that are clearly inconsequential, whether taken individually or in aggregate.

Auditing standards do not place numeric limits on the meaning of ‘clearly trivial’, however, we consider the ‘clearly trivial’ limit to be less than 1% of materiality.

We will obtain written representations from the Trustees confirming that after considering all these unadjusted items, both individually and in aggregate, no adjustments are required.

There are a number of areas where we would strongly recommend or request any misstatements identified during the audit process being adjusted. These include:

- misstatements that we believe were intentionally made to achieve targeted earnings or similar goals;
- clear cut-off errors whose correction would cause non-compliance with loan covenants, management compensation agreements, other contractual obligations or governmental regulations that we consider are significant; and
- other misstatements that we believe are material or clearly wrong.

Reporting of Audit Findings

Communication

As external auditor, we have direct access to the Trustees should the need arise. Audit findings will be communicated orally at the meeting of the Trustees at which the annual accounts are reviewed.

In addition, on completion of the audit field work an Audit Completion Memorandum will be prepared summarising the main audit findings which will be addressed to the Trustees for their responses.

Audit Adjustments

Any misstatements identified as a result of the audit work performed, which have not already been adjusted, will be reported to the Trustees. If, after discussion, there remain any material unadjusted misstatements written representation from the Trustees may be sought setting out the reasons for non-adjustment.

Misstatements which have been found, but adjusted, will only be brought to the attention of the Trustees where it is believed that an awareness is required for the Trustees to be able to fulfil their governance responsibilities or where adjustments indicate significant weaknesses in the system of internal controls.

Potential Limitation of Scope

As discussed at the planning meeting, due to the ongoing COVID-19 pandemic, there is currently limited access to the hospitals and wards. If Thomson Cooper is unable to attend the sites and perform on-site work there may be a potential limitation in the scope of our audit work which, if arises, will impact on our final audit report.

If limitations in the scope of our audit arise we will seek to bring these to the attentions of management and the Board at the earliest convenience.

Timetable

	Date
Issue Bank Confirmation Letter	3 March 2021
Audit Planning Meeting with Client	16 March 2021
Issue Audit Planning Memorandum	24 March 2021
Audit Staff Planning Meeting	30 April 2021
Audit Fieldwork Commences	4 May 2021
Audit Clearance Meeting	24 May 2021
Provide Completion Documents	1 June 2021
Board Papers Issued	1 June 2021
Audit Committee Meeting	8 June 2021
Board Meeting	29 June 2021

Proposed Fees

	Proposed 2021	Actual 2020
	£	£
Billing timetable:		
On completion of audit fieldwork	5,300	5,100
On signing of accounts	3,000	2,850
	8,300	7,950

Should we anticipate that our costs will exceed our budget due to additional work that we may require to undertake, we shall notify you immediately in order that we may agree what action, if any, is required by you and to agree the basis for any additional charges.

The above fees are exclusive of VAT and expenses.

Appendix 1 - Developments in Auditing and Financial Reporting

1. UK Generally Accepted Accounting Practice (UK GAAP)

All charities preparing 'accruals' accounts, regardless of their size, must now report under Financial Reporting Standard 102 ('FRS 102') and the FRS 102 SORP. Although there has been no revision to the FRS 102 SORP since its publication, amendments have been issued. The most recent change being the publication of the update bulletin 2 published on 5 October 2018.

Update Bulletin 2

Following the 2017 triennial review of FRS 102, the SORP making body chose not to issue an updated Charities SORP but instead issued amendments to charity accounting under FRS 102 through 'Update Bulletin 2'.

What are the changes?

Update Bulletin 2 contains three separate sections which look at 'Clarifying' amendments, 'Significant' amendments and 'Other' amendments. The changes will affect some charities more than others, particularly if your organisation has property, or is part of a group. There is also clarity for those gift aiding profits up from a trading subsidiary. The main changes are detailed below:

Comparative information – 'clarifying amendment'

Comparative information must now be provided for all amounts in the financial statements, including the notes. This includes restricted fund movement notes and the note allocating assets and liabilities across different funds. Although this allows more detailed comparison year on year, it will increase the length of your statutory accounts.

Component accounting – 'clarifying amendment'

Under FRS 102, where an asset comprises two or more major components with substantially different useful economic lives, each component must be depreciated separately over its useful life. This is something that has largely been resisted to date, with charities (and companies) relying upon a concession that allowed it to be ignored if would cause 'undue cost or effort'. This concession has now been removed, and as a result, more charities will have to consider how specific assets, for example properties, should be accounted for on a component basis. Even if the overall impact on carrying values and depreciation charges is immaterial, calculations may still be required to confirm this.

Gift aid payments by charitable trading subsidiaries – 'clarifying amendment'

An unpaid Gift Aid donation to a parent charity can only now be accrued when the subsidiary has a legal obligation to make the payment at the reporting date. It is therefore important to have a deed of covenant put in place as soon as possible to create the appropriate obligation. Tax relief can still be claimed regardless of the accrual, provided the donation is made within nine months of the year end.

The Bulletin states that the above 'clarifying amendments' are applicable to accounting periods commencing on or after 5 October 2018.

Mixed use properties – 'significant amendment'

An exemption can no longer be claimed which prevents the need to separately measure the investment property component of a mixed-use property at fair value if it would cause 'undue cost or effort'. Charities will therefore need to look closely at property let on a long-term basis that it also partly used operationally. It is now defined in the Bulletin that if the portions can be let or sold separately then this is sufficient to trigger the need to account for each element individually.

1. UK Generally Accepted Accounting Practice (UK GAAP) (continued)

Investment property let to group members – 'significant amendment'

For charities that rent investment property to another group entity there is now a choice as to how to account for that property. Currently this must be measured at fair value which causes discrepancies in group vs individual balance sheet treatments because on a group basis you generally need to revert to cost – going forward, charities can choose to measure such property either at cost (less depreciation and impairment) or at fair value in the individual balance sheet.

'Other amendments'

Other amendments include requiring charities to prepare a reconciliation of net debt as a note to the statement of cash flows, and the extension of merger accounting to transfers of activities to non-charitable wholly owned subsidiaries.

These 'significant' and 'other' amendments come into force for accounting periods commencing on or after 1 January 2019. Early adoption is not permitted for charities registered in Scotland with OSCR, including cross-border charities.

The Charities Accounts (Scotland) Regulations 2006 have been amended to bring the updates made to the SORP into law. The Regulations became law on 1 January 2019, however, the 'clarifying' amendments contained in section 3 of Update Bulletin 2 came into force for accounting periods starting on or after 5 October 2018.

Full details of Update Bulletin 2 can be found on the SORP making body's website at http://www.charitysorp.org/media/646449/update-bulletin-2.pdf.

FRS 102 SORP Information Sheet 1: Implementation Issues

The Charity SORP making body previously produced 'information sheets' which sought to clarify the application of the SORP or particular recommendations within it. Information sheets are advisory in nature and do not form part of the SORP, however, are considered best practice.

In April 2017 the SORP making body published 'Information sheet 1 – Implementation issues' which contains guidance regarding interpreting and applying the requirements of the FRS 102 SORP. Some of the key points are summarised below:

Aggregate disclosure of the total amount of donations received without conditions

The SORP requires all charities to provide an aggregate disclosure of the total amount of donations received without conditions. Disclosure is considered only to be necessary if the total amount of donations received from trustees or related parties without conditions is judged to be material in the context of the total income from donations and legacies.

Inclusion of Employer's NIC as part of employee benefits

When calculating 'employee benefits' for the disclosure of remuneration and benefits received by 'Key Management Personnel' (KMP) the definition of employee benefits should be in accordance with FRS 102. Employer's National Insurance Contributions should be included where employee benefits are disclosed as part of KMP remuneration. Where you are disclosing the numbers of employees that receive employee benefits of more than £60,000 however, Employer's NIC should be excluded.

2. A New Code of Ethics for the Charity Sector

In the wake of revelations about safeguarding failures in several charities in recent years, and in an effort to rebuild confidence in the sector, a consultation on a draft Charity Code of Ethics led by the National Council for Voluntary Organisations (NCVO) was published in July 2018.

2. A New Code of Ethics for the Charity Sector (continued)

Although different charities have their own policies for specific issues, such as working with children or vulnerable adults, there is currently no overarching set of ethical principles (such as the Nolan Principles which apply to those who hold public office), that reflect the values that should be shared across the charity sector.

In January 2019, the NCVO launched the Charity Ethical Principles code (previously referred to as the Charity Code of Ethics). The principles aim to ensure that the beneficiaries are put first and is seem as a guide to upholding the highest level of institutional integrity and personal conduct at all times, a commitment to openness, showing everyone how they work, deal with problems and spend their funds. It also states that every person coming into contact with the charity should be treated with dignity and respect and feel they are in a safe and supportive environment. Its adoption is voluntary, although all charities will be encouraged to meet the principles of the code or explain why they have not done so.

Dame Mary Marsh stated:
'This code of ethics is not just about safeguarding; its ambition is much bigger. It is designed to encourage charities to reflect on their current policies and practice, to fire further debate on key issues, to show the sector's commitment to ethical principles, and most importantly, to help prevent problems ever arising again.'

The Charity Ethical Principles can be obtained from the NCVO website https://www.ncvo.org.uk/policy-and-research/ethics/ethical-principles

3. Ethical Standards

For accounting periods commencing on or after 17 June 2016, the APB's 6 Ethical Standards (1 -5 and PASE), have been replaced by a single Ethical Standard issued by the FRC. The PASE still exists but forms section 6 of the new standard. Largely aimed at Public Interest Entities (PIEs) and listed company audits, the implementation will see little change for most businesses and charities.

The overarching purpose of the change is designed to strengthen auditor independence. The new standard views the independence threat changed from 'reduced to an acceptable level', to that of 'a level at which it is probable that an objective, reasonable and informed third party would not conclude that independence would be compromised'. If such a party would conclude that action would compromise the auditor's independence, the auditor will need to ensure that action is taken, or they will no longer be able to undertake the audit engagement.

In addition, the applicability of the independence requirements for individuals have been extended to include "any other natural person whose services are placed at the disposal or under the control of the audit firm and who is directly involved in audit" e.g. persons closely associated.

4. Scottish Charitable Incorporated Organisations (SCIOs)

Existing unincorporated charities, charitable companies, and Co-operative and community benefit societies (formerly industrial and provident societies) are allowed to apply to change their legal form to a SCIO.

The SCIO is intended to help charities enjoy the benefits of incorporation, including limited liability and legal personality, without being subject to the complex apparatus of company law and dual regulation of OSCR and Companies Law currently imposed on charitable companies.

Key characteristics:

- Separate legal entity so can contract in its own name rather than that of the trustees personally. The SCIO can also hold title to land in its own right.
- Limited liability for trustees.
- OSCR incorporates and dissolves SCIOs and is the Regulator of its legal form, not just its charitable status.
- Must have two or more members.
- SCIO members are subject to some of the same duties as charity trustees.
- Duty to keep and supply a register of members.
- There should be at least one member's meeting a year

5. Going Concern

On 30 September 2019 the Financial Reporting Council (FRC) issued a revised going concern standard in response to recent Enforcement cases and well-publicised corporate failures where the auditor's report failed to highlight concerns about the prospects of entities which collapsed shortly after.

The revised standard (ISA UK 570 Going Concern) follows concerns about the quality and rigour of audit and increases the work auditors are required to do when assessing whether an entity is a going concern. It means UK auditors will follow significantly stronger requirements than those required by current international standards.

The FRC hopes that UK experience will lead to further strengthening of requirements at the international level.

The revised standard requires:

- greater work on the part of the auditor to more robustly challenge management's assessment of going concern, thoroughly test the adequacy of the supporting evidence, evaluate the risk of management bias, and make greater use of the viability statement.
- improved transparency with a new reporting requirement for the auditor of public interest entities, listed and large private companies to provide a clear, positive conclusion on whether management's assessment is appropriate, and to set out the work they have done in this respect; and
- a stand back requirement to consider all of the evidence obtained, whether corroborative or contradictory, when the auditor draws their conclusions on going concern.

6. Persons of Significant Control

On 6 April 2016, new legislation came into effect surrounding 'persons of significant control (PSC)'. Thus, it is now a legal obligation for each company to maintain a PSC register as part of their statutory books and have them ready for inspection at their registered office.

A person is deemed to have significant control or influence if it meets one or more of the following specified conditions:

- Directly or indirectly holds > 25% of the shares.
- Directly or indirectly holds > 25% of the voting rights.
- Directly or indirectly has the power to appoint or remove the majority of the board of directors.
- Has the right to exercise or actually exercises significant influence or control over the company.
- Has the right to exercise or actually exercises significant influence or control over a trust or company, which in turn satisfies any of the first four conditions.

Each company must take reasonable steps to identify their PSCs. It is a criminal offence not to take reasonable steps to ascertain who the PSCs are within a company.

Further information regarding what information should be recorded on the PSC register can be found at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/515720/Non-statutory_guidance_for_companies__LLPs_and_SEsv4.pdf

7. Creating an effective Trustees' Annual Report

The Trustees' Annual Report can be a useful way of helping supporters understand your charity and what its passions are. OSCR are placing more emphasis on this and encouraging charity trustees to improve the quality of these reports.

Guidance can be found at: http://www.oscr.org.uk/blog/2017/february/27/telling-your-story-making-the-trustees-annual-report-work-for-your-charity

8. OSCR Update

- **Guidance Published**

Making changes to your charity (Nov 2018)
This guidance outlines the rules, process, and consents required relating to the different types of changes that a charity may wish to make.

Charity Investments: Guidance and Good Practice (Nov 2018)
This guidance sets out some of the key points to consider if your charity has investments or is thinking about investing and how your duties as charity trustees apply.

8. OSCR Update (continued)

Fraud: how to reduce the risks to your charity

As the instances of reported fraud in charities, and other entities, has been steadily increasing, OSCR has issued several publications to provide advice on mitigating the risks for charities, the most recent of which was issued in June 2018. This guidance, Fraud: how to reduce the risks in your charity, highlights some of the risks to fraud to which charities are vulnerable and provides practical advice for trustees on how to tackle it.

Many of clients are reporting an increase in email-based scams and fraud, ranging from well disguised fake invoices to requests for payment appearing to come from a recognised sender. The Action Fraud website has some useful hints and tips on avoiding these scams and reporting fraud.

Safeguarding Guidance: Keeping vulnerable beneficiaries safe

Safeguarding is the action taken to promote the welfare of children and vulnerable adults to protect them from harm. This includes making sure that appropriate policies and procedures are put in place. Safeguarding includes child protection but goes further and extends to all vulnerable beneficiaries. In May 2018 OSCR published Safeguarding Guidance which explains what is meant by safeguarding and highlights key steps charity trustees can take to make sure that it is considered in an appropriate way.

Fundraising Code of Practice

The Code of Fundraising Practice outlines the standards expected of all charitable fundraising organisations across the UK. The Code and its associated Rulebooks for Street, Door and Private Site Fundraising outline the standards expected of all charitable fundraising organisations across the UK. The standards were developed by the fundraising community through the work of the Institute of Fundraising and Public Fundraising Association.

The Code and the rule books were formally transferred to the Fundraising Regulator at its launch on 7 July 2016. Recommendations on changes to the Code are made by the Fundraising Regulator's Standards Committee in consultation with fundraising stakeholders. Decisions to change the code are subject to approval by the Fundraising Regulator's Board.

Further details can be found at the Fundraising Regulator website and the Code can be found at: https://www.fundraisingregulator.org.uk/wp-content/uploads/2016/06/Code-of-Fundraising-Practice-v1.4-310717.pdf

9. Incorporation Guidance

The process through which Scottish charities can incorporate has changed. This is designed to make the process clearer. Incorporation can be an important set for charities. Guidance on 'the route to incorporating your charity' can be found on the OSCR website.

10. Fit and Proper Persons Guidance

The Finance Act 2010 introduced a new definition for tax purposes of charities and other organisations entitled to UK charity tax reliefs. The new definition includes a requirement that to be charity an organisation must satisfy the "management condition". To do this the managers of a charity, who include the trustees and directors and any other official having control or management over the charity or its assets, must be "fit and proper persons". The term is not defined in legislation, but the guidance produced by HMRC explains how HMRC applies this test.

The fit and proper person test is about ensuring that charities are not managed or controlled by people who present a risk to the charity's tax position. HMRC may decide that a person is not fit and proper if they have:

- A history of tax fraud.
- A history of other fraudulent behaviour.
- Become known to HMRC as being involved in the abuse of tax repayment systems.
- Been barred from acting as a charity trustee or company director.

In their guidance HMRC suggest a procedure for charities to follow when they appoint new managers which includes the manager reading a model guide and signing a model declaration. On 8 March 2017, HMRC published an updated version of its "fit and proper person" model declaration, together with an updated help sheet.

11. Gift Aid

Donor benefit limits

The maximum value of the benefits that individuals and companies may receive as a result of making a donation to a charity of more than £10,000 under Gift Aid is £2,500 subject to the rule that the benefit must not exceed five per cent of the gift.

Records for small donations

The Gift Aid Small Donations Scheme (GASDS) allows eligible charities and Community Amateur Sports Clubs (CASCs) to claim top-up payments from HMRC on small cash donations that they receive. The scheme applies to cash donations of £20 or less for which no Gift Aid declaration has been obtained. From the tax year commencing 5 April 2016, tax reclaimed under the scheme for each charitable activity in a tax year cannot exceed £2,000.

Sponsored Events

Only individual donations of £500 or more shown on individual sponsor sheets will need to be separated out and listed separately on the claim.

Payment of Gift Aid

All Gift Aid claims must now be made electronically. All Gift Aid repayments will be made automatically by HMRC using BACS.

11. Gift Aid (continued)

FRS 102 Revisions for Gift Aid

In December 2017 The Financial Reporting Council (FRC) issued its "Amendments to FRS 102 : The Financial Reporting Standard applicable in the UK and Republic of Ireland" as a result of its triennial review, which included updated guidance regarding payments by subsidiaries to their charitable parents that qualify for gift aid, in response to the significant differences in accounting treatment arising in practice.

It confirms that profits from the non-charitable subsidiary may be distributed to the parent charity in a tax-efficient manner as a donation which is eligible for corporation tax relief under the gift aid rules, provided it is made during the relevant reporting period or during the following nine months, in relation to the accounting for gift aid payments made by a subsidiary to its charitable parent.

The effective date is for accounting periods beginning on or after 1 January 2019, with early application permitted provided all of the amendments are applied at the same time.

12. Cyber Security

Today's organisations collect process and retain more information than they have ever done. For not for profit, this information can be internal so can be about their own operations or employees or their 'business' or collected from external sources such as from beneficiaries, donors, or even customers, if they run any trading activities.

The impact of this digital retention of information means that organisations have become more dependent on information systems and more vulnerable to attack by sophisticated cybercriminals or even their own employees.

The results of numerous surveys and research show that organisations are still not adequately protected against cyber-attacks. Nearly two-thirds of companies across sectors and regions responding to a joint research carried out by McKinsey and the World Economic Forum described the risk of cyber-attack as a "significant issue that could have major strategic implications."

The impact of the controls put in place to mitigate against this risk is thought to be having negative business impacts by slowing the use of technology such as the use of public-cloud services and even reducing productivity by limiting the employee's ability to effectively share information.

Making organisations cyber-resilient is therefore now regarded as a key strategic risk management issue which should be monitored by Chief Executives and Boards.

During 2016 the government established the National Cyber Security Centre (NCSC). The NCSC was set up to help protect our critical services from cyber-attacks, manage major incidents and improve the underlying security of the UK Internet through technological improvement and advice to citizens and organisations.

The NCSC has a stated aim of providing the best possible cyber security advice and information to everyone in the UK, including the public and members of organisations of all kinds. One of their initial publications "10 Steps to Cyber Security" outlines the basic cyber security procedures to protect your organisation from cyber-attacks, while their "Cyber Essentials" allows organisations to advertise that they meet a government endorsed standard of cyber hygiene.

The 10 Steps to Cyber Security emphasises that protecting your information is a board-level responsibility which has benefits at strategic, financial and operational levels. It includes a set of questions to assist Senior Management and Trustees with their existing strategic-level risk discussions and specifically how to ensure you have the right safeguards and cultures in place.

13. OSCR Powers

In Scotland, OSCR can make inquiries into a charity either of its own accord or as a result of a referral by a third party, perhaps as a result of suspected misconduct or mismanagement of the charity's affairs.

OSCR has the power to look behind the charity itself and inquire into a body that controls a charity, or a person acting on behalf of the charity. Accordingly, OSCR can inquire into what may be called "shadow" directors or Trustees. However, they do not have the same power as the Charities Commission to issue official warnings to give the trustees a chance to rectify any misconduct.

If an inquiry is raised, the persons involved may be required to provide OSCR with whatever information it needs to carry out its inquiry. Following this OSCR can direct the charity or any person involved not to take any particular action for up to six months. Failure to comply with such a direction is a criminal

14. The EU General Data Protection Regulation (GDPR)

The EU's General Data Protection Regulation (GDPR) will apply from 25 May 2018, when it supersedes the UK Data Protection Act 1998. Significant and wide-reaching in scope, the new law expands the rights of individuals to control how their personal information is collected and processed and places a range of new obligations on organisations to be more accountable for data protection.

The Regulation demands that you be able to demonstrate compliance with the data protection principles. This involves taking a risk-based approach to data protection, ensuring appropriate policies and procedures are in place to deal with the transparency, accountability and individuals' rights provisions, as well as building a workplace culture of data privacy and security.

Wider Scope

The GDPR applies to all EU organisations (commercial business, charity, public authorities etc) that collect, store or process the personal data of individuals residing in the EU, even if they're not EU citizens. Organisations based outside the EU that offer goods or services to EU residents, monitor their behaviour or process their personal data will also be subject to the GDPR.

Service providers (data processors) that process data on behalf of an organisation come under the remit of the GDPR and will have specific compliance obligations. An example might be a company that processes your payroll or a Cloud provider that offers data storage.

Personal Data

Personal data must be processed according to the six data protection principles:

- Processed lawfully, fairly and transparently.
- Collected only for specific legitimate purposes.
- Adequate, relevant and limited to what is necessary.
- Must be accurate and kept up to date.
- Stored only as long as is necessary.
- Ensure appropriate security, integrity and confidentiality.

14. The EU General Data Protection Regulation (GDPR) (cont'd)

Strengthened Privacy Rights of Individuals

The regulation strengthens the privacy rights of individuals in the following areas:

- Valid consent – stricter rules for obtaining consent.
- Transparency – the right to clear information over what data.
- Correction – the right to rectify inaccurate personal data.
- Erasure – the right to have personal data erased.
- Data Portability – the right to move personal data from one service provider to another.
- Automated processing – the right not to be subject to a decision based solely on automated processing

Obligations of Organisations

The obligations on organisations have been increased to include:

- Accountability – demonstrate compliance by maintaining a record of all data processing activities.
- Data Protection Impact Assessments (DPIA) – mandatory if the processing activity is likely to result in a high risk to the rights of individuals.
- Data Security – requirement to keep personal data secure through "appropriate technical and organisational measures".
- Data Breaches – requirement to report to the regulator within 72 hours.
- Data Protection Officer (DPO) – appointment of a DPO is mandatory for certain organisations but is also considered general good practice.
- Data transfer – transfer of personal data outside the EU only allowed if appropriate safeguards are in place.

Costs of non-compliance

The costs of non-compliance are both financial and non-financial, and include:

- Fines of up to €20m or 4% of global turnover.
- Requirement to pay compensation claims for damages suffered.
- Reputational damage and loss of consumer trust.

15. Pensions Auto-Enrolment

The Pensions Act 2008 (amended 2014) includes provisions requiring employers to set up pension arrangements for employees, automatically enrol eligible members and make minimum contributions relating to their pay. By 1 February 2018, all employers must have now complied.

How much do I have to pay?

From April 2019 the minimum contribution is 8% of qualifying earnings of which at least 3% must be paid by the employer.

How do I find out more?

Information is available from the Pension Regulator's website. If you require further information or support regarding auto-enrolment please do not hesitate to contact us.

16. Anti-Money Laundering Regulations

The Money Laundering, Terrorist Financing and Transfer of Funds (Information on the Payer) Regulations 2017 (the regulations) came into effect on 26 June 2017.

The overall objective being to ensure that the UK's anti-money laundering and counter terrorist financing regime is kept up to date, is effective and is proportionate. This will enable the UK to have a comprehensive regime and ensure that the UK's financial system is an increasingly hostile environment for money laundering and terrorist financing.

On 10 January 2020, further changes came into force which set out amendments to the 2017 regulations.

To comply with the new regulations, relevant entities are required to:

- Conduct a money laundering and terrorist financing risk assessment.
- Implement systems, policies, controls and procedures to address money laundering and terrorist financing risks and meet the requirements under the regulations.
- Apply the policies, procedures and controls across the entity's group structure (if relevant).
- Adopt appropriate internal controls.
- Provide training to staff.
- Apply for approval if you are the beneficial owner, officer or manager of an entity.
- Comply with new customer due diligence, enhanced due diligence and simplified due diligence requirements.
- Comply with requirements relating to politically exposed persons.
- Ensure record keeping and data protection systems, policies and procedures meet the requirements of the regulations.
- Comply with new obligations relating to record keeping and the provision of information about beneficial ownership if acting as a trustee of a relevant trust.

17. National Minimum Wage and National Living Wage

The National Minimum Wage (NMW) is the minimum pay per hour most workers under the age of 25 are entitled to by law. The government's National Living Wage (NLW) is the minimum pay per hour most workers aged 25 and over are entitled to by law.

The government's National Living Wage is different from the Living Wage, which is an hourly rate of pay and updated annually. The Living Wage is set independently by the Living Wage Foundation and is calculated according to the basic cost of living in the UK. Employers choose to pay the Living Wage on a voluntary basis.

The rate will depend on a worker's age and if they are an apprentice. Current rates from April 2020 are as follows:

- £8.72 per hour for ages 25 and over (from April 2021 increases to £8.91 per hour for ages 23 and over)
- £8.20 per hour for ages 21 to 24 (from April 2021 increases to £8.36 per hour)
- £6.45 per hour for ages 18 to 20 (from April 2021 increases to £6.56 per hour)
- £4.55 per hour for school leaving age to 17 (from April 2021 increases to £4.62 per hour)
- £4.15 per hour for apprentices (from April 2021 increases to £4.30 per hour)

Appendix 2 – Engagement Letter

An electronic copy of our newly issued Engagement Letter is as follows:

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24 March 2021

The Trustees
Fife Health Charity
Evans Business Centre
Mitchelston Industrial Estate
Mitchelston Drive
Kirkcaldy
Fife
KY1 3NB

Dear Trustees

We are pleased to continue the instruction to act as your advisers and are writing to confirm the terms of our appointment.

The purpose of this letter together with the attached terms and conditions is to set out our terms for carrying out the work and to clarify our respective responsibilities.

We are bound by the ethical guidelines of the Institute of Chartered Accountants Scotland and accept instructions to act for you on the basis that we will act in accordance with those guidelines.

1. Engagement letter

1.1 Thank you for engaging us as your advisers. Alan Mitchell will be your main point of contact and will have primary responsibility for this assignment. This letter and the attached schedule(s) of services together with this firm's standard terms and conditions set out the basis on which we will act.

2. Who we are acting for

2.1 For the avoidance of doubt Margo McGurk is acting as nominated first point of contact. Any change to the nominated person should be notified to us in writing and will not be effective until acknowledged by us in writing.

3. Period of engagement

3.1 This engagement will start from the date this letter is signed. It replaces all previous engagements that we have had with you.

4. Our responsibility to you

4.1 We have set out the agreed scope and objectives of your instructions within this letter of engagement. Any subsequent changes will be discussed with you and where appropriate a new letter of engagement will be agreed. We shall proceed on the basis of the instructions we have received from you and will rely on you to tell us as soon as possible if anything occurs which renders any information previously given to us as incorrect or inaccurate. We shall not be responsible for any failure to advise or comment on any matter which falls outside the specific scope of your instructions. We cannot accept any responsibility for any event, loss or situation unless it is one against which it is the expressed purpose of these instructions to provide protection.

5. Your responsibility to us

5.1 The advice that we give can only be as good as the information upon which it is based. Insofar as that information is provided by you, or by third parties with your permission, your responsibility arises as soon as possible if any circumstances or facts alter as any alteration may have a significant impact on the advice given. If the circumstances change therefore or your needs alter, advise us of the alteration as soon as possible in writing.

6. Services

6.1 Attached is the schedule of services listed below which records the work we are instructed to carry out. This also states your and our responsibilities in relation to the work to be carried out.

Schedules

Unincorporated Charity Audit (April 2015 version 2)

6.2 You may request that we provide other services from time to time. We will issue a separate schedule of service or, if necessary, a new letter of engagement and scope of work to be performed accordingly.

6.3 Because rules and regulations frequently change you must ask us to confirm any advice already given if a transaction is delayed or a similar transaction is to be undertaken.

7. Fees

7.1 Our fees will be charged in accordance with our standard terms and conditions. Please review these to ensure you understand the basis of our charges and our payment terms.

8. Limitation of liability

8.1 You have agreed that our liability as auditors to the company will be limited in accordance with sections 532 to 538 of the Companies Act 2006. The terms of this agreement are in our standard terms and conditions which are attached to this engagement letter.

8.2 We specifically draw your attention to paragraph 23 of our standard terms and conditions which sets out the basis on which we limit our liability to you and to others. You should read this in conjunction with paragraph 11 of our standard terms and conditions which excludes liability to third parties.

8.3 There are no Third Parties that we have agreed should be entitled to rely on the work done pursuant to this engagement letter.

9. Your agreement

9.1 Once it has been agreed, this letter will remain effective until it is replaced.

9.2 We shall be grateful if you could confirm your agreement to the terms of this letter, the schedule of services and the standard terms and conditions by signing the enclosed copy and returning it to us immediately.

9.3 If this letter and schedule of services is not in accordance with your understanding of the scope of our engagement or your circumstances have changed, please let us know.

Yours sincerely

Thomson Cooper

Acceptance

We confirm that we have read and understood the contents of this letter, schedules and related terms and conditions and agree that it accurately reflects our fair understanding of the services that we require you to undertake.

Signed ..... Date .....

For and on behalf of
Fife Health Charity

SCHEDULE OF SERVICES

This schedule should be read in conjunction with the engagement letter and the standard terms and conditions.

UNINCORPORATED CHARITY AUDIT

1. Your responsibilities as trustees of the charity

1.1 In agreeing to these engagement terms, you acknowledge your responsibilities and confirm that you understand them.

1.2 As trustees of the charity you are responsible for:

a) ensuring that adequate accounting records are maintained which disclose the charity's financial position with reasonable accuracy at any time;

b) preparing financial statements for each financial year that:

i) give a true and fair view of the charity's state of affairs at the end of the financial year and of its incoming resources and application of resources for that year; and

ii) are in accordance with the Charities and Trustee Investment (Scotland) Act 2005 and regulations thereunder;

c) preparing an annual report on the activities of the charity during the year that complies with the requirements of the relevant regulations.

1.3 In preparing the financial statements (or arranging for them to be prepared) you are required to:

a) select suitable accounting policies and then apply them consistently;

b) make judgements and estimates that are reasonable and prudent;

c) prepare the financial statements on the going concern basis unless it is inappropriate to assume that the charity will continue in business; and

d) have regard to applicable accounting standards and the relevant statement of recommended practice.

1.4 You are responsible for such internal controls as you consider necessary to enable the preparation of the financial statements that are free from material misstatement, whether due to fraud or error.

1.5 Under the Charities Accounts (Scotland) Regulations 2006 (as amended) and the Charities SORP you are required to report as to whether you have given consideration to the major risks to which the charity is exposed, and to the systems designed to manage those risks. We are not required to audit this statement, or to form an opinion on the effectiveness of the risk management and control procedures.

1.6 You are responsible for safeguarding the assets of the charity and to ensure their proper application, and hence for taking reasonable steps to prevent and detect fraud and other irregularities.

1.7 You are responsible for ensuring that the charity complies with laws and regulations that apply to its activities, and for preventing non-compliance and detecting any that occurs.

1.8 You undertake to make available to us, as and when required, all the charity's accounting records and related financial information, including minutes of management and members' meetings that we need to do our work. You will disclose to us all relevant information in full. In particular, you agree to provide:

a) access to all information of which management is aware that is relevant to the preparation of the financial statements such as records, documentation and other matters;

b) additional information that we may request from management for the purpose of the audit; and

c) unrestricted access to persons within the entity from whom we determine it necessary to obtain audit evidence.

1.9 If audited financial information is published, which includes a report by us or is otherwise connected to us, on the charity's website or by other electronic means, you must inform us of the electronic publication and obtain our consent before it occurs and ensure that it presents the financial information and auditor's report properly. We have the right to withhold consent to the electronic publication of our report or the financial statements if they are to be published in an inappropriate manner.

1.10 You must set up controls to prevent or detect quickly any changes to electronically published information. We are not responsible for reviewing these controls nor for keeping the information under review after it is first published. You are responsible for the maintenance and integrity of electronically published information and we accept no responsibility for changes made to audited information after it is first posted.

1.11 You are responsible for establishing and controlling any process for electronically distributing Annual Reports and other financial information to members and/or supporters of the charity and to the Office of the Scottish Charity Regulator (OSCR).

1.12 You are responsible for filing the charity's financial statements and an annual report for the financial year complying in its form and content, as well as other relevant documentation, with OSCR in accordance with their requirements, unless otherwise agreed.

1.13 The audited financial statements and annual report are required to be delivered to OSCR within nine months of the end of the charity's financial year end and it is the trustees' responsibility to ensure that this deadline is met.

2. Our responsibilities as auditor

2.1 We have a statutory responsibility to report to you whether, in our opinion, the financial statements give a true and fair view of the state of affairs of the charity at the end of the financial year and of its incoming resources and application of resources in that year and whether they have been properly prepared in accordance with the Charities and Trustee Investment (Scotland) Act 2005 and regulations thereunder. In deciding this, we must consider the following matters, and report on any that we are not satisfied with:

a) whether the charity has kept proper accounting records;

b) whether the charity's balance sheet and statement of financial activities are in agreement with the accounting records and returns;

c) whether we have obtained all the information and explanations which we consider necessary for the purposes of our audit; and

d) whether the information given in the annual report of the charity trustees is not consistent with that contained in the audited financial statements.

2.2 We may also need to deal with certain other matters, according to the circumstances, in our report such as any material concerns we may have relating to the financial effects of any non-compliance with relevant laws and regulations.

2.3 We have a professional responsibility to report if the financial statements do not significantly comply with applicable financial reporting standards or the relevant statement of recommended practice unless, in our opinion, the departure is justified in the circumstances. In deciding whether or not this is the case we consider:

a) whether the non-compliance is necessary for the financial statements to give a true and fair view; and

b) whether the non-compliance has been clearly disclosed.

2.4 Our professional responsibilities also include:

a) describing in our audit report the trustees' responsibilities for the financial statements if the financial statements or accompanying information do not include this information; and

b) considering whether other information in documents containing the audited financial statements is consistent with those financial statements.

2.5 In respect of the expected form and content of our report, we refer you to the most recent bulletin on auditor's reports published by the Auditing Practices Board at http://www.frc.org.uk/apb. The form and content of our report may need to be amended in the light of our findings.

2.6 We have a statutory duty to report to OSCR such matters (concerning the activities or affairs of the charity or any connected institution or body corporate) of which we become aware during the course of our audit which are (or are likely to be) of material significance to OSCR in the exercise of the powers of inquiry into, or acting for the protection of, charities. It is envisaged that the need to make such a report will arise only very rarely, in accordance with the guidance set out in International Standards on Auditing (UK & Ireland) 250 Section B "The Auditor's Right and Duty to Report to Regulators in the Financial Sector".

2.7 We will report solely to the charity's trustees, as a body. Our audit work will be undertaken so that we might state to the trustees those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the trustees, as a body, for our audit work, for this report, or for the opinion we have formed.

2.8 You should be aware that the charity's annual financial statements are for the specific purpose of reporting to the trustees [as well as to the members] at a particular point in time. They may therefore not be suitable for other purposes such as such as making decisions regarding borrowing or investing by you as trustees or by any other party.

3. Scope of audit

3.1 We will carry out our audit in accordance with the International Standards on Auditing (UK and Ireland) issued by the Auditing Practices Board. The audit will include such tests of transactions and of the existence, ownership and valuation of assets and liabilities as we consider necessary.

3.2 We shall obtain an understanding of the accounting and internal control systems to ensure they are adequate as a basis for the preparation of the financial statements and to establish whether the charity has kept proper accounting records. We will gather enough evidence to enable us to reach a reasonable conclusion.

3.3 You are responsible for safeguarding the charity's assets and for preventing and detecting fraud, error and non-compliance with law or regulations. We will plan our audit so that we can reasonably expect to detect significant misstatements in the financial statements or accounting records (including those resulting from fraud, error or non-compliance with law or regulations), but you cannot rely on us finding all such errors.

3.4 We shall not be treated as having notice, for the purposes of our audit responsibilities, of information provided to members of our firm other than those engaged on the audit.

3.5 Once we have issued our audit report we have no further responsibility in relation to the financial statements for that financial year.

3.6 We would appreciate receiving notice of and invitations to attend the meeting of the trustees at which the annual report and financial statements are to be approved.

3.7 To ensure that there is effective two-way communication between us and to comply with the requirements of Auditing Standards we will:

a) contact you prior to the audit to discuss any relevant matters and to agree any required action; and

b) contact you to discuss any matters arising from the audit and to confirm any agreed action.

4. Reporting to the Trustees and Management

4.1 The nature and extent of our procedures will vary according to our assessment of the charity's accounting system and, where we wish to place reliance on it, the internal control system, and may cover any aspect of the charity's operations that we consider appropriate. Our audit is not designed to identify all significant weaknesses in the charity's systems but, if such weaknesses come to our notice during the course of our audit which we think should be brought to your attention, we shall report them to you. Any such report may not be provided to third parties without our prior written consent. Such consent will be granted only on the basis that such reports are not prepared with the interests of anyone other than the charity in mind and that we accept no duty or responsibility to any other party as concerns the reports.

5. Representations by management/trustees

5.1 As part of our normal audit procedures, we may request written confirmation of oral representations which we have received during the course of the audit on matters having a material effect on the financial statements.

6. Documents issued with the financial statements

6.1 In order to assist us with the examination of your financial statements, we shall request sight of all documents or statements, including the trustees' report, which are due to be issued with the financial statements. If it is proposed that any documents or statement which refer to our name, other than the audited financial statements, are to be circulated to third parties, please consult us before they are issued.

7. Irregularities, including fraud

7.1 The responsibility for the prevention and detection of fraud, error and non-compliance with law or regulations rests with yourselves. However, we shall endeavour to plan our audit so that we have a reasonable expectation of detecting material misstatements in the financial statements or accounting records (including those resulting from fraud, error or non-compliance with law or regulations), but our examination should not be relied upon to disclose all such material misstatements or frauds, errors or instances of non-compliance as may exist.

8. Provision of Service Regulations

8.1 Details of our audit registration can be viewed at www.auditregister.org.uk under reference number 0538.

24 March 2021

Thomson Cooper

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**13 May 2021**
Title:	**Update on NHS Fife Board Assurance Framework**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Report Author:	**Pauline Cumming, Risk Manager**

1 Purpose

This is presented to the 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 19 January 2021.

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)
- Digital and Information

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

Table 1 - Risk Level and Rating over time

Risk ID	Risk Title	Initial Risk Level & Rating LxC	Likelihood (L)	Consequence (C)	Current Level & Rating June / Jul 2020	Current Level & Rating Aug/Sept 2020	Current Level & Rating Oct/ Nov 2020	Current Level & Rating Dec / Jan 2021
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	**Digital and Information**	High 20	Possible 3	Major 5	15 (3x5) High	15 (3x5) High	15 (3x5) High	15 (3x5) High

Since the last report to the Committee, the BAF risks have been considered at the January 2021 committees. This update summarises the key points reported **at that time**; the associated BAFs are provided separately in appendices.

The BAFs were not considered at the March 2021 committees as a decision was taken to focus on other priority business. The BAFs have been updated and the current versions will be considered during the April / May 2021committee cycle.

Key points

Financial Sustainability BAF

The Director of Finance & Strategy reported on the BAF to the Finance, Performance & Resources (F, P&R) Committee on12 January 2021. The BAF score remained High, with the target score remaining Moderate. The score continued to recognise the ongoing financial challenges facing Acute Services, as well as the pressures within the Health & Social Care

Partnership, specifically in relation to social care budgets and the work to review the risk share arrangement. It also reflected the continuing level of challenge in delivering the Board efficiency savings target as a consequence of COVID-19.

Environmental Sustainability BAF
The Director of Estates, Facilities and Capital Services reported on the BAF to the F, P&R Committee on 12 January 2021. There were no changes reported to any aspect of the risk.

Workforce Sustainability BAF
The Director of Workforce reported to the Staff Governance (SG) Committee on 13 January 2021 that risks remained around the National Shortage of Radiologists, and Medical Staff Recruitment and Retention.

She reported an additional linked operational risk had been identified Risk ID 1652: Lack of Medical Capacity in Community Paediatric Service, summarised below.

Between 2014 and 2020, the Community Paediatric Service staffing reduced from 14 wte to 4.25 wte substantive general Community Paediatricians in post. This was due to the service being unable to fill vacancies following retirals. Permanent and Child Protection specialist posts were being delivered by a 0.6 wte Associate Specialist, a 0.7 wte Consultant Clinical Lead Paediatrician and a 0.4 wte Locum Consultant Community Paediatrician.

The service was unable to meet demand both in terms of new patient and review patient caseloads. There was a risk that care would be compromised and patient safety impacted.

Management actions included discussions at divisional level about the Attention Deficit Hyperactivity Disorder Service and the governance and improvement actions required across HSCP and Community Paediatrics. Interviews were held in September 2020 for Consultants and a Specialty Doctor; recruitment was successful and appointees were due to start this year, which will improve the staffing position.

Quality & Safety BAF
The Medical Director reported on the BAF to the Clinical Governance Committee (CGC) on14 January 2021. He assured the committee that there are systems and processes in place to monitor quality and safety, and that work relating to managing related risks continues.

He reported that a review of all high level risks relating to quality & safety is underway. Pending the outcome, there are currently no changes to the existing linked operational risks.

The Internal Audit plan for 2021-22 will consider the Quality & Safety BAF in line with assurance mapping principles, and assess whether the risk has been suitably updated to take account of the impact of COVID-19.

Strategic Planning BAF
The Director of Finance & Strategy reported on the above risk to F, P&R on12 January 2021 and to CGC on 14 January 2021.

There are five local key priorities for NHS Fife during 2020/21 aligned to the Clinical Strategy and Strategic Plan which underpin all aspects of the Health Board's strategic plan following the review of the integrated transformation programme:

1. Acute Services Transformation Programme
2. Joining Up Care - Community Redesign
3. Mental Health Redesign
4. Medicines Efficiencies
5. Integration and Primary Care

The priorities for the organisation will be reviewed and revised as part of the Strategic Planning Resource Allocation (SPRA) process, taking into account the COVID-19 environment, service redesign and change programmes. As previously reported, a full review of the Transformation programme and Strategic Planning has been undertaken in line with the Clinical Strategy and Remobilisation Plan. Due to the COVID -19 Emergency Planning Measures in place until 31 March 2021, the transformation work had been paused but will recommence when appropriate to do so; this will include a revised management and reporting structure.

Digital & Information BAF

The Medical Director reported on the above risk to the CGC on 14 January 2021.Its title has changed from eHealth Delivering Digital and Information Security **to** Digital &Information. As previously reported, the risk level and target score were high and moderate respectively.

Since the previous report to the Committee, no new high risks had been linked to the BAF. The following risks had been unlinked:

- 1929 - Inability to audit nhs.scot mail accounts - Risk closed; audits now available and continually monitored.
- 1928 - Deliberate unauthorised access or misuse to email by outsiders (Hackers etc.) - Risk reduced to 'moderate' after review based on implementation of improved security software upgrades and improvement in 'exposure' scores.

As reported previously, the assurance mapping exercise being undertaken by Internal Audit, Digital and Information leads and the Risk Manager has been reinstated although at a slow pace due to COVID.

The Committee was assured that systems and processes are in place to monitor D&I performance, and work continues to manage the risks.

Integration Joint Board (IJB)

The last report to the Committee indicated that a review of the Integration Scheme had recommenced which would include clarifying the delegation of functions to the IJB and specifically, the implications for risk management, governance and assurance.

In January 2021, the Director of Health and Social Care advised as follows:

A Governance Manual is currently being finalised. This seeks to bring all relevant governance information into one reference document for all IJB members and officers.

The Ministerial Strategic Group for Health and Community Care's report – Review of Progress with Integration of Health and Social Care published in February 2019 has been reviewed by the IJB and its partners to ensure they are incorporated in to the work that is ongoing within Fife.

A group, including representatives from NHS Fife, Fife Council and the HSCP, was set up to review the Integration Scheme. This review is focussing on governance arrangements and takes into account the actions from the Ministerial Strategic Group action plan and also the Scottish Government's Model Scheme for Integration. Although progress was hampered by the coronavirus pandemic, the review has continued with regular meetings held towards the end of 2020. It was anticipated the review would be completed by March 2021. Following completion of the review of the Integration Scheme, the IJB will undertake a further review of its Governance Framework and structures.

Following an initial development session on governance for officers and IJB members held in Nov 2019 facilitated by the Director of Delivery, Health and Social Care Integration, Scottish Government, a programme of development days took place from May 2020. At January 2021, four sessions had been completed with further sessions planned. Topics covered include: Governance, Directions, Roles and Responsibilities, the IJB Annual report, Remobilisation of Services, Leadership and Structures, Best Value and Performance.

Regular updates continue to be provided to the IJB and its Governance Committees and EDG and SLT. The risk score was unchanged at this time as work is ongoing to conclude the review of the Integration Scheme, which aims to support agreement and clarity across all partners.

Developments

In the coming months, the focus will be to further review and strengthen the Board's risk management arrangements, particularly the processes through which assurance is provided that these are operating effectively. This will include:

- assessing the extent to which the organisation's risk profile aligns with the strategic planning agenda
- updating the Board's risk appetite statement

Importantly, the sequencing of reporting will be reviewed in order to provide the committee with the most up to date position on the BAF.

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 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

Margo McGurk, Director of Finance and Strategy, on 19 April 2021 and EDG on 6 May 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 120121
- Appendix 2, NHS Fife BAF Environmental Sustainability - F,P& RC 120121
- Appendix 3, NHS Fife BAF Workforce Sustainability - SGC 130121
- Appendix 4, NHS Fife BAF Quality & Safety - CGC 140121
- Appendix 5, NHS Fife BAF Strategic Planning - CGC 140121 & F,P&R120121
- Appendix 6, NHS Fife BAF Integration Joint Board (IJB)
- Appendix 7, NHS Fife BAF Digital & Information - CGC 140121

Report Contact
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NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Financial Sustainability																											
1671	Sustainable	04/01/2021	5 February 2021	There is a risk that the funding required to deliver the current and anticipated future service models, particularly in the context of the COVID 19 pandemic, will 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 Risk	4 – Likely – Strong possibility this could occur	4 – Major	16	High Risk	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.	Margo McGurk Director of Finance	Finance, Performance & Resources (F,P&R) Rona Laing	*Ongoing actions designed to mitigate the risk including:* Implementation of the Strategic Planning and Resource Allocation (SPRA) process to underpin our Annual Operating Plan (AOP) process. 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.	Nil	1. Continue a relentless pursuit of all opportunities identified through the transformation programme in the context of sustainability & value. Responsible Person: Director of Finance / Director of Acute Services / Director of Health & Social Care Timescale: Ongoing 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 Responsible Person: Director of Finance Timescale: 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 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 second COVID 19 peak. The financial impact of COVID 19 is significant however we have now received full funding for 2020/21 Q1 additional costs and 70% of the forecast costs to the year-end. There is a significant challenge remaining however regarding undelivered savings as a consequence of COVID 19 and the IJB Risk-Share arrangement.	3 – Possible – May occur occasionally – reasonable chance	4 – Major	12	Moderate Risk	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.

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
1364	Efficiency Savings	Active	High	20	McGurk, Margo
1513	Financial and Economic impact of Brexit	Active	High	20	McGurk, Margo
1363	Health and Social Care Integration	Active	High	20	McGurk, Margo
1784	Finance (Short Term/Immediate)	Active	High	16	Connor, Nicky
522	Prescribing and Medicines Management - Prescribing Budget	Active	High	15	McKenna, Christopher

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
1357	Financial Planning, Management & Performance	No longer a high risk	Moderate	12	McGurk, Margo
1846	Test and Protect	No longer a high risk	Moderate	12	Connor, Nicky

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Environmental Sustainability																											
1672	Clinically Excellent, Sustainable	08/12/2020	5 February 2021	There is a risk that Environmental & Sustainability legislation is breached which impacts negatively on the safety and health of patients, staff and the public and the organisation's reputation.	4 - Likely – Strong possibility this could occur	5 - Extreme	20	High Risk	4 – Likely – Strong possibility this could occur	5 - Extreme	20	High Risk	Estates currently have significant high risks on the E&F risk register; until these have been eradicated this risk will remain. Action plans have been prepared and assuming capital is available these will be reduced in the near future.	Andrew Fairgrieve Director of Estates	Finance, Performance & Resources (F,P&R). Rona Laing.	*Ongoing actions designed to mitigate the risk including:* 1. Operational Planned Preventative Maintenance (PPM) systems in place 2. Systems in place to comply with NHS Estates 3. Action plans have been prepared for the risks on the estates & facilities risk register. These are reviewed and updated at the monthly risk management meetings. The highest risks are prioritised and allocated the appropriate capital funding. 4. The SCART (Statutory Compliance Audit & Risk Tool) and EAMS (Estates Asset Management System) systems record and track estates & facilities compliance. 5. Sustainability Group manages environmental issues and Carbon Reduction Commitment(CRC) process is audited annually. 6. Externally appointed Authorising Engineers carry out audits for all of the major services i.e. water safety, electrical systems, pressure systems, decontamination and so on.	Nil	1. Capital funding is allocated depending on the E&F risks rating Responsible person: Director of Estates, Facilities & Capital Services Timescale: Ongoing as limited funding available 2. Increase number of site audits Responsible person: Estates Compliance Manager Timescale: Ongoing	1. Capital Investment delivered in line with budgets 2. Sustainability Group minutes. 3. Estates & Facilities risk registers. 4. SCART & EAMS 5. Adverse Event reports.	1. Internal audits 2. External audits by Authorising Engineers 3. Peer reviews.	None.	High risks still exist until remedial works have been undertaken, but action plans and processes are in place to mitigate these risks.	1 – Remote – Can't believe this event would happen	5 - Extreme	5	Low Risk	All estates & facilities risk can be eradicated with the appropriate resources but there will always be a potential for failure i.e. component failure or human error hence the target figure of 5.

Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
1296	Emergency Evacuation, VHK Phase 2 Tower Block	Active Risk	High Risk	20	Fairgrieve, Andrew
1252	Flexible PEX hoses in PHASE 3 VHK	Active Risk	High Risk	15	Fairgrieve, Andrew
1007	Theatre Phase 2 Remedial work	Active Risk	High Risk	15	Cross, Murray

Previously Linked Operational Risk(s)

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

NHS Fife Board Assurance Framework (BAF)

					Initial Score				Current Score													Target Score				
Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Likelihood (Initial)	Consequence (Initial)	Rating (Initial)	Level (Initial)	Likelihood (Current)	Consequence (Current)	Rating (Current)	Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Likelihood (Target)	Consequence (Target)	Rating (Target)	Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Workforce Sustainability																										
1673	Exemplar Employer	13/12/2020	5 February 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 Risk	4 – Likely – Strong possibility this could occur	4 – Major	16	High Risk	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.	Linda Douglas Director of Workforce	Staff Governance Margaret Wells	*Ongoing actions designed to mitigate the risk including:* 1. • Implementation and revision of the Workforce Strategy to support the Clinical Strategy and Strategic Framework. 2. • Implementation and revision 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" and the associated values and behaviours. 4. • Establishment of a Bronze Workforce Group to consider the impact on the workforce in respect of the EU Exit. Organisational support to affected employees is still being provided and publicised. 5. • Implementation of eESS as a workforce management system within NHS Fife 6. • 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. Initial university liaison sessions held to secure next year's graduates. 7 • 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, including a single bank for NHS Fife. NHS Fife currently has COVID-19 supplementary staffing resources deployed to support the substantive workforce where the need is greater, thereby reducing external costs on staffing. 8. • 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, Regional Workforce Group, Physicians Associates Group and International Medical Recruitment campaigns. 9. • 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, 10. • Well@Work and staff HWB initiatives continue to support the health and wellbeing of the workforce, facilitating early intervention to assist staff experience and retain staff in the workplace, along with Health Promotion and the OH and Wellbeing Service. This has been expanded to take account of COVID-19 HWB initiatives and with investment in our OH service. 11. • The iMatter 2020 cycle has been paused during the COVID-19 pandemic with a Pulse Survey run instead and reports available in December 2020. Staff engagement activity is being evaluated to reflect the impact of the pandemic. 12. • Staff Governance and Partnership working underpins all aspects of workforce activity within NHS Fife and is key to development of the workforce. 13. • Training and Development: 14. • Development of the Learning and Development Framework strand of the Workforce Strategy. 15. • Leadership and Management development provision is constantly under review and updated as appropriate to ensure continuing relevance to support leaders at all levels. 16. • Improvement to be achieved in Core Skills compliance to ensure NHS Fife meets its statutory obligations. 17. • The implementation of the Learning Management System module of eESS to ensure all training and development data is captured and to facilitate reporting and analysis. 18. • Continue to address the risk of non compliance relating to TURAS Appraisal. 19. • Utilisation of the Staff Governance Standard and Staff Governance Action Plans,(the "Appropriately trained" strand) is utilised to identify local priorities and drive local actions. 20. • The development of close working relationships with L&D colleagues in neighbouring Boards, with NES and Fife Council to optimise synergistic benefits from collaborative working.	Nil	(1-3) 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. (4-5) Implementation of proactive support for the workforce affected by the EU Exit. Early renewal of UKVI Sponsor Licence and successful increase in numbers of Certificates of Sponsorship to support future recruitment activity as required. Communication with and support for recruiting managers. (6) 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. (7-10) Strengthen workforce planning infrastructure ensuring a co-ordinated and cohesive approach is 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 Workforce Planning Group, now established. These groups will take account of recent and anticipated SG guidance on Integrated Workforce Planning. (11-12) 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 learned from COVID-19 health and wellbeing activities and initiatives and the continuation of these supports in the long term and from investment in our OH service. (13) Optimise use of iMatter process and data to improve staff engagement and retention. As agreed Nationally, a Pulse Survey ran instead of iMatter in September 2020, Directorate and Board level reports were available in December 2020, with relevant managerial actions being considered, but will not include team reports. (14) Continue to implement and promote Staff Governance Action plans and staff engagement, through the Pulse Survey in 2020. (15-17) Implementation of the Learning and Development Framework strand of the Workforce Strategy. Increased utilisation of virtual learning opportunities. (18) Review of L&D processes, planning and resources to ensure alignment to priorities. (19) Full roll out of Learning Management self service (20) Continuing implementation of the KSF Improvement and Recovery Plan throughout the Board, led by EDG. (21) Responsible Person: Director of Workforce / Partnership (22) Responsible Person: Director of Workforce	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, in particular the Workforce strategy supporting the Clinical Strategy and the implementation of eESS, should provide appropriate levels of control.	2 – Unlikely – Not expected to happen – potential exists	2 – Minor	4	Low Risk	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.

Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
1652	Lack of Medical Capacity in Community Paediatric Service	Active Risk	High Risk	25	Couser, Gemma
1324	Medical staff recruitment and retention	Active Risk	High Risk	16	Kennedy, John
90	National Shortage of Radiologists	Active Risk	High Risk	16	Anderson, Jane

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
503	Diabetes	Closed Risk			
1042	Staffing Levels	Active Risk	Moderate Risk	12	Nolan, Karen
1349	Service Provision - GP locums may no longer wish to work for NHS Fife Salaried Practices	Closed Risk			
1353	Service Provision - Shortfall in GP Cover will limit service provision	Closed Risk			
1375	Breast Radiology Service	Active Risk	Moderate Risk	12	Cross, Murray
1420	Loss of consultants	Active Risk	Moderate Risk	12	Harkins, Nicola
1846	Test and Protect	Active Risk	Moderate Risk	12	Connor, Nicky
1858	workload resulting from deterioration in mental health	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?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Quality & Safety																											
1674	Clinically Excellent, Person Centred	30/12/2020	5 February 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 Risk	3 – Possible – May occur occasionally – reasonable chance	5 - Extreme	15	High Risk	Failure in this area could have a direct impact on patients' health, organisational reputation and exposure to legal action. While it is recognised that several adverse events ranging from minor to extreme harm can occur daily, the proportion of these in relation to overall patient activity is very small.	Christopher McKenna Medical Director	Clinical Governance Dr Les Bisset	*Ongoing actions designed to mitigate the risk including:* 1. Strategic Framework 2. Clinical Strategy 3. Clinical Governance Structures and operational governance arrangements 4. Clinical & Care Governance Strategy 5. Participation & Engagement Strategy 6. Risk Management Framework 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 28. Revalidation programmes for professional staff 29. Electronic dissemination of safety alerts	1.Reviewing together of patient experience, complaints, adverse events and risk information to provide an overview of good practice, themes, trends, and exceptions to the norm. 2.Weaknesses in the process for recording completion of actions from adverse event reviews including evidence of steps taken to implement and share learning from actions. 3.Weaknesses in related oversight and monitoring processes at operational level. 4.Risk Management Framework has been updated; it is still to be rolled out.	1. Give due consideration to how to balance the remobilisation of clinical services and manage staff and public expectations, while dealing with the ongoing COVID-19 pandemic. 2. Continually review the Integrated Performance and Quality (IPQR) to ensure it provides an accurate, current picture of clinical quality / performance in priority areas. 3. Refresh the extant Clinical Governance structures and arrangements to ensure these are current and fit for purpose. 4..Review the coverage of mortality & morbidity meetings in line with national developments and HIS 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. 7. Review 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. internal audit, external peer and 'deep dives'.	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 – Not expected to happen – potential exists	5 - Extreme	10	Moderate Risk	The organisation can identify the actions required to strengthen the systems and processes to reduce the risk level.

Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
1652	Lack of Medical Capacity in Community Paediatric Service	Active Risk	High Risk	25	Couser, Gemma
1667	Infusion pumps, volumisers and Syringe Divers in Paediatrics and Neonatal Units	Active Risk	High Risk	25	Holloway, Lynne
43	Vascular access for heamatology/Oncology	Active Risk	High Risk	20	Savage, Shirley-Anne
1296	Emergency Evacuation, VHK Phase 2 Tower Block	Active Risk	High Risk	20	Fairgrieve, Andrew
1514	Impact of the UK's withdrawal from the EU on the availability and cost of medicines and medical devices	Active Risk	High Risk	20	Garden, Scott
521	Capacity Planning	Active Risk	High Risk	16	Watts, Miriam
529	Information Security Risk	Active Risk	High Risk	16	McGurk, Margo
1287	Overcapacity in AU1 Assessment Unit	Active Risk	High Risk	16	Shepherd, Angie
1365	Cancer Waiting Times Access Standards	Active Risk	High Risk	15	Couser, Gemma
1515	Impact of the UK's withdrawal from the EU on Nuclear Medicine and the ability to provide diagnostic and treatment service(s)	Active Risk	High Risk	15	Anderson, Jane
1670	Temperature within fluid storage room within critical care.	Active Risk	High Risk	15	Watts, Miriam

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
356	Clinical Pharmacy Input	Closed Risk			
528	Pandemic Flu Planning	Active Risk	Moderate	12	Milne, Dona
637	SAB LDP standard	Active Risk	Moderate	9	Cook, Julia
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?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Strategic Planning																											
1675	Clinically Excellent, Exemplar Employer, Person Centred, Sustainable	05/01/2021	1 March 2021	There is a risk that NHS Fife will not deliver the Clinical Strategy within a timeframe that supports the service transformation and redesign required to ensure service sustainability, quality and safety at lower cost with the consequence that the Clinical Strategy does not reflect current priorities. Key Risks 1. Community/Mental Health redesign is the responsibility of the H&SCP/IJB which hold the operational plans, delivery measures and timescales 2. Governance of the transformation programmes remains between IJB and NHS Fife. 3. Regional Planning - risks around alignment with regional plans are currently reduced as regional work is focussed on specific workstreams 4. Clinical Strategy does not reflect that the strategic direction of the organisation following the COVID-19 pandemic.	4 – Likely – Strong possibility this could occur	4 – Major	16	High Risk	4 – Likely – Strong possibility this could occur	4 – Major	16	High Risk	Integrated Transformation Board now 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. Programme management approach being refreshed through Strategic Planning Resource Allocation (SPRA) process.	Margo McGurk Director of Finance	Clinical Governance. Dr Les Bisset.	*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 strategic guidance to the programme. Collaborative oversight is provided by the ITB. 4. The annual Service Planning Reviews and regular Performance and Accountability Reviews of individual services supported this process but has now been replaced by the SPRA process. CONTROLS WILL BE REVIEWED DURING REMOBILISATON OF SERVICES WHICH WILL INCLUDE TRANSFORMATION AND REDESIGN WORK	Pause in governance of transformation since COVID-19 – will be restarted when services are remobilised.	Leadership to strategic planning coming from the Executive Directors Group. Clinical Strategy workstream update has been produced to reflect progress against recommendations. Establishment of governance group 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. Refresh of the Clinical Strategy has been paused over COVID-19. Programme management approach being refreshed through Strategic Planning Resource Allocation (SPRA) process. ON HOLD OVER COVID19 PERIOD Responsible Person: Director of Finance Timescale: 31/03/2021	1. Minutes of meetings record attendance, agenda and outcomes. 2. New governance in place with newly formed governance group. 3. Performance and Accountability Reviews now underway which will provide assurance to committees on performance of all services. 4. Reporting of key priorities to governance groups from the SPRA process .	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 approach to programme management. Risks to delivery have been identified at Programme level and mitigating actions are in place and regularly monitored.	Current challenges associated with delivery of our strategic objectives – key priorities to be agreed but on hold given emergency planning measures still in place. ON HOLD OVER COVID19 PERIOD. WILL BE RESTARTED AS PART OF REMOBILISATION	3 – Possible – May occur occasionally – reasonable chance	4 – Major	12	Moderate Risk	Once governance and monitoring is in place and transformation programmes are being realised, the risk level should reduce. WILL BE REVIEWED AFTER COVID19 PERIOD.

Linked Operational Risk(s)

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

Previously Linked Operational Risk(s)

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

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Integration Joint Board																											
1676	Sustainable	10/12/2020	29 January 2021	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 Risk	3 – Possible – May occur occasionally – reasonable chance	4 – Major	12	Moderate Risk	The level of risk has been actively reviewed and, as there is considerable work ongoing to support the conclusion of the Integration Scheme review and this is being regularly monitored, the risk score has been maintained at a moderate level. If timescales slip then the risk score will be reviewed upwards in January 2021	Nicky Connor Director of Health & Social Care	NHS Fife Board. Tricia Marwick.	*Ongoing actions designed to mitigate the risk including:* 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. 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 and is due to complete in March 2021. 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. A programme of development days has been progressed since May 2020. Four sessions have been completed to date with further sessions planned. Topics covered include: Governance, Directions, Roles and Responsibilities, the IJB Annual report, Remobilisation of Services, Leadership and Structures, Best Value and Performance. 8 The level of risk has been actively reviewed and, as there is considerable work ongoing to support the conclusion of the review and this is being regularly monitored, the risk score has been maintained at a moderate level. If timescales for the review completion were to slip then the risk score will be reviewed upwards in January 2021.	Nil	Nothing more to be done than the ongoing actions set out. Responsible Person: Director of Health & Social Care	1. Through regular updates to SLT and EDG about the progress of the reviews. 2. Updates to Audit & Risk Committees, the Integration Joint Board (IJB) and NHS Fife. .	1. • The views of auditors will be the key independent assurance mechanism around this risk. We will involve them in the work to clarify governance arrangements as it progresses. 2. • Scottish Government will also provide useful advice and an independent perspective on the work to be carried out.	None.	The problem should be largely resolved with the action taken.	1 – Remote – Can't believe this event would happen	4 – Major	4	Low Risk	Once resolved and given effect to in IJB integration scheme and NHS Fife corporate governance arrangements, the issue should largely be resolved. But given maturity of relationships and dynamics around regional approaches a remaining risk will remain..

Linked Operational Risk(s)

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

Previously Linked Operational Risk(s)

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

NHS Fife Board Assurance Framework (BAF)

Board Assurance Framework (BAF) - Digital & Information

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
1677	Clinically Excellent, Exemplar Employer, Person Centred, Sustainable	15/12/2020	16 February 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 Risk	3 – Possible – May occur occasionally – reasonable chance	5 - Extreme	15	High Risk	Failure in this area could have a direct impact on patients care, organisational reputation and exposure to legal action. While it is recognised that several adverse events ranging from minor to extreme can occur daily, the proportion of these in relation to overall activity is very small and reporting to competent authorities is minimal.	Christopher McKenna, Medical Director	Clinical Governance, Finance Performance & Resources (FP&R) Dr Les Bisset (CGC), Rona Laing (FP&R)	*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) 8. Performance reports and availability of data through dashboards 9. Performance Review 10. System for writing and reviewing all policies and procedures 11. Participation in national and local audit 12. Work to improve the resilience of key digital systems and develop robust technical recovery procedures and regular failover (DR) testing. 13. Commitment to ensure appropriate implementation of Cyber Defence Measures, including support of national centralised cyber incident reporting and co-ordination protocols. 14. Staff Learning & Development, both eHealth staff and the wider organisation including leadership skills. 15. Robust Business Case development to include costed resilience by design and ongoing support activities. 16. Enhancing monitoring of our digital systems. 17. Working towards strong governance and procedures following ITIL professional standards 18. Development and Implementation of the NHS Fife Information and Digital Technology Strategy 2019 - 2022	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. Responsible Person: Lesly Donovan Timescale: 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 Annual - Digital Maturity Assessment	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 – Not expected to happen – potential exists	5 - Extreme	10	Moderate Risk	1. Difficulty in securing investment in people, tools and maintaining systems that are resilient and always within support cycles. 2. Fully implementing resistance to attack through 'resilience by design', well practised response plans and recovery procedures. 3. Reduce the 'human factor' through ongoing 'user base education' and improving organisational digital readiness. 4. Enhanced controls and continuing improvements to systems and processes for improved usage, monitoring, reporting and learning are continually being put in place. Aim for Moderate Risk as target rather than Low Risk is due to the fact that likelihood whilst unlikely may still happen and consequence will be extreme due to level of fines that may be imposed, reputational damage and patient harm.

Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
1504	Lack of a central IT location to store guidance documents	Active Risk	High Risk	20	McKenna, Christopher
1422	Unable to meet NIS & Cyber Essentials compliance	Active Risk	High Risk	20	Young, Allan
1338	End of support lifecycle for Microsoft Office 2007	Active Risk	High Risk	16	Young, Allan
1424	End of support lifecycle for Microsoft Server Products	Active Risk	High Risk	16	Young, Allan
529	Information Security Risk	Active Risk	High Risk	16	McGurk, Margo
1746	O365 May Cause Disruptive Network Overhead	Active Risk	High Risk	16	Young, Allan
1393	Patch Management Risk	Active Risk	High Risk	16	Young, Allan
1576	Risk of not meeting SaMD full compliance	Active Risk	High Risk	16	McKenna, Christopher
226	Security of data being transferred off/on site	Active Risk	High Risk	16	Donovan, Lesly
1927	T1 - Deliberate unauthorised access or misuse by insiders (staff, contractors etc.)	Active Risk	High Risk	16	Fowles, Malcolm
1932	T4 - User error (including those supporting system)	Active Risk	High Risk	16	Fowles, Malcolm
1934	T9 - Network connection failures	Active Risk	High Risk	16	Young, Allan
537	Failure of Local Area Network causing loss of access to IT systems	Active Risk	High Risk	15	Young, Allan

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
913	MIDIS replacement	Closed Risk			
1928	T2 - Deliberate unauthorised access or misuse by outsiders (e.g. hackers)	Active Risk	Moderate Risk	12	Young, Allan
1929	T7 - Inadequate or absent audit trail	Closed Risk			

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**13 May 2021**
Title:	**Risk Management Key Performance Indicator (KPI) Report**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy and Dr Chris McKenna, Medical Director**
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 the organisation is on track to meet its objectives. This report provides an update on performance since the previous report in January 2021.

2.2 Background

NHS Fife agreed to introduce risk management KPIs to strengthen the governance around key elements of risk management activity and as a mechanism through which to give additional assurance on the adequacy and effectiveness of its risk management systems. 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. Data presentation is under review. As previously reported, further consideration is being given to the adverse event data within the Board Integrated Quality and Performance Report (IPQR).Any developments will be reported in the next update to the committee.

All services currently have access to risk management information in Datix for their areas of responsibility. The Risk Management team provides the necessary training and support.

Initial discussions have taken place with Directors to clarify the processes governing risk management arrangements at service, directorate and divisional levels. These discussions will Inform the further development of organisational arrangements in 2021.

In response to the Adverse Event Management audit B19/20, several improvement actions have been agreed. The audit findings will be shared with services across the organisation and the actions will be discussed and refined in consultation with key stakeholders, and to ensure the improvements are implemented. The specific responses will be reported to the committee as part of the final audit report. Key areas for action include the following:

- Visibility of Data
- Datix System
- Training and Education
- Governance & Oversight
- SAER Process
- Clinical Governance Strategy

2.3.1 Quality/ Patient Care

Effective risk management, including adverse event review, identifies opportunities for improvement and innovation, e.g. by highlighting gaps in capacity, procedures or services, and actions to avoid, prevent and reduce risk, enhance service delivery and 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 20 April 2021. All KPI s were shared with the Director of Finance and Strategy and the Medical Director on 19 April 2021*.

2.3.8 Route to the Meeting

As above* and EDG on 6 May 2021.

2.4 Recommendation

Discussion – Examine and consider the implications of a matter.

3 List of appendices

Appendix 1, Risk Management KPI Report to Audit & Risk Committee on 13 May 2021

Report Contact
Author Name: Pauline Cumming
Author's Job Title: Risk Manager, NHS Fife
Email Pauline.Cumming@nhs.scot

Risk Management KPI Report to the Audit & Risk Committee on 13 May 2021

Report Criteria
Risks - KPI 1 to 3 - All Active Risks as at 25/02/2021
Risks - KPI 4 - BAF reports to Committees as at 25/02/2021
Adverse Events - KPI 5 - where event reported 01/03/2020 to 28/02/2021
Adverse Events - KPI 6a / 6b / 6c - where event closed 01/03/2020 to 28/02/2021
Adverse Events - KPI 7 - where event reported 01/04/2018 to 28/02/2021

KPI 1:

All risks are within timescale for review:

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	577	368	64	100

1. **Note:** Previously 597 risks at 63% compliance

There is still room for improvement in relation to the timely review and update of risks. Performance continues to be affected in part due to the impact of the pandemic on workload. As previously reported, there is a need to clarify oversight and governance arrangements and identify the measures and support required to improve performance.

KPI 2:

All risks must have a review date scheduled commensurate with the assessed risk level:

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	577	Very High (25)	6	2	33	296	51	100
			High (15-20)	74	36	49			
			Moderate (8-12)	341	155	45			
			Low (4-6)	144	93	65			
			Very Low (1-3)	11	10	91			
			No value	1	N/A	#VALUE!			

2**. Note:** Previously 597 at 52% compliance

KPI 3:

Length of time 'Very High' level risks have been at that level:

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)	6	Number of risks open <= 1 year	5	83	Very High (25)	4	80	100
							High (15-20)	0	0	
							Moderate (8-12)	1	20	
							Low (4-6)	0	0	
							Very Low (1-3)	0	0	
				Number of risks open >1 year	1	17	Very High (25)	1	100	100
							High (15-20)	0	0	
							Moderate (8-12)	0	0	
							Low (4-6)	0	0	
							Very Low (1-3)	0	0	

Length of time 'High' level risks have been at that level:

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)	74	Number of risks open <= 1 year	29	39	Very High (25)	3	10	100
							High (15-20)	24	83	
							Moderate (8-12)	2	7	
							Low (4-6)	0	0	
							Very Low (1-3)	0	0	
				Number of risks open >1 year	45	61	Very High (25)	1	2	100
							High (15-20)	38	84	
							Moderate (8-12)	6	13	
							Low (4-6)	0	0	
							Very Low (1-3)	0	0	

3. The Risk Manager requires to follow up on the initial discussions held with Directors towards the end of 2020, and to engage with them and their teams to address their risk management training and education needs and thereby support more effective systems for managing risk.

KPI 4:

A bi monthly Board Assurance Framework (BAF) report is submitted bi monthly to the aligned governance committee:

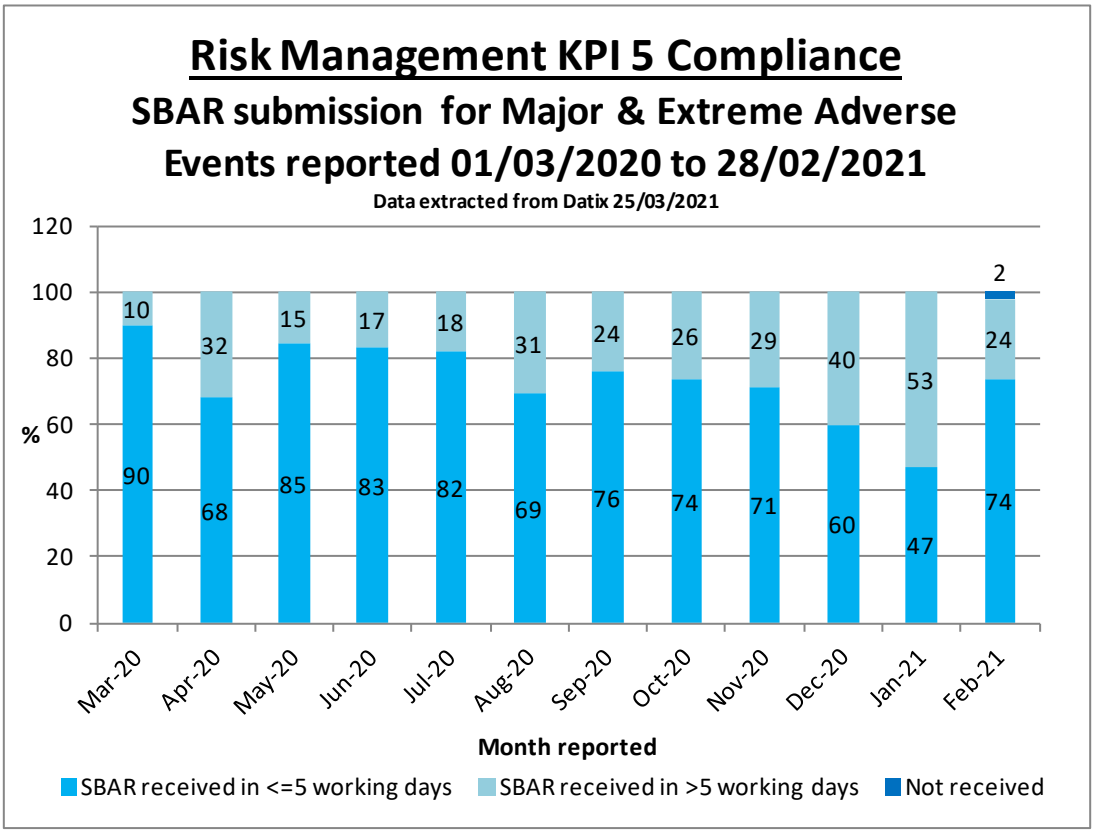
Committee		Jan-20	Mar-20	May-20	Jul-20	Sep-20	Nov-20	Jan-21
Finance, Performance & Resources (FPR)								
BAF	Financial Sustainability	√	√	*	√	√	√	√
	Environmental Sustainability	√	√	*	√	√	√	√
	Strategic Planning	√	√	*	√	√	√	√
Clinical Governance (CGC)								
BAF	Quality & Safety	√	√	*	√	~	√	√
	Digital & 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.

The BAF reports were not submitted to the March 2021 governance committees as the agendas were prioritised to COVID -19 related business.

KPI 5:

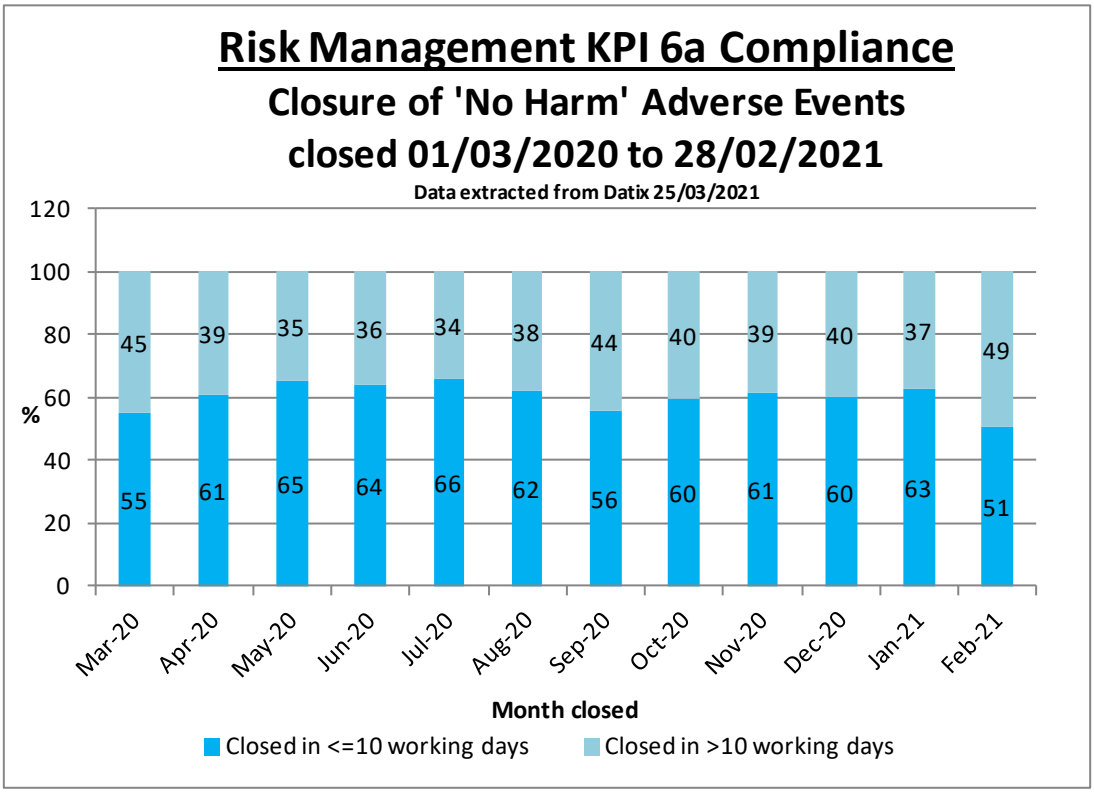
Decision Making SBAR for Major and Extreme Adverse Events should be submitted in line with Adverse Events Policy GP/I9 - within 5 working days of reported date (or upgraded if applicable)



Performance dropped considerably between November 2020 and January 2021 but has now started to recover. The reasons for reduced performance were not formally interrogated but can be attributed to high levels of activity and the impact of the pandemic.

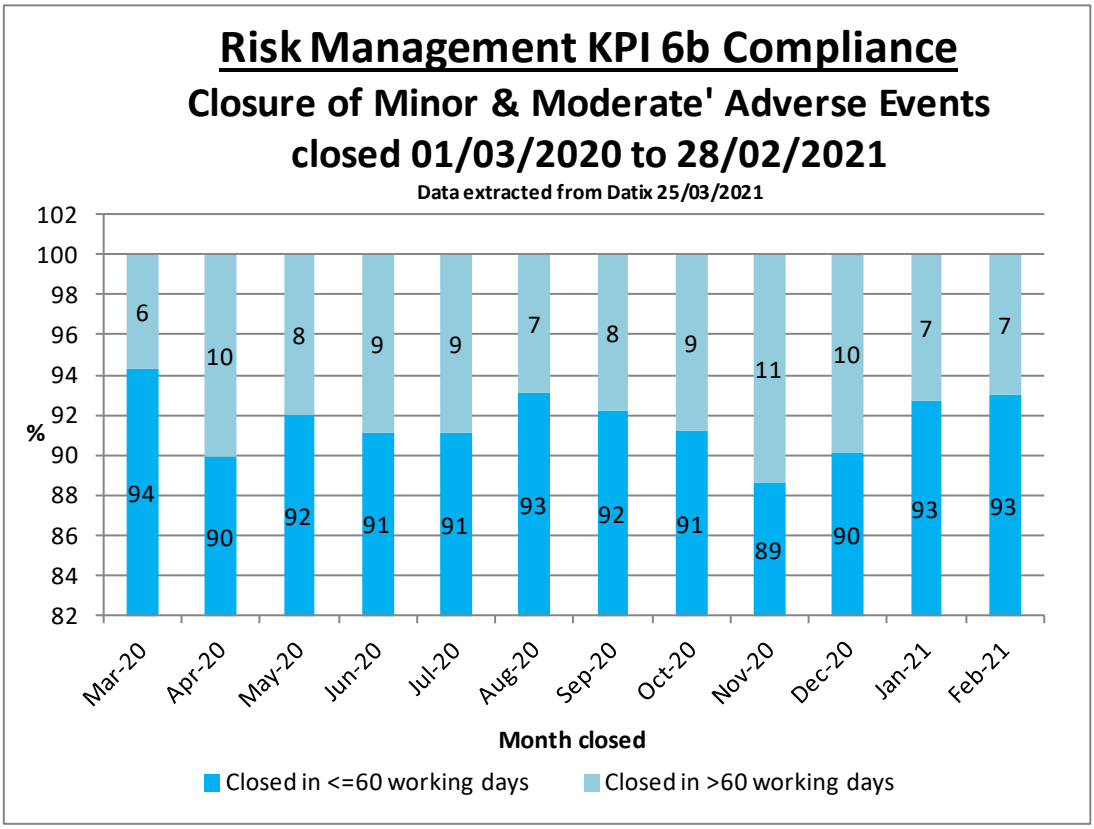
KPI 6a:

Adverse Events with severity reported as 'No Harm' should be closed within 10 working days of reported date.



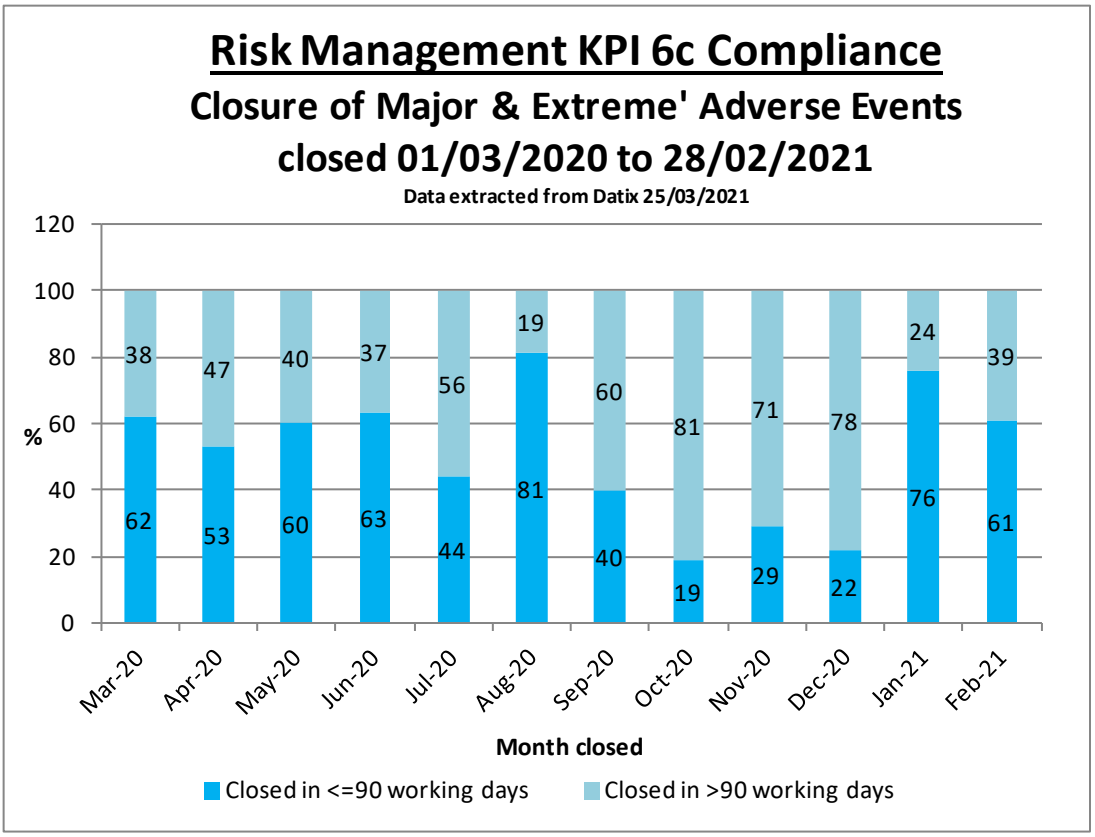
KPI 6b:

Adverse Events with severity reported as 'Minor' or 'Moderate' should be closed within 60 working days of reported date.



KPI 6c:

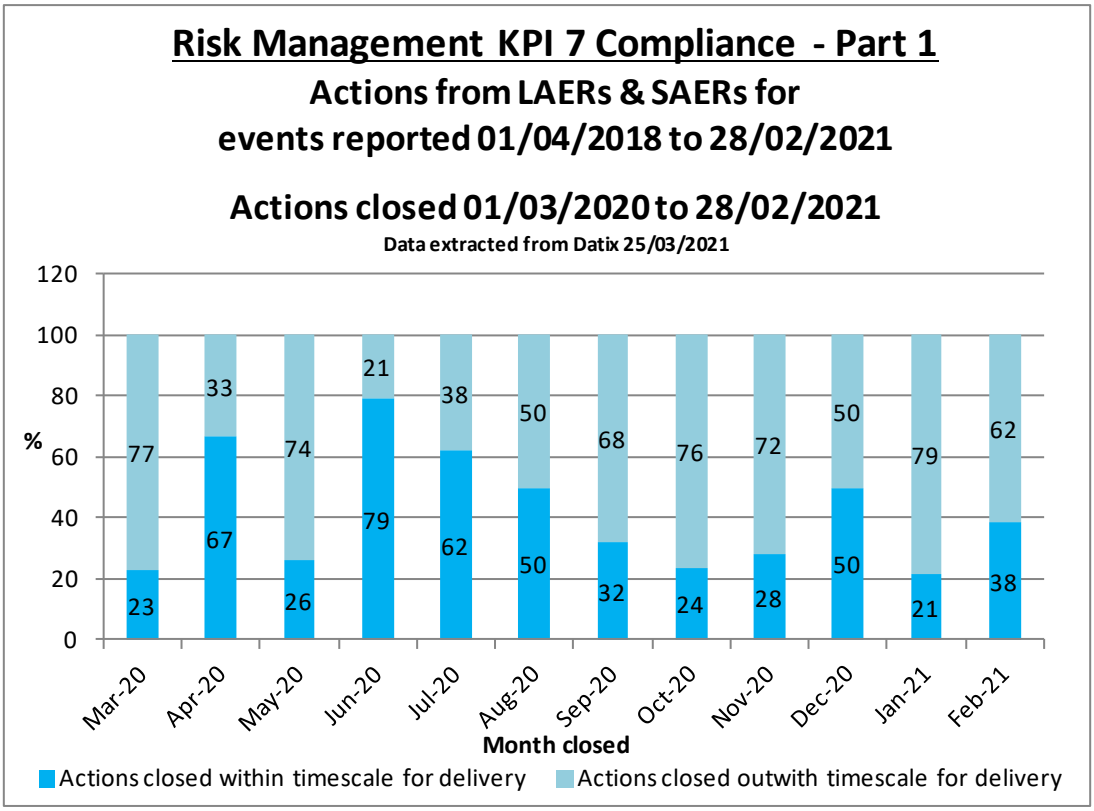
Adverse Events with severity reported as 'Major' or 'Extreme' should be closed within 90 working days of commissioned date.

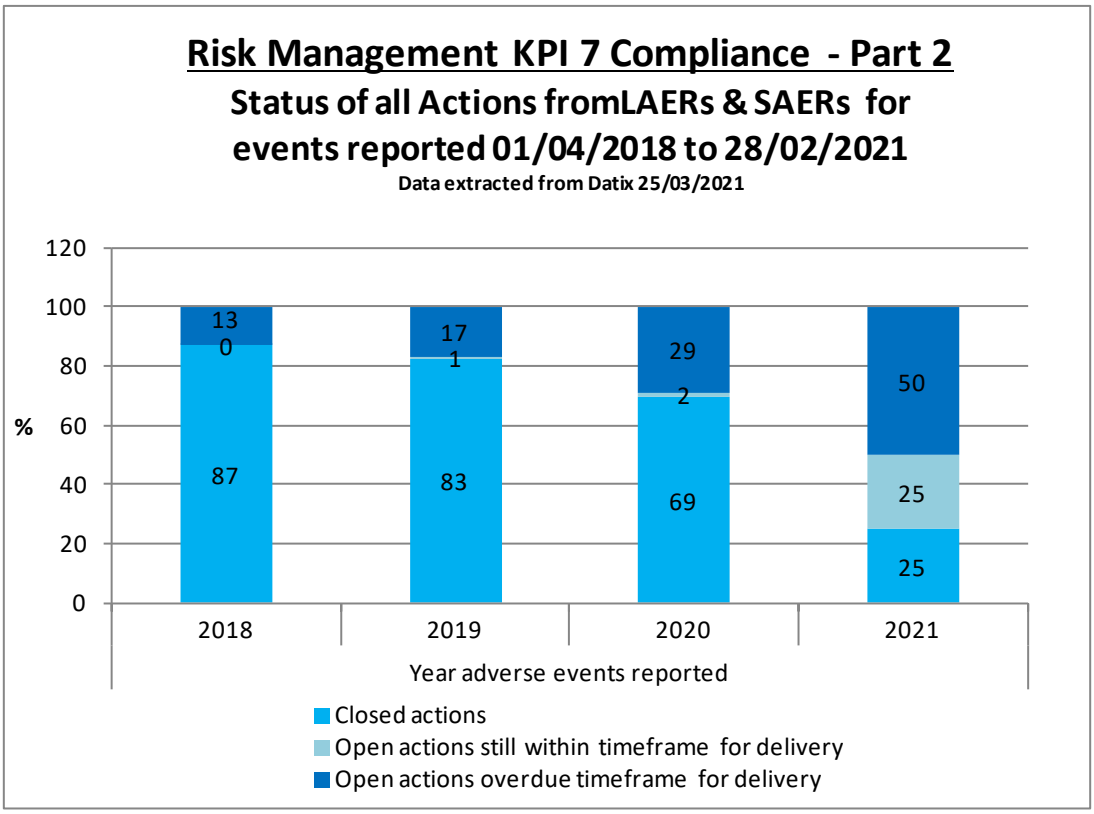


6a), 6b) & 6c).The Board Medical and Nurse Director have continued to reinforce the expectation that **all** adverse events will have timely reviews, action completion and closure, in accordance with local Policy GP/I9 and the national framework for adverse event management.

The Associate Medical and Nurse Directors and other senior managers monitor performance through their local governance arrangements, and the Adverse Events & Duty of Candour Group continues to maintain an overseeing role. In the aftermath of the most recent phase of the pandemic, an adverse events recovery plan is being developed. This schedules significant adverse event reviews according to service prioritisation and executive approval. A review of Policy GP/19 and related processes is also underway.

KPI 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)





In response to the Adverse Event Management Audit B19/20, several further improvement actions have been agreed.

The processes for reporting the status of actions through local governance routes are evolving. This information is now included in the reports which the directorates present to the Acute Services Division Clinical Governance Committee. The HSCP are also extending their reporting to include outstanding actions.

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**13 May 2021**
Title:	**Update on NHS Fife Risk Management Workplan for 2020-2021**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Report Author:	**Pauline Cumming, Risk Manager**

1 Purpose

This is presented to EDG for:

- Awareness

This report relates to a:

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

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

- Effective

2 Report summary

2.1 Situation

This report provides the Committee with an update on progress against the NHS Fife Risk Management Workplan 2020-21 since the last report on 17 September 2020.See Appendix 1.

2.2 Background

The Workplan identifies the key pieces of work to be accomplished against stated timescales. The Committee requires assurance that the activities have been completed.

2.3 Assessment

STANDARD REPORTING TO THE AUDIT & RISK COMMITTEE

The Committee is asked to note the following specific updates:

Corporate Risk Register (CRR)

Since 2017, the Board Assurance Framework (BAF) has superseded the CRR as the key document subject to governance committee and Board scrutiny. In January 2021, the former Executive Lead for Risk Management presented a proposal to reposition the CRR as a key component of the board's risk management system to the Executive Directors' Group (EDG). Due to other pressing items of business, it was not possible to fully consider the proposal. Further discussion with EDG is required to conclude this piece of work which will be subject to a high level Internal Audit review in the coming months.

Board Assurance Framework (BAF)

A report on the BAF is provided separately to the Committee.

Risk Management Key Performance Indicators (KPI)

A report on the KPIs is provided separately to the Committee.

RISK MANAGEMENT ACTIVITY

Risk Appetite

The Board agreed its risk appetite in November 2019. The risk appetite statement was due to be reviewed and updated by the end of November 2020. This activity was delayed due to competing priorities arising from the coronavirus pandemic. Further work is required to develop this fully and to agree an updated risk appetite statement. The review process will be scheduled in the next few months and will consider afresh, the level and types of risk the Board is prepared to take to deliver on the strategic priorities in the context of the prevailing conditions and the organisation's attitude to risk.

Assurance Arrangements

The proposed transfer of the BAF process from manual to Datix was achieved in September 2020.

In line with assurance mapping principles, the Digital & Information (D&I) BAF has been reviewed and updated by the former General Manager for D&I, in collaboration with Internal Audit and the Risk Manager. It now requires to be considered by the Associate Director of Digital and Information and the responsible Executive, the Medical Director, NHS Fife, prior to submission for approval and assurance via EDG and the governance routes of the Board.

The Quality & Safety BAF is scheduled for review as part of Audit B19/21 in line with assurance mapping principles; this will include an assessment of whether the risk has been appropriately updated to take account of the impact of COVID 19.

Further work to strengthen assurance arrangements across the Board will be carried out and reported on by November 2021.

Developments

A proposal to appropriately raise the profile of risk management through integration with the strategic planning process, deliver the risk management portfolio and enable the

organisation to achieve its strategic priorities, will be considered by the EDG in May 2021 and will be submitted to the Committee for consideration and assurance in July 2021

This will include consideration of the risk management resource required to:

- ensure there is appropriate capacity to deliver the coordination and delivery of the central risk management function and responsibilities
- implement a structured approach to the review and management of risks through appropriate governance structures
- align the organisational risk profile to the strategic planning agenda
- agree an annual Board risk appetite statement; stating the type and level of risks to be eliminated, tolerated or managed based on an assessment of the balance of risk versus reward
- apply assurance mapping principles to the spectrum of the organisation's business
- continue to promote a just culture to encourage the proactive identification and mitigation of risk from ward to Board

2.3.1 Quality/ Patient Care

Risk management seeks to minimise risk and support the delivery of safe, effective, person centred care.

2.3.2 Workforce

The arrangements for risk management are contained within current resource. Effective risk management should empower staff to make decisions and improvements to ensure risks are identified and addressed, enhance the working environment, protect health and wellbeing and reduce staff exposure to risk.

2.3.3 Financial

There are no specific financial implications associated with this paper. Proportionate management of risk should assist in the efficient and effective use of scarce resources. There is likely however to be an additional financial investment to secure the capacity arrangements required going forward and this will be addressed in the review being considered by EDG.

2.3.4 Risk Assessment/Management

The paper relates directly to activities intended to provide appropriate assurance to the NHS Board.

2.3.5 Equality and Diversity, including health inequalities

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

2.3.6 Other impact

Not applicable

2.3.7 Communication, involvement, engagement and consultation

Not applicable

2.3.8 Route to the Meeting

This paper has been considered in draft by the Director of Finance and Strategy

2.4 Recommendation

The paper is provided for:

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

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Risk Management Workplan Update 2020 - 2021 to NHS Fife Audit and Risk Committee on 130521 V1.0

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Appendix 1

RISK MANAGEMENT WORK PLAN 2020 - 2021

REPORTING TO THE AUDIT & RISK COMMITTEE			
ACTION	**TARGET DATE**	**STATUS**	**REVISED DATE**
Quarterly report on Corporate Risk Register	March 2021,Sept 2021, Dec 2021	Work in progress	June 2021
Quarterly report on Board Assurance Framework	March 2021, Sept 2021, Dec 2021	Reported on 13/05/21	
Quarterly report on Risk Management Key Performance Indicators	March 2021, Sept 2021, Dec 2021	Deferred from March 2021. Reported on 13/05/21	
6 monthly report against Risk Management Work Plan	March 2021, Sept 2021, March 2022	Deferred from March 2021. Reported on 13/05/21	
Risk Management Annual Report 2020-21	June 2021		

RISK MANAGEMENT ACTIVITY

ACTION	**TARGET DATE**	**STATUS**	**REVISED DATE**
Develop Risk Management Framework launch programme and implement.	End Oct 2020	Key elements of the framework are still to be agreed e.g. Corporate Risk Register and risk appetite.	Sept 2021
Review the governance infrastructure and processes, including the accountability arrangements that support risk management across the organisation.	End Nov 2020	In progress	Sept 2021
Undertake a wholesale review of the organisation's risk registers and current risk profile.	End Nov 2020	In progress. Initial review of risks carried out with Directors Nov/ Dec 2020.	Sept 2021
Review and update the risk appetite statement.	End Dec 2020	Work delayed and to be rescheduled.	Sept 2021
Embed risk appetite and tolerance across the	March 2021	See above	Nov 2021

organisation.			
Strengthen assurance arrangements and specifically the structure, content and governance arrangements associated with the Board Assurance Framework.	March 2021	Work in progress	Nov 2021
Analyse risk management training needs, refresh existing resources, and provide training according to staff group and role requirements in order to support delivery of the Risk Management Framework.	March 2021	Not started	Nov 2021
Overhaul Datix Risk Register Module incl BAF structure.	End Nov 2020	Work in progress	Sept 2021
Transfer Legal Services Claims activity from Datix Rich Client to DatixWeb.	End Dec 2020	Complete 31/03/21	N/A
Complete the transfer of Complaints module to DatixWeb.	End Dec 2020	Complete 31/03/21	N/A
Continue to develop the Datix IT Risk Management system to ensure it remains fit for purpose and supports organisational requirements.	N/A	Business as usual	N/A
Further develop the management and learning from adverse events in line with national framework & local policy.	N/A	Business as usual	N/A
Continue to support organisational Duty of Candour implementation including the production of the Year 3 Duty of Candour Annual Report in line with legislative requirements.	June 2021	Business as usual	N/A