AGENDA

A MEETING OF THE NHS FIFE AUDIT & RISK COMMITTEE WILL BE HELD ON THURSDAY 16 SEPTEMBER 2021 FROM 2PM – 4.30PM VIA MS TEAMS

Note: There will be a pre meeting of Non-Executive Members only at 1.30pm via MS Teams

Martin Black
Chair

1. Apologies for Absence

2. Declaration of Members' Interests

3. Minutes of Previous Meeting held on 17 June 2021 (***MB***) (enc)

4. Action List / Matters Arising (***MB***) (enc)

5. GOVERNANCE - GENERAL

5.1 Audit & Risk Committee Final Annual Statement of Assurance 2020/21 (***GM***) (enc)
5.2 Committee & Directors' Annual Assurances for 2020/21 (***GM***) (enc)

- Clinical Governance Committee
- Finance, Performance & Resources Committee
- Remuneration Committee
- Staff Governance Committee
- Fife Integration Joint Board
- Executive Directors' Assurance Letters

6. GOVERNANCE - INTERNAL AUDIT

6.1 Annual Internal Audit Report 2020/21 (***TG***) (enc)
6.2 Review of Property Transactions (***BH***) (enc)

7. ANNUAL ACCOUNTS

7.1 Patients' Private Funds – Receipts and Payments Accounts 2020/21 (***KB***)
7.2 Service Auditor Reports on Third Party Services (***MM***)

7.3 NHS Fife Annual Accounts for the Year Ended 31 March 2021 (***MM***)
7.4 Draft Annual Audit Report ***(PF)***
7.5 NHS Fife Independent Auditors Report - Including Draft Letter of Representation (***PF***)
7.6 Annual Assurance Statement to the NHS Board (***MB***)

Under the terms of the Public Finance & Accountability (Scotland) Act 2000, the Board is not permitted to make the Accounts publicly available prior to the Audited Accounts being formally laid before Parliament. These papers are therefore not included in this pack.

8. RISK

8.1 Report against Risk Management Workplan 2021/22 (***PC***) (enc)
8.2 Risk Management Key Performance Indicators Report ***(PC)*** (enc)
8.3 Update on Corporate Risk Register Arrangements (***PC***) (enc)
8.4 NHS Fife Board Assurance Framework Update (***PC***) (enc)

9. INTERNAL AUDIT REPORT

9.1 Internal Audit Report - Information Technology Infrastructure Library (ITIL) Audit (***AG***) (enc)

10. STRATEGY / PLANNING

10.1 NHS Fife Population Health and Wellbeing Strategy Progress ***(MM)*** (enc)

10.2 Joint Remobilisation Plan 2021/22 (RMP3/RMP4) ***(MM)*** (enc)

11. ITEMS FOR NOTING

11.1 Corporate Calendar – Committee Dates for 2022/23 (***GM***) (enc)

12. ESCALATION OF ISSUES TO NHS FIFE BOARD

13. ANY OTHER BUSINESS

Date of Next Meeting: **Thursday 9 December 2021 at 2pm** via MS Teams

Fife NHS Board

Unconfirmed

MINUTE OF THE AUDIT & RISK COMMITTEE MEETING HELD ON THURSDAY 17 JUNE 2021 AT 2PM VIA MS TEAMS

Present:

M Black, Non-Executive Member & Chair
S Braiden, Non-Executive Member
A Lawrie, Non-Executive Member

In Attendance:

K Booth, Head of Financial Services & Procurement
A Clyne, Audit Scotland
L Douglas, Director of Workforce
P Fraser, Audit Scotland
H Thomson, Board Committee Support Officer (Minutes)
B Hudson, Regional Audit Manager
Dr G MacIntosh, Head of Corporate Governance & Board Secretary
M McGurk, Director of Finance & Strategy
S Raynor, Senior HR Manager (for Item 6.4 only)

1. Members' Training Session – The Role and Function of the Audit & Risk Committee

The Chair welcomed P Fraser from Audit Scotland. A presentation on the role & function of the Audit & Risk Committee was provided. The main topics covered were:

- Remit of Audit & Risk Committee
- Responsibilities of Audit & Risk Committee in relation to the Annual Accounts
- Member review of Governance Statement
- Member review of Draft Accounts
- Recommending approval of Accounts to the Board

A Clyne gave a short summary of the audit work that has begun, following receipt of the draft accounts at the end of May.

Following a question on any common themes in the matters arising from last year's audit, it was advised they were mainly in relation to fixed assets, the statement of financial position, and also the remuneration report. Review of any potential matters arising from this year's audit are being progressed, with the experience of last year giving an indication of specific areas to prioritise as the initial audit work gets underway.

Permission was given to the Chair to adapt the presentation slides as a checklist for members as they review and scrutinise the Annual Accounts in September.

P Fraser and A Clyne were thanked for providing the helpful and informative session.

2. Welcome / Apologies for Absence

The Chair welcomed everyone to the meeting, in particular, the Director of Workforce, who was attending the meeting as an observer, and the Board Committee Support Officer, who is attending her first meeting as the new Secretary to the Committee.

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 were received from Cllr D Graham (Non-Executive Member), K MacDonald (Non-Executive Member), and attendees C Potter (Chief Executive), T Gaskin (Chief Internal Auditor) and P Cumming (Risk Manager).

3. Declaration of Members' Interests

There were no declarations of interest made by members.

4. Minute of the last Meeting held on 13 May 2021

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

5. Action List / Matters Arising

The Director of Finance & Strategy gave a positive update at the last meeting on reported progress from NHS National Services Scotland (NSS) in addressing the recommendations from the Service Audit Reports in 2019/20. However, in the last few weeks, a qualified Service Audit Report has been received by NSS on the Practitioner Services Audit and an urgent meeting was called to brief all Board Directors of Finance. A formal assessment is being worked on, including a potential disclosure in the NHS Fife governance statement, to reflect the national agreed position. It was noted this does not impact our financial statements directly.

The Committee **noted** the outstanding action and that a further update would be given at the next meeting.

6. GOVERNANCE – GENERAL

6.1 Draft Committee Annual Assurance Statement

The Head of Corporate Governance & Board Secretary gave an update on the draft Committee Annual Assurance Statement.

An initial draft of the Committee Annual Assurance Statement was presented in May, along with all other Board Committee Statements to the respective meetings. A slight update has been made to the Audit & Risk Annual Assurance Statement since May under section 4.8, which now details the conclusions of each of the Committees' own Annual Reports.

All other Board Committees have now finalised their reports, with the exception of the Clinical Governance Committee, who will finalise their version at their meeting on 7 July 2021. The Audit & Risk Committee will receive these in final form at their next meeting.

The Integration Joint Board (IJB) Assurance Statement has now been received, following consideration at the IJB's Audit & Risk Committee at the start of June. The Committee **noted** a final version of its draft Assurance Statement will be considered by the Committee in September, which will make mention of the IJB's statement now thus received.

6.2 Draft Governance Statement

The Director of Finance & Strategy presented the draft Governance Statement and the areas highlighted in the cover paper. These included reflecting the impact of Covid on the Board's governance arrangements; improvements to Information Governance & Security assurances; and the strategy development work, including the new Strategic Planning and Resource Allocation process.

A full review of the governance arrangements supporting Information Governance & Security controls has been carried out, and it was highlighted it is important to recognise the improvements delivered in the last 12 months. It was noted not all issues are cleared and the new arrangements will take time to embed, and this will be evidenced in this year's review, along with highlighting areas of significant improvement.

It was reported that revising the Fife Integration Scheme, specifically relating to agreeing the principles and wording around the risk share agreement has taken some time. An agreement between the Officers is now in place on a way forward. The final proposal will go the NHS Board and Fife Council in September for consideration. It is expected the revised Scheme will be concluded by the end of September.

A section to reflect the NSS Service Audit Report on practitioner services, as per the discussion on the earlier Action List agenda item, will be included in the Governance Statement.

Action: MM

The Committee were asked to review the statement, to ensure it adequately covers all the governance arrangements in place throughout the year, and makes reference to any key areas of control, weakness or challenges.

It was noted there was no specific national guidance on what Health Boards should be including in the Governance Statement in terms of the pandemic, and it was questioned whether our Governance Statement is reflective and in line with what other Health Boards are doing nationally. The Regional Audit Manager advised that, based on initial review, the Governance Statement is reflective of the year's challenges and the section on the pandemic is appropriate to fulfil the requirements. P Fraser from Audit Scotland agreed and noted the section is well detailed as it is currently drafted. It was noted the national guidance has not changed to require any additional disclosures or content specifically to address the pandemic.

The Regional Audit Manager agreed to feedback to the Committee on other Health Boards' Governance Statements when available.

Action: BH

A draft internal audit report has been issued for Information Governance, which includes an assessment of revised governance arrangements and a collation of outstanding recommendations that required audit follow up. The report reflects the positive changes and progress made.

The Committee **approved** the current draft Governance Statement, subject to the inclusion of a paragraph on the Service Audit Report on practitioner services, if that is agreed as a national requirement. A final draft would be submitted to the Committee with the Annual Accounts.

6.3 Draft Letter of Significant Issues of Wider Interest

The Head of Financial Services & Procurement summarised the paper.

The Committee **approved** the letter and draft Governance statement, to inform approval of the response to Scottish Government by 30 June.

6.4 Whistleblowing Standards Implementation

The Chair welcomed Sandra Raynor, Senior HR Manager, who joined the Committee for this item.

The Director of Workforce presented on the successful implementation of the new national Whistleblowing Standards, thanking the Senior HR Manager and team for all their hard work.

The Standards, role of the Independent National Whistleblowing Officer (INWO) and the new reporting arrangements came into effect from 1 April 2021. To support the implementation of the Standards, a Non-Executive Whistleblowing Champion was introduced across all NHS Boards, and K Macdonald was announced in early in June as being the appointee to that role.

The Standards are reflected in the internal NHS Fife policies and guidance that accompanies their roll-out. Training is available for staff to raise awareness and ensure staff and managers are competent in being able to raise concerns under the Whistleblowing Standards. The Chair asked if staff are aware of how to access the training, and if they feel safe and secure to raise a Whistleblowing issue. In response, it was advised Whistleblowing was available before implementation of the Standards, and training is promoted through various routes and includes the use of national materials; there are several access points both locally and nationally for staff to access information, and also through Staff Link. Whistleblowing training is also mandatory for all new staff.

The Standards are an enhancement to the arrangements in place before 1 April 2021, and encompass the delivery of NHS services through any external organisations, such as an independent contractor or a third sector organisation, which are all covered through the Whistleblowing Standards. Initial arrangements were established prior to the launch and the arrangements will continue to be refined through our implementation group.

In the reporting year 2020/21, NHS Fife had no Whistleblowing complaints, and it was questioned how that compares nationally. In response, it was advised there is a mixed picture across NHS Scotland, and larger Boards have more complex environments. It was noted, however, it was not unexpected to have no Whistleblowing complaints this year due to the pandemic, since often issues are raised and resolved locally and subsequently changes are made as appropriate. Some issues also fall under grievances, business-as-usual procedures or the bullying and harassment policy.

The Standards, as they are, are not due to be reviewed regularly; however, a post implementation review will take place internally through the Staff Governance Committee. The Scottish Public Services Ombudsman (SPSO) over the coming years may look at the overall data sets in terms of concerns and complaints handling, which might impact upon the content of the Standards in future.

The Committee **noted** the update on the implementation of the national Whistleblowing Standards.

7. GOVERNANCE – INTERNAL AUDIT

7.1 Internal Audit Progress Report & Summary Report

The Regional Audit Manager advised that the Internal Audit Progress Report provides the detail around internal audit activity since the last meeting in May. Outstanding work to complete the 2020/21 Plan is progressing, with four draft reports being finalised, and these will be issued in draft format within the coming week to the Committee.

Assignments have commenced from the 2021/22 Plan, with the Annual Report and the Post Transaction Monitoring Review, and these will be reported to the September Committee.

The Committee **noted** the progress on the delivery of the Internal Audit Plan.

7.2 Audit Follow Up Report

The Regional Audit Manager reported that the short time period between the May and June meetings had impacted on the closure of some of the recommendations; however, there has been continued engagement with officers to discuss outstanding recommendations to allow them to be progressed to completion. The number of outstanding recommendations is gradually reducing.

The continued scrutiny from the Executive Directors Group (EDG), on a quarterly basis, has had a positive impact on reducing the number of recommendations, and it will be useful that this continues.

Following a question from the Chair, it was advised that a three-stage approach is being introduced for extensions to complete actions arising from audit recommendation for next year, as detailed further within the report.

The Committee **noted** the current status of Internal Audit recommendations recorded within the audit follow up system.

8. GOVERNANCE – EXTERNAL AUDIT

8.1 NHS Fife Interim Management Report 2020/21

P Fraser from Audit Scotland advised that the NHS Fife Interim Management Report provides a summary on the interim work carried out in April / May, detailing the key issues from that review. The overall conclusion is that the key controls in place for NHS Fife are operating satisfactorily, and reliance can be placed on the systems which are used to create the figures in the Annual Accounts.

A few issues were raised in the report in relation to internal controls: changes to supplier details, payroll validation and the lower response rate received this year, unauthorised use of journals and payments to primary care practitioners. With exception of payments to primary care practitioners (which is an ongoing matter), none of these risks represent risks of material misstatement in the financial statements. A summary of additional work to be carried out has been provided. Management assurances have been received on all these points.

In terms of wider audit dimension work, the ongoing progress has been noted within the Strategic Planning and Resource Allocation (SPRA) process, which remains a work in progress. Until it is fully developed and embedded into the organisation, there is a risk NHS Fife will be unable to deliver the savings required to achieve a balanced budget.

Around 90% of efficiency savings are expected to come from the transformation programme due to the pandemic and redirection of priorities. This will be monitored going forward.

The Director of Finance & Strategy advised that timelines are now agreed in terms of confirming responses to the issues raised on internal controls.The Head of Financial Services & Procurement advised a review on the Financial Operating Procedures is being carried out and an update will be provided later in the year, once the Audit process is complete.

Action: KB

Following a question from the Chair, the Director of Finance advised that work is ongoing at the moment to fully assess the underlying financial position.

Action: MM

The Committee **noted** the draft report and that the final report will include timescales from management to address the recommendations

9. RISK

9.1 Risk Management Leadership

The Director of Finance & Strategy advised that the separation of risk management leadership arrangements from those in relation to adverse events/organisational duty of candour will progress as soon as possible, and agreement has been made to have this in place from the end of the July 2021, to ensure delivery of some essential improvements.

A draft internal audit report has been received and has some significant findings within. It was agreed that the profile of the risk management function needs to be raised across the organisation by integrating work more closely with strategic and operational planning to ensure delivery of improvements.

A full-time resource on risk management is expected to be available by the end of July 2021. Risk management leads from other Boards may also be able to provide support with the initial phases.

The Committee **noted** the proposed change to risk management arrangements and expressed their support for that.

9.2 Board Assurance Framework

The Director of Finance & Strategy advised that the paper summarises the position on each Board Assurance Framework (BAF) documents. Significant changes have been proposed for the financial sustainability BAF and the strategic planning BAF, and the risk descriptions and risk levels are detailed to reflect the current position.

An EDG workshop is being arranged along with a Board development slot to examine the baseline of the BAF and to ensure our reporting is delivering the assurance which Committees require.

The Committee **noted** the report.

9.3 Corporate Risk Register Quarterly Report

The Director of Finance & Strategy advised that the quarterly report is at the development/improvement stage. Background to the report was provided. It was noted that EDG and Board discussions are required to determine the reporting mechanism and its regularity, and also to determine if the way we report risk is effective. It was also noted discussion is required on the level of specific risks, particularly if these have remained static over time.

It was suggested that the Board may wish to consider developing two risk appetite statements. One would relate to safety and effectiveness of our clinical services/business as usual activities (which would have a low risk appetite), and the

other in relation to our strategic ambition (which could be more nuanced than the other).

It was noted the timeframes work well alongside the Committee Assurance principles discussed at the previous meeting, and will ensure the Board and Committees agendas are risk focussed.

A simpler method of presenting risks, with less extraneous detail and clearer formatting to report effectively, was agreed as an effective way forward.

9.4 Annual Risk Management Report 2020/21

The Director of Finance & Strategy introduced the report. A significant proportion of the report is on adverse events management, and this level of detail is being reviewed.

Discussion took place on the level of scrutiny and ownership of risks. Suggestion was made to invite the Chairs from the other Committees along to an Audit & Risk Committee to discuss the current assessment of risk management reporting.

The Director of Finance & Strategy advised the Audit & Risk Committee have a lead role in overseeing the effectiveness of risk management arrangements across the Board. It was noted the risk profile will form part of the new strategy discussions when they commence.

The Board will be requested to discuss risks, reporting mechanisms and continuous improvement at a future Board Development Session.

Action: MM

The Committee **considered** the assurances provided in the report and **noted** the areas of continuous improvement planned for 2021/22.

10. OTHER

10.1 Feedback from the Sharing Intelligence for Health & Care Group

The Head of Corporate Governance & Board Secretary gave background to the paper, noting it is an annual exercise NHS Fife has been asked to respond to. A meeting is still to take place when the group discuss with key officers the data held on NHS Fife by other external organisations.

Once feedback has been received at the scheduled meeting, a further update will be provided.

Action: GM

The Committee **noted** the feedback letter and its main findings.

10.2 Issues for Escalation to NHS Board

There were no issues to highlight to the Board.

11. ANY OTHER BUSINESS

There was no other business.

Date of Next Meeting: Thursday 16 September 2021 at 2pm via MS Teams

KEY:	Deadline passed / urgent
	In progress / on hold
	Closed

AUDIT & RISK COMMITTEE – ACTION LIST

Meeting Date: Thursday 16 September 2021

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	TIMESCALE	COMMENTS / PROGRESS	RAG
1.	17/06/2021	**Annual Risk Management Report 2020/21**	The Board will be requested to discuss risks, reporting mechanisms and continuous improvement at a future Board Development Session.	**MM**	A future Board Development Session	Expected to take place in November 2021, after EDG session takes place on 23 September. To be included as substantive item on December A&R Committee meeting.	Deadline not reached
2.	17/06/2021	**Financial Operating Procedures**	The Head of Financial Services & Procurement advised a review on the Financial Operating Procedures is being carried out and an update will be provided later in the year, once the Audit process is complete.	**KB**	December 2021	Draft of revised FOPs to come to December Audit & Risk Committee meeting.	Deadline not reached
3.	19/11/2020	**Service Auditor Reports on Third Party Services**	M 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**	As per comments / progress column	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. 7/9/21 – Closed. On agenda for September 2021 meeting.	Closed
4.	17/06/2021	**Draft Governance Statement**	A section to reflect the NSS Service Audit Report on practitioner services will be included in the Governance Statement.	**MM**	September 2021	To be reflected in revised Governance Statement. 7/9/21 - Closed. Revised Governance Statement included in the Annual Accounts paper for meeting on 16/9/21.	Closed

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	TIMESCALE	COMMENTS / PROGRESS	RAG
5.	17/06/2021	**Feedback from the Sharing Intelligence for Health & Care**	A meeting is still to take place when the group discuss with key officers the data held on NHS Fife by other external organisations. Once feedback has been received at the scheduled meeting (July 2021), a further update will be provided.	**GM**	On agenda for September 2021 meeting	7/9/21 – Closed. On agenda for Private Session at September 2021 meeting.	Closed

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**16 September 2021**
Title:	**Audit & Risk Committee Final 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 final draft of this year's report, with a view to its approval.

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. The Audit & Risk Committee has reviewed previous drafts of this report at its meetings in May and June and comments thereon have been captured in this final draft. The report also reflects the final content of each Board Standing Committee's individual assurance reports, agreed separately by each Committee, as well as the IJB's assurance statement, considered by the IJB's Audit & Risk Committee at their 4 June meeting.

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. The Committee also reviewed an earlier draft at their meetings in both May and June.

2.4 Recommendation

The paper is provided for:

- **Approval** – for onward submission to the Board.

Report Contact
Dr Gillian MacIntosh
Head of Corporate Governance & Board Secretary
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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 For assurance purposes, the Audit & Risk Committee has 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 remits and an outline of what assurance the Board can take on key matters delegated to them. No significant issues were identified from these reports for disclosure in the financial statements, as per the related content of the Governance Statement. Each individual assurance statement has appropriately reflected the impact of Covid-19 on the respective Committee's workplans and usual schedule of business, noting the need to prioritise key risk areas during the year and to ensure that members were apprised in particular of activity aimed at addressing the operational pressures and challenges of Covid, especially during resurgent periods of infection. Appropriate assurance has however been provided that each Committee has fulfilled their key remit areas on behalf of the Board during the reporting year. Use of a checklist provided initially by Internal Audit, to ensure appropriate coverage of key risks, has helpfully informed agenda planning. The Clinical Governance Committee report has provided an enhanced level of information on progress in improving controls around information governance and security, reflecting the expanded content of the assurance reporting template from the Committee's three sub-groups. Further detail has also been provided on the various external inspections carried out within the Board, including those by the Health & Safety Executive and Health Improvement Scotland, each of which had a focus on infection prevention and correct usage of PPE in light of Covid risks. The Finance, Performance & Resources Committee has closely monitored the position in relation to the uncertainty in-year of the impact on expenditure and availability of national funding to support the additional costs associated with the pandemic, and has considered also the impact of Covid on key performance targets. The Staff Governance Committee has received regular updates on the mobilisation of workforce and recruitment to support key programmes, such as Test & Protect and Covid vaccination delivery, in addition to ongoing detail on staff well-being initiatives, such as the dedicated support hubs in operation across a number of sites. The Remuneration Committee has continued its work during the pandemic period, reflecting within its workplan key directives from

the Scottish Government related to remuneration, discretionary points and overtime arrangements, in addition to completing its usual business of performance appraisal and Executive cohort objective setting. Further detail on all these areas can be found within the individual Committee reports mentioned above.

4.9 In reference to the assurance statement received from the Fife Integration Joint Board, as considered by the IJB's Audit & Risk Committee at their meeting in June, it concludes that internal and external audit findings provide evidence that the Fife Health & Social Care Integration Joint Board is developing a sound system of corporate governance and internal control that is appropriately monitored and reviewed. The Chief Internal Auditor's opinion is that a medium level of control exists, with further work required in the areas of: strengthening financial and performance management; completing the review of the current Integration Scheme; and clarifying accountability of risk and assurance processes between the partners, including the framework for transformation and change projects, which have been negatively impacted by the prioritisation of Covid-related activities. The Fife IJB's assurance statement recognises that this has been a challenging year, and progress on areas for improvement identified in last year's assurance statement has been impacted by the need to prioritise the Covid-19 response and recovery. Implementation of actions in response to audit recommendations has also been delayed as a consequence, though revised timescales have been agreed.

4.10 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.

4.11 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.

4.12 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.

4.13 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.

4.14 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.

4.15 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.

4.16 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 & Risk Committee**
Meeting date:	**16 September 2021**
Title:	**Committee & Directors' Annual Assurances for 2020-21**
Responsible Executive:	**Respective Executive Directors**
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

The purpose of this report is to present the Annual Assurance Statements for each standing Committee of the Board, the assurance statement produced by the IJB's Chief Internal Auditor, and the individual Executive Director assurance letters for consideration by the Audit & Risk Committee as part of the overall annual accounts and assurance process for 2020/21.

2.2 Background

The Code of Corporate Governance requires all standing committees of the NHS Board to provide an Annual Report (Assurance Statement). As part of this Assurance Statement, each Committee must demonstrate that it is fulfilling its remit, implementing its work plan and ensuring the timely presentation of its minutes to the Board. These reports are designed to provide assurance that there are adequate and effective governance arrangements in place. Each Committee must identify any significant control weaknesses or issues at the year-end which it considers should be disclosed in the Governance Statement and should specifically record and provide assurance that the Committee has carried out the annual self- assessment of its effectiveness.

Separately, each Executive Director is asked to complete to the Chief Executive a letter at year-end to give individual assurance, for the respective areas under each Executive Director, that there are no control weaknesses that should otherwise be disclosed in the annual accounts.

2.3 Assessment

The Annual Assurance Statements for the Clinical Governance Committee, Finance, Performance & Resources Committee, Remuneration Committee and Staff Governance Committee are attached for consideration by members of the Audit & Risk Committee. Each has been discussed and approved by the respective Committee at their April or July 2021 cycle of meetings. Also included is the IJB's assurance statement from their Chief Internal Auditor, considered by the IJB's Audit & Risk Committee at their meeting on 4 June 2021. A final appendix gives the collated responses from the Executive Directors on their areas of responsibility.

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 respective assurance statements have been considered and approved by each Committee at the meetings below:

- Clinical Governance Committee, 7 July 2021
- Finance, Performance & Resource Committee, 11 May 2021
- Remuneration Committee, 25 May 2021
- Staff Governance Committee, 29 April 2021
- IJB Audit & Risk Committee, 4 June 2021

The collated pack of Executive Directors' letters have been reviewed by Internal Audit as part of their year-end work.

2.4 Recommendation

The paper is provided for:

- **Assurance**

3 List of appendices

The following appendices are included with this report:

- Appendix No.1 – Standing Committee & IJB Annual Statements of Assurance
- Appendix No.2 – Executive Directors' Annual Letters of Assurance

Report Contact
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ANNUAL STATEMENT OF ASSURANCE FOR NHS FIFE CLINICAL GOVERNANCE COMMITTEE 2020/21

1. Purpose

1.1 To provide the Board with the assurance 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.

2. Membership

2.1 During the financial year to 31 March 2021, membership of the Clinical Governance Committee comprised: -

Dr Leslie Bisset	Chair / Non-Executive Member
Martin Black	Non-Executive Member
Sinead Braiden	Non-Executive Member
Wilma Brown	Area Partnership Forum Representative
Helen Buchanan	Director of Nursing (to February 2021)
Cllr David Graham	Non-Executive Member
Rona Laing	Non-Executive Member
Aileen Lawrie	Area Clinical Forum Representative (from March 2021)
Dr Christopher McKenna	Medical Director
Dona Milne	Director of Public Health
Janette Owens	Area Clinical Forum Representative / Director of Nursing (from March 2021)
Carol Potter	Chief Executive
John Stobbs	Patient Representative
Margaret Wells	Non-Executive Member

2.2 The Committee may invite individuals to attend the Committee meetings for particular agenda items, but the 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), Head of Quality & Clinical Governance and Board Secretary will normally be in 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 seven occasions during the financial year to 31 March 2021, on the undernoted dates:

- 15 June 2020
- 8 July 2020
- 7 September 2020
- 4 November 2020
- 18 November 2020
- 14 January 2021
- 11 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. 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, to help enhance agenda planning and ensure that no areas of risk have been overlooked.

4.3 The Clinical Governance 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.

4.4 At the June 2020 meeting, the Committee also received individual updates from the respective Directors on: the shielding of vulnerable patients from Covid-19; community testing arrangements (including Test & Protect work); care home support and changes to the professional responsibilities of Nurse Directors in relation to this area; learning from outbreaks of Covid within the hospital setting; ensuring PPE and Medicines availability; and plans for the gradual remobilisation of services, as the first wave of Covid reduced from its initial peak. At the Committee's request, many of the reports given to members were delivered verbally or via a presentation, to ensure that the Committee had the most up-to-date information on what was a fast-developing and rapidly changing situation.

4.5 At its scheduled July 2020 meeting, the Committee's agenda was prioritised to review further updates on the organisation's ongoing response to Covid-19 and also governance-related items linked to the 2019-20 year-end process. Written briefings on testing policy and delivery arrangements for Covid-19 in Fife, care home support arrangements and a Lessons Learned

report on hospital onset coronavirus infections were carefully scrutinised by the Committee. In relation to the latter report, the complex network of potential transmission of infection in a hospital setting was highlighted, and key learning was outlined in the areas of atypical presentation of coronavirus symptoms, movement of staff and patients, social distancing, cleaning protocols, and the reduction of the bed base, to increase spacing, particularly in the community setting.

4.6 The new responsibility placed on the Board around nursing leadership and infection control arrangements in support of care homes also received detailed scrutiny, with the Committee congratulating the work done in partnership with colleagues in the social care sector aimed at protecting vulnerable residents in the care home setting. All 76 individual care homes in Fife received an assurance visit, where a supportive and collaborative approach was undertaken to provide advice and guidance around Covid-19 prevention. A Specialist Nursing Support team was put in place to give assistance to those homes identified with areas to improve, again taken forward in a collaborative manner. The Committee received the required assurance that the Board's new responsibilities in this area have been met in a robust and thorough way, in accordance with the Cabinet Secretary's instruction.

4.7 A draft of the remobilisation plan for restarting clinical services, formally agreed with the Scottish Government in June 2020, was reviewed by the Committee at its meeting in July. The Plan detailed the adopted methodology around the planning for resumption of normal services, based around a 'Respond, Recover and Renew' approach. To ensure governance around the restart of clinical services, the Remobilisation Oversight Group was initially established to oversee the restarting of health and care services in Fife during this phase. This group was intended to drive the reintroduction of clinical services in a safe, measured and Covid-19 sensitive way, with a wide representation of clinical leaders, and it has overseen the whole system restart to improve integrated pathways from primary care, community, social care and secondary care, adhering to our routine governance arrangements and with learning from our Covid-19 response.

4.8 During the pandemic, strategic decisions were made in relation to both the configuration of services and which services could reasonably be provided. Changes to service provision were risk assessed and the Committee has recognised that some patients may be affected by these decisions. As such, any consequences that resulted would not be considered avoidable given that this was based on the strategic decision to prioritise services to address the pandemic. Importantly, actions to mitigate identified risks were implemented at all opportunity. The Committee considers that the local response to the pandemic was appropriate, considered and aligned to Scottish Government direction. Throughout the pandemic urgent services such as cancer services and urgent care were prioritised. The governance route for changing or stopping services were carefully scrutinised through the pandemic response structures of Bronze, Silver and Gold Command groups. Critically, clinical teams and leaders were central to decision-making, to ensure that any potential harm resulting from cessation or service change was appropriately mitigated. Examples of mitigation include the nationally-agreed surgical prioritisation framework, use of Near Me for the continuance of remote appointments, and outpatient prioritisation. The dynamic nature of the pandemic and the evolving understanding of the virus has necessitated a continual review of changes, which were considered through the command structures described and discussed by the Committee during the year. As services continue to remobilise, the Clinical Governance Committee will receive an overview at each meeting, to provide assurance in relation to the recovery of services.

4.9 Also discussed in July 2020 was the Joint Health Protection Plan 2020-22, as developed between Fife Council Environmental Health and NHS Fife Public Health departments, which provided an overview of health protection priorities, provision and preparedness for the NHS Fife Board area. Although drafted before the full impact of the coronavirus pandemic became

clear, the greater priority of public health-related measures in light of society's response to Covid has been appropriately reflected in the Committee's schedule of business, with appropriate consideration of reports such as this.

4.10 In relation to Seasonal Flu Immunisation, the Committee considered at its September 2020 meeting the delivery plan and governance around this year's programme, noting that the campaign was expected to be more challenging than previous years, due to the ongoing restrictions of the pandemic, and with a different model of delivery from the previous GP-led clinics. On the programme's launch in mid-September, the increased demand for flu vaccinations quickly overwhelmed the planned delivery model and communications hub, resulting in a less than satisfactory patient experience and reputational damage to the Board. An independent review into the seasonal flu programme was commissioned in October 2020 and a Lessons Learned report considered in depth by the Committee at its meeting in early November. The report made a number of important recommendations in the areas of governance, reporting routes and clarity of roles and responsibilities; planning and project management support; workforce; communications; and IT support. A related Action Plan has been developed, and regular reporting on addressing these individual improvement actions has continued to the Committee. In addition, an external review has since been commissioned to consider how the Board delivers immunisation programmes in general (noting the additional activity due to Covid), and in particular clarifying the respective responsibilities for Public Health and colleagues in the Partnership. The outcome and recommendations from this will be considered at a future meeting of the Committee.

4.11 An Extraordinary Meeting of the Committee was held on 18 November 2020, for members to specifically consider the arrangements for the imminent launch and delivery of the Covid-19 vaccination programme, the single largest public health intervention in modern times. Members discussed issues ranging from the availability of vaccine, the prioritisation of cohorts, the governance, risk and project management arrangements for the roll-out of the programme, planning for venues, scheduling and appointing mechanisms, and the likely workforce and financial implications. Noting the vital importance of learning from the challenges faced with the delivery of the 2020 seasonal flu vaccination, and in particular the recommendations of the independent review into that programme considered in depth at the Committee's previous meeting on 4 November, the Committee took assurance from the risk-focused approach of planning for the Covid programme, and in particular the enhanced support offered by a dedicated Programme Management Office. Meetings of the Committee since the Covid vaccination launch have continued to focus attention on the effective delivery of the vaccine to the people of Fife, in a person-centred, responsive manner. The strong performance of the Board when compared with other nationally has given the appropriate assurance that the planning and implementation of the large-scale programme has taken due cognisance of the lessons learned from the review of seasonal flu immunisation, in addition to benefitting from the expertise, dedication and knowledge of staff from across a range of services, including many volunteer vaccinators.

4.12 A presentation by the Medical Director on the Redesign of Urgent Care was delivered to members in November 2020, with a further update given in January 2021. Noting the challenges of making these service changes as Covid-related activity increased with the second wave of widespread infection, the planned 'hard' launch of the service was postponed, due to challenges with the resilience of NHS24 services. A soft launch of the programme, however, gave the opportunity to test the model and ensure local readiness. In March 2021, the Committee considered a further report on the design and operation of the Flow & Navigation Hub within the Urgent Care Service, following Scottish Government guidance for all Boards to establish a local hub to ensure patients are directed to the appropriate point of care. This continues to operate successfully, helping ensure A&E attendances are managed and patients are directed to the right forms of support for their own individual needs.

4.13 The Committee carefully scrutinises at each meeting key indicators in areas such as performance in relation to falls, pressure ulcers, complaints and the number of Adverse Events, via the Integrated Performance & Quality Report. Specific scrutiny has been given in recent meetings to the rate of Staphylococcus aureus Bacteraemia (SABs), with members receiving an update at its July 2020 meeting on community C.Diff cases, with detail on how an increase in cases pre-Covid was being addressed and monitored. Despite the challenges of the pandemic, the Board has had the lowest number of SABs since 2005, with no MRSA case within the 2020 calendar year. Staff were congratulated for their successful work aimed at reducing cases to a minimal level.

4.14 The Committee noted that robust action plans have been developed following Health Improvement Scotland HAI inspection visits to Glenrothes Hospital (7-8 July 2020) and to Adamson Hospital (28 October 2020), with members receiving an update on progress in addressing actions at their May 2021 meeting. The Glenrothes Hospital Inspection resulted in the identification of four areas of good practice (particularly around hospital cleanliness and infection control support) and five requirements in areas to be improved (the majority related to improved documentation to ensure that people's health and wellbeing were being supported and safeguarded during the pandemic). The Adamson Hospital Inspection highlighted three areas of good practice (including robust standards of hospital cleanliness and thorough completion of assessment such falls, oral care and pressure ulcers prevention) and eight requirements to be followed up. Six requirements related to improved documentation to ensure that people's health and wellbeing were being supported and safeguarded during the pandemic and two requirements were in relation to infection control practices supporting a safe environment for patients and staff. At their May 2021 meeting, the Committee were pleased to note that the action plan in relation to the Glenrothes Hospital inspection has been fully completed, and that for Adamson Hospital is well advanced towards full completion.

4.15 The preparation of a robust plan for dealing with Winter demand was covered by the Committee at their meeting in November 2020, and regular performance reports have followed since. Despite the operational challenges of dealing with increased demand due to coronavirus activity, the delay position in general has been an improving one, recognising the close partnership working across health and social care.

4.16 Papers were provided to the Committee on various capital projects, including, in November 2020, the full business case for large-scale Elective Orthopaedic Centre to be established at Victoria Hospital and the full business case for the implementation of Hospital Electronic Prescribing & Medicines Administration (HEPMA). Both projects were recommended for approval by the Committee to the Board, noting the potential transformational nature of both initiatives for patient care in Fife.

4.17 Annual reports were received on the subjects of the work of the Clinical Advisory Panel, Equality Outcomes, Fife Child Protection, Integrated Screening, Radiation Protection, Medical Revalidation, Prevention & Control of Infection, Organisational Duty of Candour, Research & Development Strategy & Annual Review, and any relevant Internal Audit reports that fall under the Committee's remit, such as that on Adverse Events Management (in which the Committee commissioned a separate update on progress made in addressing the various action points). Updates were also provided on public engagement matters, including, in January 2021, dedicated reports on Equality Outcomes and Mainstreaming Equality across the organisation.

4.18 The Committee has received minutes and assurance reports from its three sub-groups, namely the Digital & Information Board, Health & Safety Sub-Committee, and the Information Governance & Security Steering Group, detailing their business during the reporting year. Updates to Terms of Reference and workplans for these groups have also been considered

when necessary. As agreed last year, guidance and a template for the format of sub-groups annual assurance statements has been created for the groups to follow, to improve the consistency and content of information provided, and the annual reports of each of the groups have been reviewed at the Committee's May 2021 meeting.

4.19 In reference to the Health & Safety Sub-Committee, their work has been detailed in their annual report to the Committee. Whilst Covid has dominated their proceedings, including HSE visits to check compliance, the policy and procedure reviews scheduled for this year have been completed. In November 2020, NHS Fife received a Covid Management 'spot check' visit to the Victoria Hospital site from HSE inspectors. The visit resulted in a 'Notice of Contravention' being issued to the organisation with a requirement for actions to be taken. The December 2020 sub-committee meeting was therefore given over to discussion on the detail of the Notice to ensure that actions were being addressed and that appropriate managers and staff were involved in this work, and updates on the delivery of this action plan were given to the sub-committee in March, with progress noted in the implementation of the HSE's recommendations.

4.20 Over the past year, the Digital & Information Board has developed the governance, process and controls necessary to assure the organisation about the consideration and delivery of the Digital Strategy and associated delivery plan, as outlined in a report submitted in July 2020 on the eHealth Governance Review. This work has included consideration of a number of significant and outstanding Internal Audit findings given in previous reports, as well as the action points from the NIS audit carried out in March 2020. The Digital & Information Strategy 2019-2024 was presented to the NHS Fife Board and approved on 30 September 2020. The necessity to support the Covid-19 pandemic response has impacted the planned activities of the group and the delivery plan associated with implementing the Strategy, as outlined in a report submitted to the Clinical Governance Committee in September 2020. The group noted there had been considerable benefits to digital adoption in many key areas during this time, supported by key financial investment decisions. The Board recognised that the lessons learnt through this year should have significant impact on Digital delivery going forward.

4.21 In relation to Digital enhancements, the Committee has received updates on the hospital electronic prescribing and medicines administration system (HEPMA) being introduced in Fife. In September 2020 the Committee noted progress and approved a revised timeframe for submission of the business case. The full business case was considered and approved in November 2020. The Digital & Information Board's annual report has also detailed areas of significant activity across the organisation, particularly those in support of enabling enhancements for remote working / patient consultation and in implementing O365 roll-out etc. The Committee has noted that the new Associate Director of Digital & Information has initiated a full risk audit within the areas of Digital & Information, with particular attention being given to the correct ownership of the risks within the organisation and being able to evidence the mitigation actions being planned and taken. An early focus is a financial assessment of the Digital and Information Strategy, to ensure affordability can be matched with expectation and ambition. It is also anticipated that this work will ensure the completion of a number of outstanding internal audit recommendations, to enhance the overall control environment and governance structures of this key directorate. Reporting arrangements to the Clinical Governance Committee will also be part of this work, to ensure appropriate scrutiny and oversight.

4.22 The Clinical Governance Committee has also considered the annual report from the Information Governance & Security Steering Group, which has been restructured during the reporting year. The newly refreshed Group first met in October 2020 and has developed appropriate Terms of Reference for itself and its supporting operational groups. The Group has reviewed a report detailing the current baseline of performance and controls within the remit of

the Information Governance & Security activities, recognising that whilst compliance and assurance in some areas is effective, in others improvement is necessary to ensure the confidentiality, availability and integrity of patient, corporate and staff information. Whilst the appropriate governance structures and controls are now in place, the production of evidence to the Steering Group on all matters under its remit remains a work in process. Therefore, the Clinical Governance Committee notes that the assurance the Steering Group is in a position to provide this year is necessarily partial, though there are no significant issues that would otherwise merit a disclosure in the Governance Statement.

4.23 An annual statement of assurance has also been received and considered from the Clinical & Care Governance Committee of the Integration Joint Board, detailing how Clinical & Care Governance mechanisms are in place within all Divisions of the Fife Health & Social Care Partnership and that systems exist to make these effective throughout their areas of responsibility. Updates have also been given to the Committee on the ongoing review of the Fife Integration Scheme, which has been delayed from its original timeline due to Covid-related pressures. The new Scheme will seek to further clarify clinical governance assurance mechanisms and reporting routes and will reflect input from the Board's internal auditors and Central Legal Office, in addition to recommendations made from the Council side.

4.24 Minutes of Clinical Governance Committee meetings have been subsequently 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 a rolling action log 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 2 provides evidence of where and when the Committee considered the relevant characteristics during 2020/21.

6. Risk Management

6.1 In line with the Board's agreed risk management arrangements, NHS Fife Clinical Governance 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 in the areas of Quality & Safety, Strategic Planning and Digital & Information. Progress and appropriate actions were noted. In addition, many of the Committee's requested reports in relation to Covid have been commissioned on a risk-based approach, to focus members' attention on areas that were central to the Board's priorities around care, service delivery and vaccination during the height of the pandemic. Examples include requested reports on arrangements for shielding individuals, progress updates on the roll-out of Test & Protect programme, detail on the preparedness of Acute Services for a resurgence in Covid-related activity, and an assessment of laboratory capacity to handle an upsurge in demand.

6.2 During the year, in relation to Quality & Safety, the Committee has specifically considered the risk of lack of medical capacity in both the Community Paediatrics and Child Protection services. In relation to the former, an update was given on potential collaborative approaches with other Boards and the resilience that could be offered by utilising hospital-based paediatricians. The absence of the Board's Clinical Lead for Child Protection has resulted in help and support being sought from a neighbouring Board, to improve capacity. Members took

assurance from the mitigating actions and supported the planned programme of service improvement work going forward.

6.3 The Committee recognises that, as mentioned above, further work is required around the reporting of Digital and Information Governance & Security risks and also those related to transformation programmes, noting that the ongoing strategy review will bring an overall focus and direction to a number of hitherto individual strands of work. Updates have been given to the Committee on the new Strategic Planning & Resource Allocation process, which has linkages to the overall Remobilisation planning, and the Committee looks forward to being a central part of the development of the new Health & Well-Being Strategy currently under preparation. It is considered that this focus will improve the overall lines of reporting and assurance to the Committee over the forthcoming year.

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

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

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

Signed: Christina Cooper Date: 7 July 2021

Christina Cooper, Chair
On behalf of the Clinical Governance Committee

Appendix 1 – Attendance Schedule
Appendix 2 – Best Value

APPENDIX 1

NHS Fife Clinical Governance Committee Attendance Record
1st April 2020 to 31st March 2021

	15.06.20	08.07.20	07.09.20	04.11.20	18.11.20 (private)	14.01.21	11.03.21
Dr L Bisset (Chair)							

APPENDIX 1

	15.06.20	08.07.20	07.09.20	04.11.20	18.11.20 (private)	14.01.21	11.03.21
In attendance (cont.)							
M McGurk, Director of Finance & Strategy							
Dr E Curnock, Deputy Director of Public Health							
Dr G MacIntosh, Board Secretary							
H Woodburn, Head of Quality & Clinical Governance							
G Couser, Head of Quality & Clinical Governance							
A Ballantyne, Clinical Lead							
L Barker, AND, H&SCP							
J Crichton, Interim Director, Project Management Office							
L Donovan, eHealth General Manager							
B Hannan, Chief Pharmacist							
B Johnston, Project Manager							
E Muir, Clinical Effectiveness Coordinator							
BA Nelson, Independent Reviewer							
G Smith, Lead Pharmacist, Medicine Governance & Education							

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 strategic plan is translated into annual operational plans with meaningful, achievable actions and outcomes and clear responsibility for action.	Winter Plan Capacity Plan	**FINANCE, PERFORMANCE & RESOURCES COMMITTEE** **CLINICAL GOVERNANCE COMMITTEE** **BOARD**	Annual Bi-monthly Bi-monthly	Winter Plan review NHS Fife Clinical Governance Workplan is approved annually and kept up-to-date on a rolling basis Minutes from Linked Committees e.g. · NHS Fife Area Drugs & Therapeutics Committee · Acute Services Division, Clinical Governance Committee · NHS Fife Infection Control Committee · NHS Fife H&SCP Care & Clinical Governance Committee NHS Fife Integrated Performance & Quality Report is considered at every meeting

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 openness and transparency. Public reporting should show the impact of the organisations activities, with clear links between the activities and what outcomes are being delivered to customers and stakeholders. Good governance provides an assurance that the organisation has a suitable focus on continuous improvement and quality. Out with 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**	Ongoing	Clinical Strategy updates considered regularly Via the NHS Fife 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 section on all reports

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
NHS Fife has developed and implemented an effective and accessible complaints system in line with Scottish Public Services Ombudsman guidance.	Complaints system in place and regular complaints monitoring.	**CLINICAL GOVERNANCE COMMTTEE**	Ongoing Bi-monthly	Single complaints process across Fife health & social care system NHS Fife Integrated Performance & Quality Report is discussed at every meeting. Complaints are monitored through the report.
NHS Fife can demonstrate that it has clear mechanisms for receiving feedback from service users and responds positively to issues raised.	Annual feedback Individual feedback	**CLINICAL GOVERNANCE COMMITTEE**	Ongoing Bi-monthly	Update on Participation & Engagement processes and groups undertaken during the reporting year NHS Fife Integrated Performance & Quality Report is discussed at every meeting. Complaints are monitored through the report.

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
There is a robust information governance framework in place that ensures proper recording and transparency of all NHS Fife's activities.	Information & Security Governance Steering Group Annual Report Digital & Information Board Annual Report Digital & Information Board minutes	**CLINICAL GOVERNANCE COMMITTEE**	Annual	Minutes and Annual Report considered, in addition to related Internal Audit reports
NHS Fife understands and exploits the value of the data and information it holds.	Remobilisation Plan Integrated Performance & Quality Report	**BOARD** **COMMITTEES**	Annual Bi-monthly	Integrated Performance & Quality Report considered at every meeting Particular review of performance in relation to SSIs and community-based SABs undertaken in current year

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, Annual Operational Plan 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 considered at every meeting Minutes from Linked Committees e.g. · Area Drugs & Therapeutics Committee · Acute Services Division, Clinical Governance Committee · Digital & Information Board · Infection Control Committee · Information Governance & Security Steering Group
The Board and its Committees approve the format and content of the performance reports they receive	The Board / Committees review the Integrated Performance & Quality Report and agree the measures.	**COMMITTEES** **BOARD**	Annual	Integrated Performance & Quality Report considered at every meetings. Review of format undertaken in reporting year

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
Reports are honest and balanced and subject to proportionate and appropriate scrutiny and challenge from the Board and its Committees.	Committee Minutes show scrutiny and challenge when performance is poor as well as good; with escalation of issues to the Board as required	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance & Quality Report considered at every meetings Minutes of Linked Committees are reported at every meeting
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 considered at every meeting The Committee commissions further reports on any areas of concern, e.g. as with adverse events
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 considered at every meeting Minutes of Linked Committees · Area Clinical Forum · Acute Services Division, Clinical Governance Committee · Area Drugs & Therapeutics Committee · Fife Resilience Forum

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	Clinical Strategy updates regularly considered Digital & Information Strategy reviewed in current year All strategies have a completed EQIA
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	Clinical Strategy updates regularly considered Digital & Information Strategy reviewed in current year All strategies have a completed EQIA
NHS Fife's policies, functions and service planning overtly consider the different	In accordance with the Equality and Impact Assessment Policy, Impact Assessments consider the current and future needs and	**BOARD** **COMMITTEES**	Ongoing	All NHS Fife policies have a EQIA completed and approved. The EQIA is published alongside the policy

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE:**
current and future needs and access requirements of groups within the community.	access requirements of the groups within the community.			when uploaded onto the website
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	Update on Participation & Engagement processes and groups undertaken during the reporting year, which encompassed effectiveness of engagement with key groups of users

ANNUAL STATEMENT OF ASSURANCE FOR THE FINANCE, PERFORMANCE & RESOURCES COMMITTEE 2020/21

1. Purpose of Committee

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 these arrangements are working effectively.

2. Membership of Committee

2.1 During the financial year to 31 March 2021, membership of the Finance, Performance & Resources Committee comprised:

Rona Laing	Chair / Non-Executive Member
Dr Les Bisset	Non-Executive Member
Wilma Brown	Stakeholder Member
Helen Buchanan	Director of Nursing (to February 2021)
Eugene Clarke	Non-Executive Member
Alistair Morris	Non-Executive Member
Janette Owens	Stakeholder Member (to February 2021) / Director of Nursing (from March 2021)
Carol Potter	Chief Executive
Margo McGurk	Director of Finance & Strategy
Dr Chris McKenna	Medical Director
Dona Milne	Director of Public Health

2.2 The Committee may invite individuals to attend the Committee meetings for particular agenda items, but the Director of Acute Services, Director of Health & Social Care, Director of Property & Asset Management, Director of Pharmacy & Medicines and Board Secretary will normally be in 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 financial year to 31 March 2021, on the undernoted dates:

- 17 June 2020
- 7 July 2020
- 8 September 2020
- 10 November 2020
- 12 January 2021

- 16 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. 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, to help enhance agenda planning and ensure that no areas of risk have been overlooked.

4.3 The Finance, Performance & Resources 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, and the phased approach to future audit work, aimed at considering how public money has been used during the period.

4.4 The Committee received an update on financial planning in light of the Covid response, building upon the information presented to full Board in May 2020. Noting that Scottish Government had requested a resubmission of the remobilisation financial plan, to reflect actual April and May financial performance, the Committee reflected on the areas of expenditure that were still to be quantified, such as those around Test & Protect and Care Home support. A further submission of the remobilisation plan was anticipated in July, in which costs and forecasts could be further refined. As the financial year progressed, further iterations of the plan have been prepared and submitted, the most recent being the Remobilisation Plan 3, agreed with Scottish Government in April 2021.

4.5 At its scheduled July 2020 meeting, the Committee's agenda was prioritised to review key performance updates and also governance-related items linked to the 2019-20 year-end process.

The significant impact of the pandemic upon waiting times performance, for surgery and outpatients appointments, was discussed, noting that NHS Fife was in a similar position to other Boards, having paused all elective procedures at the height of the pandemic (though urgent cancer surgery was in Fife maintained throughout). The importance of service redesign as the Board remobilised its activities was noted, especially the need to make use of technology and digital access, as part of a blended approach to delivery, since it is recognised that many services will not be able to go back to their way of operating pre-Covid, not least because of ongoing restrictions on physical distancing and reduced footfall within hospital buildings. The Committee took assurance from the various iterations of the remobilisation plans discussed with members, including the measured approach to standing services back up as coronavirus activity has reduced, to ensure appropriate patient safety and infection control.

4.6 In July 2020, in private session, the Committee considered and supported the guiding principles for financial reporting during the pandemic and scrutinised the potential impact on savings and efficiency targets and also the potential treatment of cost-offsets arising from reductions in planned activity. A report on Annual Operational Plan / Remobilisation Plan costings was also discussed, to provide assurance and to evidence the robustness of the financial plans presented to members. The Committee recognised the uncertainty around the financial impact of Covid, noting however this would become clearer as the financial year progressed and confirmation of funding from Scottish Government crystallised. Members were however assured about the planning then underway, particularly to provide for the new workstreams created to support the mobilisation of the Board against Covid.

4.7 At the Committee's September 2020 meeting, members received an update on work underway to support smoking cessation at the Stratheden Intensive Psychiatric Care Unit (IPCU), prior to legislative changes requiring a fully smoke-free site from mid-2021. This report closed off a long-standing action on the Committee's rolling list, which concerned potential risks to staff and patients should a smoking shelter be constructed within the facility's secure areas. Members welcomed the work undertaken by Health Promotion and Mental Health Quality Improvement colleagues to train and support staff, in advance of the implementation date of the legislation requiring a fully smoke-free site.

4.8 The draft Corporate Objectives 2020-21 were presented to the Committee in September 2020, with the Chief Executive detailing the Executive Team's participation in a recently held workshop to review the corporate objectives and bring forward any ideas for review and consideration. The main change for this year is that clarity has been provided on the Executive Leads' revised areas of responsibility, which was welcomed by members. The report described what NHS Fife aims to achieve in year, in tandem with a looking-back review of Directors' Objectives for 2019/20, and these will form part of ongoing strategy development work.

4.9 At each meeting the Finance, Performance & Resources Committee considers the most up-to-date financial position for the year for both revenue and capital expenditure. This function is of central importance, as the Committee provides detailed scrutiny of the ongoing financial position and all aspects of operational performance across NHS Fife activities, including those delegated to the Integration Joint Board. Considerable time was spent in meetings discussing and reviewing the financial pressures facing the Board, the delivery of in-year savings and consideration of the financial consequences particularly of Covid. The Committee also noted the potential for Covid related costs to recur in 2021/22.

4.10 The Committee scrutinised operational performance at each meeting through review of the Integrated Performance & Quality Report (IPQR), specifically those measures that fall within its own remit. The impact of coronavirus on traditional key performance measures monitored by the Committee was significant, particularly in relation to Treatment Times Guarantee measures, numbers of new referrals and diagnostic performance. The plans to tackle the resultant backlog from the pause of services during the height of the pandemic will be a significant focus of the Committee going forward.

4.11 In November 2020, detailed updates, at the request of the Committee, were given on performance within the services of Psychological Therapies and CAMHS, particularly in relation to ongoing concerns about failure to meet Referral to Treatment (RTT) targets and the potentially worsening impact of Covid on the capacity to meet existing demand for both services. The issues were explained in detail by the relevant service managers and Committee members scrutinised the various improvement actions and recovery plans, noting that the reduction in referrals during the height of the pandemic could have the potential to complicate the actual picture on performance. Members noted that a number of resources have been created in a digital format, to support virtual working during the height of the pandemic. It was advised that it is difficult at present to know the impact this work will have, but the Committee noted that staff are optimistic the work undertaken will have a positive impact on patient care and will reduce the rates of patients waiting for help and support via both services. The risks of increased referrals post-Covid remain significant, however, and it is of concern that the services cannot meet existing demand, let alone increased activity. Further updates are expected later this year for members to consider how these risks are being effectively managed and reduced.

4.12 The preparation of a detailed plan for managing Winter demand was considered by the Committee in November 2020, recognising that enhanced management was required due to the likelihood of parallel Covid pressures in addition to the usual Winter activity. The Committee was assured by the robust approach to planning, and the reflection on lessons learned from previous years. Performance reporting on Winter 2020/21 has continued to the Committee in January and March 2021, and lessons learned from what has been a challenging year will be taken forward in the planning for Winter 2021/22.

4.13 Details on the new Strategic Planning & Resource Allocation Process (SPRA) were considered by the Committee in January 2021. A consolidated approach across the whole organisation and all individual programmes, to identify key objectives and operational objectives collectively for the next three years, is the ambition of this work. The Committee recognised that the key objectives in 2021/22 may be significantly influenced by Scottish Government direction and the range of political priorities that Fife are being tasked to deliver, against the general backdrop of the pandemic. The Committee noted the inter-dependency and associated risks between delays in progressing a review of strategic planning and our ability to progress recurring savings and confirmed their support for the SPRA process as the initial step towards addressing this inter-dependency. Members, however, welcomed the aim to deliver a meaningful and structured prioritisation process for resource allocation across the range of operational, workforce and financial planning activities, with a medium-term focus. One of the key tasks of this process is to support the delivery an overarching health and wellbeing strategy, with underpinning and enabling frameworks, such as estates, workforce etc., which are aligned to deliver to overall strategy to the best effect. The Committee looks forward to inputting into that work as it develops further over the current year.

4.14 The Committee has considered updates around the status of General Policies & Procedures, noting that this has been a challenging year to progress this backlog of work due to Covid-related pressures on staff time. Members have been supportive of efforts to move to a more streamlined review process, utilising electronic software solutions where appropriate, and this remains under investigation as a project suitable for wider organisational support. Dedicated staff resource has been secured to assist with the general administration and review of General Policies, and this is expected to improve the situation in the long term.

4.15 The Committee considered matters in relation to the following capital schemes:

- Elective Orthopaedic Centre
- Hospital Electronic Prescribing & Medicines Administration (HEPMA)
- Robotic Assisted Surgery

Updates were provided to members in July and September 2020 on the progress towards finalising a Full Business Case for the Elective Orthopaedic Centre, with minimal delay to the original timeline noted despite Covid pressures. At its November meeting, the Committee considered the final Business Case for the new centre. Recognising the significance of this project for enhancing patient care in Fife and for creating world-leading facilities for the innovative orthopaedic team, the Committee endorsed the Business Case for full Board approval. Also approved in November 2020 was the full Business Case for the HEPMA project, with further detail provided to members on the chosen supplier, revenue charging model and length of contract, to provide assurance that the right model for Fife was being followed. In March 2021, the Committee supported the initial Business Case for the purchase of a surgical robot, from 2020/21 capital funding availability, noting that a full Business Case will be reviewed at a future meeting.

4.16 The Committee also considered and endorsed the Capital Programme 2020/21 to 2024/25, noting the individual projects within the plan, such as those related to mental health, Kincardine and Lochgelly Health Centres, pharmacy robotics, digital & information, and laboratory information systems. A Procurement Governance Programme Board has been established to ensure all procurements are supported effectively and capture the required capacity and expertise. This will help to ensure projects progress strategically, to ensure projects take place in the right sequence, are well governed and opportunities are not missed.

4.17 The annual Public Private Partnership (PPP) Monitoring Report for 2019-20, covering the sites of St Andrews Community Hospital and Phase 3 of the Victoria Hospital in Kirkcaldy, was considered by the Committee in November 2020, with members gaining assurance from the positive audit opinion detailed therein. Members reviewed the Interim Property & Asset Management Strategy (PAMS) update for 2020 in detail at its March 2021 meeting. The PAMS follows a prescribed format given nationally, which addresses Scottish Government reporting requirements and forms part of a 'state of the nation' report, putting Fife into context with other NHS Boards. It was recognised that this year all Boards' processes had been heavily impacted by Covid, though there was still a requirement to report on the key indicators through NHS Fife's governance process. A more comprehensive and up-to-date document will be presented shortly to the Committee, which will be more forward looking and with particular focus on what the future Estates plans and challenges are. Members look forward to contributing to discussions around the long-term Estates strategy and the opportunities in this area to support the new strategy development.

4.18 In November 2020, the Committee considered the Payroll Consortium Business Case, which has also had input from Staff Governance Committee. The proposal outlines the ambition to build a single employer, with multiple bases, to ensure the resilience of payroll on a regional basis in the future, given long-standing capacity challenges across boards. Members supported the proposal in principle, noting the criticality of the service to the Health Board, but recommended discussions take place about a more phased approach than the draft timeline suggested. At the January 2021 meeting, a report on the East Region Recruitment Transformation project was given to members, summarising the broad principles agreed by several boards to move to a shared recruitment service (a single employer, with multiple locations). Members flagged the requirement for any new service to remain responsive to the specific needs of NHS Fife, ensuring that the successful engagement that presently takes places with local schools and colleges continues and that it supports improvements in the length of time taken to hire new staff.

4.19 In January 2021, members reviewed the national outline Business Case for the replacement of the Laboratory Information Management System (LIMS), in which NHS Fife is involved as part of a consortium with ten other boards. The requirement to translate the national case into a local delivery plan was highlighted, as was the need to identify saving opportunities, given the anticipated cost of a replacement system and the uncertainty as yet over Scottish Government funding support.

4.20 Within its agenda during the year, the Committee has considered internal audit reports relevant to its remit and the actions required thereunder, which are monitored for completion by the Audit & Risk Committee. In addition, in September 2020, the Committee received the first annual report on the Laboratories Managed Service Contract, focused on the performance against contract. An underspend was noted in the reporting year and the reasons for this considered by the Committee. Also considered in November was a detailed report on the demand for and supply of PPE and supplies during the height of the pandemic, ensuring that any lessons learned are recognised and implemented.

4.21 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. Outcomes

5.1 The Committee has, through its scrutiny and monitoring of regular finance reports and other one-off reports, been able to assure the Board that NHS Fife:

- complied with statutory financial requirements and achieved its financial targets for the financial year 2020/21;
- met specific reporting timetables to both the Board and the Scottish Government Health & Social Care Directorates;
- made adequate progress in the delivery of efficiency savings (on a recurring and non-recurring basis), noting the continuing challenges within Acute non-delivery of savings and social care spend within the Fife Health & Social Care Partnership; and
- has taken account of planned future policies and known or foreseeable future developments in the financial planning process.

6 Best Value

6.1 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 2 provides evidence of where and when the Committee considered the relevant characteristics during 2020/21.

7 Risk Management

7.1 In line with the Board's agreed risk management arrangements, the Finance, Performance & Resources 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 Frameworks (BAF) covering Financial Sustainability, Strategic Planning and Environmental Sustainability. Progress and appropriate actions were noted. Within the Committee's remit specifically, the ongoing risks presented by the failure to achieve savings targets within Acute, in addition to ongoing pressures in the Partnership in relation to the Social Care budget and the potential impact of the Integration risk share arrangement, were considered in detail, with assurances sought over mitigating actions.

7.2 In the current year, the complexity of financial reporting increased as a result of maintaining the core and Covid financial monitoring and reporting arrangements. The Committee has maintained an appropriate focus on these risks in its discussions, in addition to its regular scrutiny of the Financial Sustainability BAF and the tracking of the high risks identified therein.

7.3 The Committee closely monitored the position in relation to the uncertainty in-year of the impact on expenditure and availability of national funding to support the additional costs associated with

the pandemic. The Committee noted confirmation of a first tranche of national funding in October 2020 and then a second in January 2021. The final allocation in January ensured that all Covid costs would be covered in full. Some aspects of this funding and a number of late allocations have been ear-marked in reserves held by the IJB to cover continuing streams of Covid-related activity in 2021/22. The Committee also noted that as a result of national support for the under delivery of NHS Fife and IJB savings targets, that the IJB will break-even in 2020/21 and there will be no requirement to enact the risk-share agreement.

7.4 The Committee closely monitored progress in mitigating a range of environmental and estate sustainability risks and also recommended that the NHS Fife Board support an important Consort proposal to address the long-standing medium temperature hot water issues on the Victoria Hospital site.

8 Self-Assessment

8.1 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.

9. Conclusion

9.1 As Chair of the Finance, Performance and Resources Committee at 31 March 2021, 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 financial planning and monitoring and governance arrangements were in place throughout NHS Fife during the year, including scrutiny of all aspects of non-financial performance metrics, noting the particular impact of Covid upon the indicators generally.

9.2 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: R. Laing Date: 14 May 2021

Rona Laing, Chair
On behalf of the Finance, Performance and Resources Committee

Appendix 1 – Attendance Schedule
Appendix 2 – Best Value

APPENDIX 1

FINANCE, PERFORMANCE AND RESOURCES COMMITTEE
ATTENDANCE SCHEDULE 2020/21

	17.06.20	07.07.20	08.09.20	10.11.20	12.01.21	16.03.21
R Laing (Chair)						

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	17.06.20	07.07.20	08.09.20	10.11.20	12.01.21	16.03.21
N McCormick, Director of Property & Asset Management						
S Raynor, Senior HR Manager						

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
Resources required to achieve the strategic plan and operational plans e.g. finance, staff, asset base are identified and additional / changed resource requirements identified.	Financial Plan Workforce Plan Property & Asset Management Strategy	**FINANCE, PERFORMANCE & RESOURCES COMMITTEE** **STAFF GOVERNANCE COMMITTEE** **BOARD**	Annual Annual Annual Bi-annual Bi-monthly	Annual Operational / Remobilisation Plan Financial Plan Workforce Plan Property & Asset Management Strategy Integrated Performance & Quality Report
The strategic plan is translated into annual operational plans with meaningful, achievable actions and outcomes and clear responsibility for action.	Winter Plan Capacity Plan	**FINANCE, PERFORMANCE & RESOURCES COMMITTEE** **CLINICAL GOVERNANCE COMMITTEE** **BOARD**	Annual Bi-monthly Bi-monthly	Winter Plan Minutes of Committees Integrated Performance & Quality Report

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 publically available. Committee papers and minutes are publically available	**BOARD** **COMMITTEES**	On going	NHS Fife 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 section on all reports

APPENDIX 2

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
NHS Fife conducts rigorous review and option appraisal processes of any developments.	Business cases	**BOARD** **FINANCE, PERFORMANCE & RESOURCES COMMITTEE**	Ongoing	Business Cases

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 understands and measures and reports on the relationship between cost, quality and outcomes.	Reporting on financial position in parallel with operational performance and other key targets	**BOARD** **FINANCE, PERFORMANCE & RESOURCES COMMITTEE**	Bi-monthly	Integrated Performance & Quality Report
The organisation has a comprehensive programme to evaluate and assess opportunities for efficiency savings and service improvements including comparison with similar organisations.	National Benchmarking undertaken through Corporate Finance Network. Local benchmarking with similar sized organisation undertaken where information available. Participation in National Shared Services Programme Systematic review of activity / performance data through use of Discovery tool	**FINANCE, PERFORMANCE & RESOURCES COMMITTEE** **BOARD**	Annual Bi-monthly Ongoing	Financial Plan Integrated Performance & Quality Report Financial overview presentations

APPENDIX 2

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
Organisational budgets and other resources are allocated and regularly monitored.	Annual Operational / Remobilisation Plan Integrated Performance & Quality Report	**FINANCE, PERFORMANCE & RESOURCES COMMITTEE**	Bi-monthly	Integrated Performance & Quality Report SPRA Process
NHS Fife has a strategy for procurement and the management of contracts (and contractors) which complies with the SPFM and demonstrates appropriate competitive practice.	Code of Corporate Governance Financial Operating Procedures	**FINANCE, PERFORMANCE & RESOURCES COMMITTEE**	Reviewed annually	Code of Corporate Governance Financial Operating Procedures
NHS Fife understands and exploits the value of the data and information it holds.	Annual Operational / Remobilisation Plan Integrated Performance & Quality Report	**BOARD** **COMMITTEES**	Annual Bi-monthly	Annual Operational / Remobilisation Plan Integrated Performance & Quality Report

APPENDIX 2

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
Fixed assets including land, property, ICT, equipment and vehicles are managed efficiently and effectively and are aligned appropriately to organisational strategies.	Property and Asset Management Strategy	**FINANCE, PERFORMANCE & RESOURCES COMMITTEE**	Bi-annual Ongoing Bi-monthly Monthly	Property and Asset Management Strategy Report on asset disposal Integrated Performance & Quality Report Minutes of NHS Fife Capital Investment Group

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

APPENDIX 2

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 & Quality 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

APPENDIX 2

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
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

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 respects the limits of the planet's environment, resources and biodiversity in order to improve the environment and ensure that the natural resources needed	Sustainability and Environmental report incorporated in the Annual Accounts process.	**FINANCE, PERFORMANCE & RESOURCES COMMITTEE** **BOARD**	Annual	Annual Accounts

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
for life are unimpaired and remain so for future generations.				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 section 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 section 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 section on reports

APPENDIX 2

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 section on reports

ANNUAL STATEMENT OF ASSURANCE FOR
NHS FIFE REMUNERATION COMMITTEE FOR 2020/21

1. Purpose

1.1 The purpose of the Remuneration Committee is 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. Membership

2.1 During the financial year to 31 March 2021, membership of the Remuneration Committee comprised: -

Tricia Marwick	Chair / Chair of the NHS Fife Board
Dr Les Bisset	Non-Executive Director
Martin Black	Non-Executive Director
Wilma Brown	Employee Director
Carol Potter	Chief Executive

2.2 The Committee may invite individuals to attend Committee meetings for particular agenda items. The Director of Workforce, and the PA to the Director of Workforce/Corporate Services Manager will normally be in 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 financial year to 31 March 2021, on the undernoted dates:

- 2 June 2020
- 7 October 2020
- 9 November 2020 (meeting reconvened from 7 October 2020 due to items of business from that meeting being outstanding)
- 14 December 2020
- 26 January 2021
- 30 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 to some extent by the need for NHS Fife as a whole to address the ongoing challenges of the global Coronavirus pandemic, e.g. appraisal activities and the submission of associated performance information. In recognition 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 since that date.

4.2 Whilst the scheduled dates were revised during the year the Committee continued to meet, utilising videoconferencing technology. The 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.

4.3 The Remuneration Committee's first meeting of the 2020/21 reporting year was in June 2020, where the Annual Report for 2019/20 was considered. Also discussed in June 2020 was a detailed report on the impact on remuneration and performance activities as a result of the COVID-19 response. The Committee also considered a request for the application of Discretionary Point and the Suspension of the Prohibition of Overtime.

4.4 At its meetings in October/November 2020 the Committee considered the Performance Appraisals for the Executive and Senior Management Cohort for 2019/20, ensuring the submission to the NPMC (National Performance Management Committee).

4.5 The Committee also approved; the Award of Discretionary Points for Consultants (2020), and the Schedule for its meetings during 2021/22.

4.6 In December 2020, the Committee received an update on the actions to complete recent Executive Appointments, endorsed the proposed values-based recruitment approach, and considered the proposed scheme of delegation for Executive Portfolios presented by the Chief Executive.

4.7 The letter from the Cabinet Secretary describing the extension of duties into Care Homes for the Director of Nursing was noted by the Committee.

4.8 In January 2021, the Committee reviewed the Chief Executive Job Description for its submission to the National Evaluation Committee.

4.9 The Letter of Assurance from the NPMC was also received at the January meeting, confirming the ratings as previously recommended by the Committee. The objectives for the Executive Cohort for 2020/21 were agreed.

4.10 At its meeting in March, the Committee completed the annual review of its Terms of Reference, agreeing a minor revision. The revised Terms of Reference were then to be presented to the Board for consideration.

4.11 Executive Cohort Objectives for 2020/21 were considered and approved, and an additional annex demonstrating the link between the Corporate Objectives and individual objectives assigned to Directors was noted. This meeting also considered the Job Description for the Director of Acute Services and noted the process to appoint to this post.

4.12 The Committee received throughout the year papers relating to remuneration of individual postholders, e.g. commencing salary. The individual decisions are recorded in its minutes.

4.13 At each meeting appropriate circulars and letters were presented and noted by the Committee.

5. Self Assessment

5.1 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 Committee level.

6. Conclusion

6.1 As Chair of the Remuneration Committee during financial year 2020/21, I am satisfied that, 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 appropriate arrangements were in place for the implementation of the circulars and the Committee fulfilled its remit and purpose.

6.2 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: 25 May 2021

Tricia Marwick, Chair

Appendix 1 – Attendance Schedule
Appendix 2 – Best Value

APPENDIX 1

NHS FIFE REMUNERATION COMMITTEE

ATTENDANCE SCHEDULE 1 APRIL 2020 – 31 MARCH 2021

	02.06.20	**07.10.20**	**09.11.20**	**14.12.20**	**26.01.21**	**30.03.21**
Tricia Marwick, Chair	ü	ü	ü	ü	ü	ü
Carol Potter, Chief Executive	ü	ü	ü	ü	ü	ü
Les Bisset, Non-Executive	ü	ü	ü	ü	ü	ü
Martin Black, Non-Executive	ü	ü	ü	ü	ü	ü
Wilma Brown, Employee Director	ü	ü	ü	ü	ü	ü
In attendance						
Linda Douglas, Director of Workforce	ü	ü	ü	ü	ü	ü

Best Value

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**
There are mechanisms within the organisation to develop and monitor relevant leadership and strategic skills in Board members and senior management.	This is achieved through the development of Personal Development Plans and Annual Appraisals.	**CHAIR / CHIEF EXECUTIVE** **REMUNERATION COMMITTEE**	Annual	Annual Appraisal process for Executive and Senior Management (ESM) posts

EFFECTIVE PARTNERSHIPS

The “Effective Partnerships” theme focuses on how a Best Value organisation engages with partners in order to secure continuous improvement and improved outcomes for communities, not only through its own work but also that of its partners.

OVERVIEW
A Best Value organisation will show how it, and its partnerships, are displaying effective collaborative leadership in identifying and adapting their service delivery to the challenges that clients and communities face. The organisation will have a clear focus on the collaborative gain which can be achieved through collaborative working and community engagement in order to facilitate the achievement of its strategic objectives and outcomes.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
There is no responsibility in this area under the remit of the Remuneration Committee				

GOVERNANCE AND ACCOUNTABILITY

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

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

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
Board and Committee decision-making processes are open and transparent.	Board meetings are held in open session and minutes are publicly available. Committee papers and minutes are publicly available.	**BOARD** **COMMITTEES**	On going	NHS Fife 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

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 understands and exploits the value of the data and information it holds.	Annual Operational Plan /Remobilisation Plan. Integrated Performance & Quality Report.	**BOARD** **COMMITTEES**	Annual Bi-monthly	Annual Operational Plan Integrated Performance & Quality Report
NHS Fife ensures that all employees are managed effectively and efficiently, know what is expected of them, their performance is regularly assessed and they are assisted in improving.	Executive and Senior Manager (ESM) performance reporting.	**REMUNERATION COMMITTEE**	Annual and as required	Minutes of Remuneration Committee
Staff performance management recognises and monitors contribution to ensuring continuous improvement and quality.	Executive and Senior Manager Objectives Setting and Review.	**REMUNERATION COMMITTEE**	Annually	Minutes of Remuneration Committee

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**
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	Minutes of Committees

APPENDIX 2

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**
There is no responsibility in this area under the remit of the Remuneration Committee				

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.	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 appropriate reports

ANNUAL STATEMENT OF ASSURANCE FOR
NHS FIFE STAFF GOVERNANCE COMMITTEE FOR 2020/21

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, 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 all services, including those devolved to the Integration Joint Board.

2. Membership

2.1 During the financial year to 31 March 2021, membership of the Staff Governance Committee comprised: -

Margaret Wells	Chair / Non-Executive Member
Wilma Brown	Employee Director
Helen Buchanan	Director of Nursing (to February 2021)
Eugene Clarke	Non-Executive Director
Christina Cooper	Non-Executive Director
Simon Fevre	Co-Chair, H&SCP Local Partnership Forum
Alistair Morris	Non-Executive Director
Janette Owens	Director of Nursing (from March 2021)
Carol Potter	Chief Executive
Andrew Verrecchia	Co-Chair, Acute Services Division Local Partnership Forum

2.2 The Committee may invite individuals to attend Committee meetings for particular agenda items, but the Director of Workforce, Director of Acute Services, Director of Health & Social Care, Deputy Director of Workforce, Heads of Service Workforce Directorate, and Board Secretary will normally be in 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 seven occasions during the financial year to 31 March 2021, on the undernoted dates:

- 18 June 2020
- 3 July 2020
- 4 September 2020
- 29 October 2020
- 13 January 2021

- 4 March 2021
- 9 March 2021 (meeting reconvened from 4 March 2021 due to items of business from that meeting being deferred)

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 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 increasing 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. 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 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, to help enhance agenda planning and ensure that no areas of risk have been overlooked.

4.3 The Staff Governance Committee's first meeting of the 2020-21 reporting year was in June 2020, where a briefing was given on the changes made to the Board's usual governance arrangements and structures. The report included detail on the Gold / Silver / Bronze Command operational groups set up to manage the day-to-day response to the pandemic, including the staff-related aspects of that. Assurance was taken from comments made at the meeting by staff-side representatives, who highlighted that the right people were involved in the various groups that had been established, and there were no barriers encountered if staff had any issues or concerns to raise in relation to the ongoing management of Covid-19 in the workplace.

4.4 Also discussed in June 2020 was a detailed report and presentation on the mobilisation and deployment of the current workforce to address the operational pressures caused by Covid-19 activity and, as this reduced, the remobilisation of services thereafter. The Committee considered the update provided, noting that protecting staff well-being and enhancing support had been a constant priority, and that the introduction of dedicated staff 'hubs' across a number of sites had been central to this work. The update also outlined the recruitment efforts to bolster the workforce as the pandemic hit, and the efforts of students and those who had returned to clinical practice from retirement etc. were greatly commended.

4.5 At its July 2020 meeting, the Committee's agenda was prioritised to review further updates on the workforce response and mobilisation against Covid-19 and governance-related items linked to the year-end process. An update was given on the large volume of national directives, policy changes and circulars issued during the pandemic, and the need to work closely with partnership colleagues to ensure swift, local implementation and cascade of this information throughout the organisation. Ensuring that ongoing engagement continued with candidates who came forward during the initial Covid-related recruitment campaigns was recognised, given the recruitment challenges in general facing the NHS and the ongoing difficulties in recruiting to a number of particular specialities.

4.6 Regular updates on Covid-19 related topics have been given to the Committee during the year, reflecting the priorities of the Board and it being under Scottish Government direction for the period covered by this report. In addition to detailed reports on recruitment and staff well-being during the pandemic, the Committee has also scrutinised the programme of staff testing and vaccination against Covid-19, noting the rapid roll-out and success of these.

4.7 In July 2020, the Committee also received an update on the Workforce Strategy and how significant changes to service delivery experienced during Covid-19 would require to be reflected therein. The work of the NHS Fife Strategic Workforce Planning Group, which had resumed its usual schedule of meetings at that stage, was noted as being the vehicle to take this forward. Further updates have been given throughout the year.

4.8 Enhancing the support for staff by creating permanent homes for the dedicated staff hubs has been a vital aspect of the overall NHS Fife response. The Committee received updates on staff well-being activities at its July, September 2020 and January and March 2021 meetings, noting that the significant usage of the hubs was indicative of how useful they had been to staff. Further detail was also given on the well-being activities available to the many staff who were now working off-site (either working from home in a non-patient facing role or by shielding requirements), including mindfulness sessions being delivered online for those located at a distance from a physical hub. The potential for long-term effects of the pandemic on staff well-being were noted by the Committee, as was the importance of face-to-face support as services remobilised. At its January 2021 meeting, the Committee received a report from the Director of Estates, Facilities & Capital Services, summarising the outcome of a recent Health & Safety Executive (HSE) visit to review Covid-19 compliance measures aimed at protecting staff from the risks of infection. Assurance was provided that the recommendations made by the HSE following their visit were all being actively addressed as a matter of priority.

4.9 In September and October 2020, the Committee received updates on the specific workforce requirements of the Test & Protect and the Staff Seasonal Flu Immunisation programmes, reflecting on the potential risks of staff redeployment on the sustainability of other services and on the use of short-term contracts. Further updates were given to the Committee in October 2020 on the workforce plan for the Scheduling of Unscheduled Care programme and that in place for the Board's Winter Plan activities. Minutes of the Strategic Workforce Planning Group were tabled for information to the Committee from October 2020 onwards.

4.10 The delayed launch of the National Whistleblowing Standards to 1 April 2021 has been detailed to the Committee, via a number of reports outlining how the new Standards will be rolled out within Fife. It is anticipated that the Board's new Whistleblowing Champion will contribute to the local implementation of this work, when she takes up her position as a Committee member from April 2021. The Committee at its meeting on 29 October 2020 received a report on the current arrangements for Whistleblowing and were satisfied that these arrangements were appropriate during 2020/21.

4.11 Reflecting on staff experience remains an important part of the Committee's business. The Committee has considered the Everyone Matters Pulse Survey in the reporting year, with a

presentation delivered to members in March 2021 detailing its findings. A summary of appraisal and personal development planning performance was considered by the Committee in September 2020 and January 2021, noting the negative impact of the pandemic on completion figures. The Committee has also reviewed Core Skills training compliance, which remains just short of target. Measures are in place to improve staff engagement going forward and the Committee will continue to scrutinise performance in this area.

4.12 The Committee receives regular updates on recruitment, including data on consultant recruitment (including those specialities with particular challenges) and on efforts to improving nursing and midwifery recruitment, particularly in partnership with local universities and colleges. The annual report on Medical Appraisal and Revalidation was considered by the Committee in January 2021, giving assurance that doctors within NHS Fife are practising to the appropriate professional standards.

4.13 The success of a number of dedicated recruitment campaigns aimed at increasing the workforce during the height of the Covid pandemic has been noted by the Committee. A Youth Employment Update was considered in October 2020, and an update on workforce-related matters linked to EU Exit was given at the same meeting. A discussion on vacancy levels took place in January 2021, with further work to be undertaken to identify any particular trends in specific specialities, to improve targeted recruitment activities.

4.14 Progress reports on the development of a number of 'Once for Scotland' employment policies have been supplied to members, with an update in October 2020 noting that a new digital platform for easy access to this information could be further enhanced to ensure all changes are adequately notified to line managers and staff. The improved consistency of information made across Boards was welcomed by Committee members.

4.15 At each meeting of the Committee, members routinely scrutinise the relevant section of the Board Assurance Framework on Workforce Sustainability, and also receive regular updates on Absence Management performance, and Well at Work activities. Within the Integrated Performance & Quality Report (IPQR), the Committee has responsibility for scrutiny of the measure on sickness absence. Regular updates were given to the Committee over the course of the year, particularly in relation to how Covid-19 had affected the target trajectory for this indicator. The Committee has been supportive of additional measures relating to Staff Governance being added to the IPQR, particularly those that provide a more rounded representation of workforce performance than absence statistics alone provide.

4.16 A particular strand of the Staff Governance standards is reviewed at each meeting, ensuring full coverage over the year's meeting schedule. The Committee received individual papers to demonstrate that staff are: well informed; appropriately trained and developed; involved in decisions; treated fairly and consistently, with dignity and respect, in an environment where diversity is valued; and provided with a continuously improving and safe working environment, promoting the health and well-being of staff.

4.17 The Committee has reviewed its remit during the year and a number of clarifying changes to wording within the Terms of Reference have been agreed. As part of this review, a new form of wording has been agreed to ensure that staff-side representatives have the means to nominate a deputy to attend each meeting, in the event that the substantive member is not able to attend. This ensures the Committee always has the required staff-side input into its discussions.

4.18 During the year, the Committee received a number of detailed presentations, covering a variety of relevant topics including: (i) South East Payroll Services Consortia Business Case; (ii) East Region Recruitment Transformation; (iii) the implementation and staffing requirements of the new General Medical Services contract; (iv) the new Strategic Planning & Resource Allocation process; and (v) the results of the Everyone Matters Pulse Survey

Report. The Committee thanks those who took time to attend meetings to present, noting the usefulness of these sessions.

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 In line with the Board's agreed risk management arrangements, the Staff Governance 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 Workforce Sustainability section of the Board Assurance Framework (BAF). Progress and appropriate actions were duly noted.

6.2 During the course of the year, whilst there has been no change to rating of the workforce sustainability risks reported to the Committee within the BAF, these have been updated to include Covid-19 related workforce challenges and to reflect developments. A new linked workforce high operational risk was added in January 2021 (Lack of Medical Capacity in Community Paediatrics) and the extant linked operational high risks are reviewed with the presentation of the BAF to the Committee. The key workforce risks are reviewed and used to inform the development of the Committee's workplan for the following year. The Committee approves its workplan annually.

7. Self Assessment

7.1 The Committee has undertaken a self-assessment of its own effectiveness, for the year 2020/21 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 April 2021 meeting, and action points are being taken forward at both Committee and Board level, as appropriate.

8. Conclusion

8.1 As Chair of the Staff Governance 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 Staff Governance planning and monitoring arrangements were in place throughout NHS Fife during the year.

8.2 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, and to the contribution of our staff side colleagues, particularly in this most challenging of years, set against the backdrop of the Coronavirus pandemic.

Signed:  Date: 29 April 2021

Margaret Wells, Chair

Appendix 1 – Attendance Schedule
Appendix 2 – Best Value

APPENDIX 1

NHS FIFE STAFF GOVERNANCE COMMITTEE
ATTENDANCE SCHEDULE 1 APRIL 2020 – 31 MARCH 2021

	18.06.20	03.07.20	04.09.20	29.10.20	13.01.21	04.03.21	09.03.21
Mrs M Wells	ü	ü	ü	ü	ü	ü	ü
Mrs W Brown	ü	ü	ü	ü	ü	ü (part)	ü
Ms H Buchanan	ü	ü	ü	ü	ü		
Mrs C Cooper	ü	ü	ü	ü	ü	ü	ü
Mr S Fevre	ü	ü	ü	ü	ü	x	x
Ms K Miller (to 30 November 2020)	ü	ü	x	x			
Mr A Morris	ü	ü	ü	ü	ü	ü	ü
Ms J Owens						ü	ü
Ms C Potter	ü	ü	ü	ü	ü	ü	ü
Mr A Verrecchia	ü	ü	ü	ü	ü	x	ü

In attendance

L Parsons, Depute for Co-Chair, H&SCP LPF						ü	
L Douglas, Director of Workforce	ü	ü	ü	ü	ü	ü	ü
N Connor, Director of H&SC	ü		ü	ü	ü	x	x
C Dobson, Director of Acute Services					ü	ü	ü
K Reith, Deputy Director of Workforce				Observer	ü	ü	ü
B Anderson, Head of Staff Governance	ü	ü	ü	ü			
K Berchtenbreiter, Head of Workforce Development	ü	ü	ü	ü	ü	x	x
R Waugh, Head of Human Resources	ü	ü	ü	ü	ü	ü	ü
A Mackay, Deputy Chief Operating Officer	ü	ü					
G MacIntosh, Board Secretary	ü	ü	ü	x	ü	ü	ü
L Barker, Associate Director of Nursing, H&SCP						ü	
J Crichton, Interim Project Management Director		ü					
A Fairgrieve, Director of Estates, Facilities & Capital Planning					ü		
M McGurk, Director of Finance					ü		ü
S Fraser, Associate Director of Planning & Performance		ü					

APPENDIX 1

	18.06.20	**03.07.20**	**04.09.20**	**29.10.20**	**13.01.21**	**04.03.21**	**09.03.21**
Dr H Hellewell, Associate Medical Director, H&SCP					ü		
Ms S Raynor, Senior HR Manager					ü	ü	ü

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**
NHS Fife acts in accordance with its values, positively promotes and measures a culture of ethical behaviours and encourages staff to report breaches of its values.	Whistleblowing Policy Code of Corporate Governance	**BOARD** **STAFF GOVERNANCE COMMITTEE**	Annual	Whistleblowing Champion appointed as a Board member and a member of this Committee Review of new National Whistleblowing Standards and preparation for their introduction from April 2021 Model Code of Conduct included in annually reviewed Code of Corporate Governance

APPENDIX 2

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
Resources required to achieve the strategic plan and operational plans e.g. finance, staff, asset base are identified and additional / changed resource requirements identified.	Financial Plan Workforce Plan Property & Asset Management Strategy	**FINANCE, PERFORMANCE & RESOURCES COMMITTEE** **STAFF GOVERNANCE COMMITTEE** **BOARD**	Annual Annual Annual Bi-annual Bi-monthly	Annual Operational / Remobilisation Plan Financial Plan Workforce Plan Property & Asset Management Strategy Integrated Performance & Quality Report

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 publically available. Committee papers and minutes are publically available.	**BOARD** **COMMITTEES**	Ongoing	Board section on NHS website, containing papers and instructions for those wishing to join meetings as public observers
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

APPENDIX 2

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
NHS Fife can demonstrate that it has clear mechanisms for receiving feedback from staff and responds positively to issues raised.	Annual feedback Individual feedback	**CLINICAL GOVERNANCE COMMITTEE**	Annual Ongoing Quarterly Bi-monthly	Annual Review with Ministers Care Opinion Regular meetings with MPs/MSPs Integrated Performance & Quality Report

APPENDIX 2

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 ensures that all employees are managed effectively and efficiently, know what is expected of them, their performance is regularly assessed and they are assisted in improving.	AfC appraisal process and Executive and Senior Manager Performance reporting. Medical performance appraisal (also reported to Clinical Governance Committee).	**STAFF GOVERNANCE COMMITTEE** **REMUNERATION COMMITTEE**	Annual and as required Bi-monthly	eKSF & iMatter reports Integrated Performance & Quality Report
NHS Fife understands and measures the learning and professional development required to support statutory and professional responsibilities and achieve organisational objectives and quality standards.	Core Training compliance reported Medical revalidation report and monitoring Nursing revalidation.	**STAFF GOVERNANCE COMMITTEE**	Ongoing	Minutes of Staff Governance Committee

APPENDIX 2

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
Staff performance management recognises and monitors contribution to ensuring continuous improvement and quality.	Service Improvement and Quality are core dimensions of AfC appraisal process. Executive and Senior Manager Objectives – core collective objectives include performance and leadership.	**STAFF GOVERNANCE COMMITTEE** **REMUNERATION COMMITTEE**	Ongoing	Minutes of Staff Governance Committee & Remuneration Committee

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

APPENDIX 2

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 & Quality 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

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 promotes personal well-being, social cohesion and inclusion.	Healthy workforce	**STAFF GOVERNANCE COMMITTEE** **BOARD**	Ongoing	Healthy Working Lives Gold Award Equality Outcomes reporting Public Health Annual Report

APPENDIX 2

APPENDIX 2

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.	Equality Reporting	**BOARD** **COMMITTEES**	Ongoing	EQIA section 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 section on all reports
NHS Fife's Performance Management system regularly measures and reports its performance in contributing to the achievement of equality outcomes.		**CLINICAL GOVERNANCE COMMITTEE**	Ongoing	Minutes

APPENDIX 2

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE:
NHS Fife ensures that all members of staff are aware of its equality objectives.	Induction Equality and Diversity is core dimension in KSF (Knowledge and Skills Framework) that underpins the appraisal process for AfC staff Equality and Diversity Learn Pro Module	**STAFF GOVERNANCE**	Ongoing	iMatter reports eKSF reports Minutes
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 (under review) EQIA section on reports
Wherever relevant, NHS Fife collects information and data on the impact of policies, services and functions on different equality groups to help inform future decisions.	In accordance with the Equality and Impact Assessment Policy, Impact Assessments will collect this information to inform future decisions.	**BOARD** **COMMITTEES**	Ongoing	EQIA section on reports

Fife Health & Social Care Partnership
Supporting the people of Fife together

Meeting Title:	**IJB Audit & Risk Committee**
Meeting Date:	**4 June 2021**
Agenda Item No:	
Report Title:	**IJB Annual Audit Report 2020-21**
Responsible Officer:	**Nicky Connor, Director of Health and Social Care**
Report Author:	**Avril Cunningham, Chief Internal Auditor (2021-21)**

1 Purpose

An annual audit report is a requirement of the Public Sector Internal Auditing Standards (PSIAS). This report contains the Annual Assurance Statement 2020/21, a performance overview, and an update on compliance with the PSIAS.

This Report is presented to the Board for:

- Awareness
- Discussion

This Report relates to the following National Health and Wellbeing Outcome*:*

9 Resources are used effectively and efficiently in the provision of health and social care services.

This Report aligns to the Integration Joint Board 5 Key Priority*:*

- Managing resources effectively while delivering quality outcomes.

2 Route to the Meeting

During the compilation of this report, consultation has taken place with Health & Social Care Partnership management and FTF Fife Internal Audit Service Chief Internal Auditor.

3 Report Summary

3.1 Situation

It is considered important, that at least annually, members of the Audit & Risk Committee should receive a report from the Chief Internal Auditor that includes

an assessment of the adequacy, reliability and effectiveness of the internal control system of the Fife Integration Joint Board (IJB).

3.2 Background

Assurance Statement:
The annual statement of assurance on the adequacy and effectiveness of corporate governance and the internal control system of the IJB for the year ended 31 March 2021 is included at Appendix 1.

Performance Overview 2020/21
The Fife Integration Joint Board (IJB) Operational Plan for 2020/21 was approved at the IJB Audit & Risk Committee on 13 March 2020. This included two audits, Risk Management and Transformation Programme, brought forward for completion from 2019/20, and Financial Information audit and a follow up audit (subsequently replaced by a high-level self-assessment on governance during the pandemic).

All audit reports were issued by 31 March 2021, with the governance review self-assessment report issued on 10 May 2021.

Work undertaken on post audit reviews is reported separately to Committee.

Public Sector Internal Audit Standards –Audit Services, Fife Council

Audit Services operates in accordance with the Public Sector Internal Audit Standards (PSIAS) which apply to Local Government. This was confirmed by the last External Quality Assessment report in April 2017.

The Scottish Local Authority Chief Internal Auditors Group provides the opportunity for EQAs to be performed as a peer review by the CAE of another Scottish Local Authority at least once every five years. The next independent external assessment of Audit Services' compliance against the PSIAS will be carried out in 2022 by the CAE of Aberdeen City Council.

The annual PSIAS self-assessment is underway, the outcome of which will be reported to Standards and Audit Committee in September 2021 in the Fife Council Annual Audit Report, and subsequently provided for information only to the IJB Audit & Risk Committee.

Public Sector Internal Audit Standards –FTF Internal Audit Service

An External Quality Assessment of FTF Internal Audit Service was undertaken by the Chief Internal Auditor, Midlothian Council and Scottish Borders Council, on behalf of the Chief Internal Auditors' Group in 2018/19. The annual self-assessment is underway and the outcome will be provided to this Committee for information in the Fife Council Annual Audit Report 2020/21 later in the year.

Overall, the EQA assessment undertaken concluded that "following completion of the comprehensive EQA Checklist and, based on the work undertaken, it is my opinion that the FTF Internal Audit service for Fife and Forth Valley generally conforms with the PSIAS."

3.3 Assessment

Covid-19 has had a significant impact and the IJB has had to adapt to new ways of working in difficult circumstances. Risk management, governance and internal controls and assurance have been key considerations in the recovery and redesign of services, with decision making supported by financial management and reporting. However, as may be expected, there are challenges and further action required to build on the work already undertaken.

I would like to take the opportunity to thank the Committee, NHS FTF Internal Audit Service, Audit Scotland and Health and Social Care Partnership management and staff for their support, guidance and assistance, and Audit Services staff for their efforts to fulfil the audit plan in difficult circumstances this year.

3.3.1 Quality/ Customer Care

Fife Council Audit Services and FTF Internal Audit (NHS Fife) comply with the Public Sector Internal Auditing Standards.

3.3.2 Workforce

There are no workforce implications arising directly from this report.

3.3.3 Financial

There are no financial impacts arising directly from this report.

3.3.4 Risk/Legal/Management

There are no risk or legal implications arising directly from this report.

3.3.5 Equality and Diversity, including Health Inequalities

An EqIA has not been completed and is not necessary for the following reasons. There are no EqIA implications arising directly from this report.

3.3.6 Other Impact

There are no other impacts arising directly from this report.

3.3.7 Communication, Involvement, Engagement and Consultation

During the compilation of this report, consultation has taken place between FTF Internal Audit Service and Fife Council Audit Services.

3.4 Recommendation

For awareness and discussion:

The Committee is asked to note the contents of this report, and in particular, my opinion that a medium level of control exists, and that reasonable assurance

can be placed on the adequacy and effectiveness of the systems of corporate governance and internal control in the year to 31 March 2021.

However, it is acknowledged that, in spite of the challenges, some progress has been made this year, particularly in relation to financial management, and progressing the planned reviews should lead to further improvements in governance, risk and control in the future.

4 List of Appendices

Appendix 1- Annual Assurance Statement
Appendix 2 - Evaluation Criteria

5 Implications for Fife Council

Not applicable – report will be provided to Standards and Audit Council for information

Implications for NHS Fife

Not applicable– report will be provided to FTF Audit Service for information

6 Implications for Third Sector

Not applicable

7 Implications for Independent Sector

Not applicable

8 Directions Required to Fife Council, NHS Fife or Both

Direction To:		
1	**No Direction Required**	

Report Contact

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ANNUAL ASSURANCE STATEMENT

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

As Chief Internal Auditor of Fife Integration Joint Board (IJB), I am pleased to present my annual statement on the adequacy and effectiveness of corporate governance and the internal control systems of the Integration Joint Board for the year ended 31 March 2021.

Respective responsibilities of management and internal auditors in relation to corporate governance and internal control

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

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

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

Sound internal controls

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

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

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

- poor judgement;
- human error;
- control processes being deliberately circumvented by employees and others;
- management overriding controls;

- unforeseeable circumstances;
- failure to meet objectives or
- material errors, losses, fraud or breaches of law or regulations.

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

- ongoing development of a sound corporate governance framework, including a review of the Integration Scheme and the refresh of the transformation framework;
- a governance framework, with further review of governance arrangements planned to follow the Integration Scheme review;
- a Strategic Risk Register, a Risk Management strategy and processes, with further development planned to follow the Integration Scheme review.
- the medium-term financial strategy, and regular reviews of periodic and annual financial reports which indicate financial performance against forecasts;
- an approved strategic plan for the 2019-2022 and performance framework, with plans for improved performance reporting;
- unqualified annual accounts for the last 4 years (2016-17 was the first year of operational responsibilities);
- well-defined Chief Officer responsibilities
- a well-established IJB Audit and Risk Committee.

The work of internal audit

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

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

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

An Internal Audit Output Sharing Protocol has been agreed between the IJB, Fife Council and FTF Audit and Management Services (NHS Fife) Chief to enable sharing of internal audit outputs in a controlled manner with Audit Committees for assurance purposes.

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

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

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

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

Basis of opinion

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

- the assessment of risk completed during the preparation and updating of the IJB Strategic Audit Plan;
- internal audit work undertaken (in all three organisations) for the year to 31 March 2021, and work carried out in prior years with agreed improvements being implemented in that year or later;
- reports issued during the year by Audit Scotland;
- my knowledge of the IJB's governance, risk management and performance monitoring arrangements.

The level of assurance provided for the year ended 31 March 2021 by the audit work undertaken is not limited by the onset of COVID-19 as all audit fieldwork was completed in the year.

Audit Findings

Internal and External Audit findings provide evidence that the Health and Social Care Integration Joint Board is developing a sound system of corporate governance and internal control which is appropriately monitored and reviewed.

The internal and external audits carried out in 2020/21 identified that, overall, processes and procedures had met the control requirements, or are working towards them, and revealed only relatively minor non-compliance or system weakness. Where audits identify processes where control objectives have not been fully achieved or there is a lack of compliance, action is agreed to address these areas for improvement.

Key findings include

- The Risk Management review identified the need for clarity on whether development of a shared risk management strategy has been delegated to the IJB, and the need for a timetable to drive completion of the risk review actions. These actions are delayed because they are dependent on the outcome of the IJB Integration Scheme review.
- The Transformation and Change Governance review focused on how IJB transformation and change governance arrangements align to its priorities and the IJB's overall governance structure. The recommendations related to clearly linking the IJB Strategic Plan and its resultant transformation programmes to the Plan for Fife, updating the Governance Manual to include strategic planning and transformation governance processes, developing a change management framework, and highlighting areas of improvement in the transformation governance process.
- The IJB Financial Regulations Audit confirmed that the IJB has approved regulations, which are included in the Governance Manual, but highlighted that these require to be reviewed and updated to clearly set out financial management responsibilities for the Health and Social Care Partnership.
- The overall outcome of the self-assessment on Governance arrangements during Covid-19 highlights that risk management, governance and internal controls and assurance have been key considerations in the recovery and redesign of services, with decision making supported by financial management and reporting.

In addition, my opinion on the level of internal controls, takes the following into account:

- While progress has been made, further work is still required, in conjunction with Fife Council and NHS Fife in relation to addressing accountability, assurance and governance, clarity over the ownership of risks regarding delegated services, and to drive transformation change through collaborative relationships with Fife Council and NHS Fife. Progress has been impacted by the need to prioritise the COVID-19 response, and the integration scheme review is ongoing, with some issues still to be addressed by Fife Council and NHS Fife.
- The delay in completing the integration scheme review has impacted on progress with IJB governance and risk management reviews, which are required to develop the governance framework and address areas for improvement identified in the key findings above.
- Due to the pandemic response and recovery taking priority The delivery of transformation and change has been postponed or slowed in many projects and transformation work this year, although redesign of some processes has occurred as a result of the pandemic response. However, positive steps have been made in appointing a Senior Leadership Team Lead for Transformation and discussion on refreshing both transformation projects, and the framework in which they operate, is underway.
- Progress is being made on strengthening financial and performance management, with the incorporation of Project Initiation Documents detailing efficiency and service redesign proposals into the revised Medium-Term Financial Strategy, recovery actions being identified to balance the budget and create capacity to take forward change projects, improved performance management reporting, and the development of a Directions Policy.

Level of opinion

Overall, internal controls were operating well and continued improvements to processes are being made. As part of each audit, a detailed action plan improving controls was agreed, and the outcome monitored. Where control failings or weaknesses were identified, management responded well and have agreed appropriate remedial action in line with an agreed, monitored action plan.

However, it is recognised that this has been a challenging year, and progress on areas for improvement identified in last year's assurance statement has been impacted by the need to prioritise Covid-19 response and recovery. Implementation of actions in response to audit recommendations has also been delayed as a consequence, and revised timescales agreed.

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

Opinion

It is my opinion that a medium level of control exists, and that reasonable assurance can be placed upon the adequacy and effectiveness of the Health and Social Care Integration Joint Board's systems of corporate governance and the internal control system in the year to 31 March 2021.

However, it is acknowledged that, in spite of the challenges, some progress has been made this year, particularly in relation to financial management, and progressing the planned reviews should lead to further improvements in governance, risk and control in the future.

Avril Cunningham

Service Manager, Audit and Risk Management Services, Fife Council

13 May 2021

Evaluation Criteria

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

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Date	8 April 2021
Your Ref	
Our Ref	CMcK/CD/L08042021
Enquiries to	Catriona Dziech
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Dear Margo

GOVERNANCE STATEMENT 2020/2021

As per SGHSCD guidance on the Governance Statement, which requires the Accountable Officer to receive formal assurance from senior managers that adequate and effective internal controls and risk management have been in place across their areas of responsibility, and that any breaches of Standing Orders or Standing Financial Instructions have been reported, in addition to all significant failures of internal control and Audit Reports rated as giving 'Limited or No Assurance', I can confirm that there were adequate and effective internal controls and risk management in place, for the areas under my direct responsibility, for FY2020/2021, to 31 March 2021.

The Covid-19 pandemic has altered the usual agenda and work plan of Clinical Governance Committee (CGC). The Committee has responded in an appropriate manner, with a focus on the safety and quality of care delivered as part of the pandemic response. This has included the NHS Fife Covid-19 Testing Strategy, the Covid-19 Vaccination Programme, the Seasonal Flu vaccination Programme (including overseeing the lessons learned review following the challenging start to the programme) and the remobilisation of clinical services. The Committee reviewed regular updates with respect to the use and availability of Personal Protective Equipment (PPE) and infection control processes. This included the extended role of the Health Board to include the safe and effective care in care homes.

The Committee has also had oversight of work carried out by the Board to redesign urgent care services including the development of a flow and navigation hub. The Health and Safety subcommittee have developed an action plan in relation to Covid-19 management 'spot check' by the HSE undertaken in the Victoria Hospital in November 2020.

Healthcare Improvement Scotland (HIS) undertook unannounced inspections of Glenrothes Hospital and Tarvit Ward Adamson Hospital, and the reports and action plans will be considered by the CGC in late April 2021.In addition to the areas of good practice identified, there are 5 requirements within the Glenrothes inspection (4 of which relate to protecting

and safeguarding people's health during the pandemic and 1 related to the condition of equipment) and 8 within the Adamson (6 of which relate to protecting and safeguarding people's health during the pandemic and 2 in relation to improvements in infection control standards).

The Digital and Information Board and the Information Governance and Security Steering Group (IG&S) were established following a governance review in 2020. The terms of reference of each of these groups have been comprehensively updated and their reporting arrangements to the Clinical Governance Committee reaffirmed. The IG&S has developed the governance, process and control framework to assure the organisation, via the CGC about the confidentiality, availability and integrity of the information that it holds for patients, staff and corporate services. A Network and Information Systems Directive (NISD) compliance audit was conducted in March 2021. The outcome and subsequent action plan will be considered by the IG&S in 21/22, with intention to share, where appropriate, updates on the delivery of this plan with the CGG. The previous audit undertaken in March 2020 and subsequent action plan was considered and supported by the previous eHealth Board.

The Digital and Information Board has overseen the approval of the Outline Business case for HEPMA, with subsequent support from the CGC and approval at the Board. It has also provided oversight and guidance to the rapid roll out of national initiatives during the pandemic such as Office 365 and Near Me virtual consultation. The pandemic has had both a positive and negative impact on the delivery plan associated with the Digital Strategy and this was considered in a detailed report to the CGC in September 2020.

The CGC regularly reviews and scrutinises the Board Assurance Framework for Safety and Quality, Strategic Planning and Digital and Information. The CGC has recognised that work is required on the Digital and Information risks, and activity is ongoing to ensure these are aligned and reported on appropriately.

Overall it has been an extremely busy year for clinical and digital services and colleagues have worked through unprecedented times. Having said that,

I can confirm that:

- All significant projects have followed Project Management guidelines;
- There were no known failures or weaknesses in the systems of internal control during the above period;
- There were no known breaches of the Code of Corporate Governance during the above period;
- There was no known non-compliance with relevant legislation or guidance, including the SPFM, during the above period; and
- All known or new risks for the organisation have been appropriately reported on for the areas I am responsible for.

Yours sincerely

DR C McKENNA
Medical Director NHS Fife

Claire Dobson
Director of Acute Services
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Mrs Margo McGurk
Director of Finance
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Date	6th April 2021
Your Ref	
Our Ref	CD/MMcG
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Email	Gillian.McKinnon@nhs.scot

Dear Margo

GOVERNANCE STATEMENT 2020/2021

As per SGHSCD guidance on the Governance Statement, which requires the Accountable Officer to receive formal assurance from senior managers that adequate and effective internal controls and risk management have been in place across their areas of responsibility, and that any breaches of Standing Orders or Standing Financial Instructions have been reported, in addition to all significant failures of internal control and Audit Reports rated as giving 'Limited or No Assurance', I can confirm that there were adequate and effective internal controls and risk management in place, for the areas under my direct responsibility, for FY2020/21, with effect from 23rd September 2020 to 31 March 2021.

In particular I can confirm that:

- There were no known failures or weaknesses in the systems of internal control during the above period;
- There were no known breaches of the Code of Corporate Governance during the above period;
- There was no known non-compliance with relevant legislation or guidance, including the SPFM, during the above period;
- All significant projects have followed Project Management guidelines; and
- All known or new risks for the organisation have been appropriately reported on for the areas I am responsible for.

This has been an exceptional year for the Acute Services Division as it has faced two waves of the COVID-19 pandemic. The response to this enormous challenge has been outstanding. At points when levels of COVID activity in the hospital were at their peak the Division managed three intensive care units and up to six COVID wards alongside ongoing scheduled and unscheduled activity. No part of the acute system was untouched by COVID-19 with staff having to work flexibly across different areas to ensure that patients received safe care. The impact was felt across the elective programme including theatres. In December 2020 the difficult

decision was made to pause non-urgent elective surgeries. In January 2021 out-patient activity was scaled back to urgent and urgent suspicion of cancer referrals only. I would like to assure you that despite the challenges of this period cancer care has remained a priority. Throughout this period the Senior Leadership Team managed the Division via a Silver command structure reporting and escalating issues to the Gold Command chaired by the Chief Executive.

As the numbers of patients being admitted to hospital with COVID-19 declines the Acute Services Division is remobilising the elective surgical programme as well as out-patient clinics. Clinical prioritisation is a key part of this process and weekly meetings using strict criteria support the planning of theatre capacity. In terms of the remobilisation of out-patient activity, trajectories have been established to support planned activity levels as well as the use of a capacity tool which supports safe clinic delivery in the context of physical distancing.

Despite the challenges of the pandemic there has been significant learning as well as developments, particularly in the use of technology that the Division will continue to use as it recovers and remobilises.

To conclude, I can confirm that there were adequate and effective internal controls and risk management in place, for the areas under my direct responsibility, for FY2020/21, with effect from 23rd September 2020 to 31 March 2021.

Yours sincerely

Director of Acute Services
NHS Fife

Public Health Department

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Date	20 May 2021
Your Ref	
Our Ref	DM/SN/DM Governance Statement Directors Letter 2020-21
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Direct Line	01592 226471
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Dear Margo

GOVERNANCE STATEMENT 2020/2021

As per SGHSCD guidance on the Governance Statement, which requires the Accountable Officer to receive formal assurance from senior managers that adequate and effective internal controls and risk management have been in place across their areas of responsibility, and that any breaches of Standing Orders or Standing Financial Instructions have been reported, in addition to all significant failures of internal control and Audit Reports rated as giving 'Limited or No Assurance', I can confirm that there were adequate and effective internal controls and risk management in place, for the areas under my direct responsibility, for FY2020/21, to 31 March 2021.

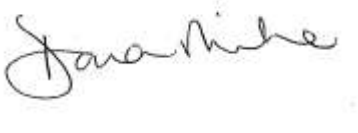
In particular I can confirm that:

- There were no known failures or weaknesses in the systems of internal control during the above period;
- There were no known breaches of the Code of Corporate Governance during the above period;
- There was no known non-compliance with relevant legislation or guidance, including the SPFM, during the above period;
- All significant projects have followed Project Management guidelines; and
- All known or new risks for the organisation have been appropriately reported on for the areas I am responsible for.

This has been an unusual year due to the Covid pandemic which has placed considerable pressure on the Public Health Department. The department has grown considerably during this time with at least 100 new staff recruited on a fixed term basis and a small number on a permanent basis. This has all been in line with Scottish Government direction and funding allocations. It is likely however, that some of this resource will be required longer term and therefore workforce planning for public health in Scotland is currently underway along with Scottish Directors of Public Health, Public Health Scotland and Scottish Government.

During this period the Board experienced significant challenges in delivering its seasonal flu programme and the Chief Executive commissioned an independent review. A number of recommendations were made and an action plan was prepared and signed off by the Clinical Governance Committee. The Director of Public Health has taken responsibility for the implementation of those actions and jointly with the Joint Director for Health and Social commissioned a further implementation review to take forward the actions. This review was completed in May 2021 and actions are underway to mitigate any further challenges in the area of immunisation delivery.

Yours sincerely



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Date	31 March 2021
Your Ref	
Our Ref	HB/CL
Enquiries to	Christine Law
Extension	27998
Direct Line	01592 647998
Email	Christine.law@nhs.net

Dear Margo

GOVERNANCE STATEMENT 2020/21

As per SGHSCD guidance on the Governance Statement, which requires the Accountable Officer to receive formal assurance from senior managers that adequate and effective internal controls and risk management have been in place across their areas of responsibility, and that any breaches of Standing Orders or Standing Financial Instructions have been reported, in addition to all significant failures of internal control and Audit Reports rated as giving 'Limited or No Assurance', I can confirm that there were adequate and effective internal controls and risk management in place, for the areas under my direct responsibility, for FY2020/21, to 31 March 2021.

In particular I can confirm that:

- All significant projects have followed Project Management guidelines;
- There were no known failures or weaknesses in the systems of internal control during the above period;
- There were no known breaches of the Code of Corporate Governance during the above period;
- There was no known non-compliance with relevant legislation or guidance, including the SPFM, during the above period; and
- All known or new risks, including COVBID19 Vaccination Workforce Risks for the organisation have been appropriately reported on for the areas I am responsible for.

Yours sincerely

M. Buchanan

HELEN BUCHANAN
Director of Director
NHS Fife

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Mrs Margo McGurk
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Date	20 April 2021
Your Ref	
Our Ref	JO/CL/corr200421
Enquiries to	Janette Owens
Extension	27998
Direct Line	01592 647998
Email	Janette.owens@nhs.scot

Dear Margo

GOVERNANCE STATEMENT 2020/2021

As per SGHSCD guidance on the Governance Statement, which requires the Accountable Officer to receive formal assurance from senior managers that adequate and effective internal controls and risk management have been in place across their areas of responsibility, and that any breaches of Standing Orders or Standing Financial Instructions have been reported, in addition to all significant failures of internal control and Audit Reports rated as giving 'Limited or No Assurance', I can confirm that there were adequate and effective internal controls and risk management in place, for the areas under my direct responsibility, for FY2020/21, to 31 March 2021.

In particular I can confirm that:

- There were no known failures or weaknesses in the systems of internal control during the above period;
- There were no known breaches of the Code of Corporate Governance during the above period;
- There was no known non-compliance with relevant legislation or guidance, including the SPFM, during the above period;
- All significant projects have followed Project Management guidelines; and
- All known or new risks for the organisation have been appropriately reported on for the areas I am responsible for.
- Action plans have been completed following HIS HAI inspection visits to **Glenrothes Hospital** (07–08 July 2020) and to **Adamson Hospital** (28 October 2020).
  - The **Glenrothes Hospital Inspection** resulted in four areas of good practice and five requirements:
    - The areas of good practice included good standard of hospital cleanliness and excellent infection control support.
    - The five requirements were as follows:
    - 4 requirements in relation to people's health and wellbeing being supported and safeguarded during the COVID-19 pandemic

- § 1 requirement relates to the condition of patient equipment.

A robust Improvement Action Plan was implemented which outlined the prioritisation of actions aligned with each of the five requirements to ensure compliance with national standards, guidance and best practice in healthcare and nursing. The teams have completed the actions identified in the Improvement Action Plan

- o The **Adamson Hospital Inspection** resulted in three areas of good practice and eight requirements.
  - § The areas of good practice included good standard of hospital cleanliness and thorough completion of assessment such falls, oral care and pressure ulcers prevention.
  - § The eight requirements were as follows:
  - § 6 requirements in relation to people's health and wellbeing being supported and safeguarded during the COVID-19 pandemic
  - § 2 requirements in relation to infection control practices supporting a safe environment for both people experiencing care, and staff

A robust Improvement Action Plan was implemented which outlined the prioritisation of actions aligned with each of the eight requirements to ensure compliance with national standards, guidance and best practice in healthcare and nursing. The teams are working towards achievement of the Improvement Action Plan, which is almost complete. This has been with support from Lead Nurse, Head of Nursing and Hospital Services Manager: there has been extensive support and work with the team to address the requirements.

- · Work is being taken forward to ensure that there is a sustainable workforce for the Covid-19 Vaccination Programme.

Yours sincerely

Director of Nursing
NHS Fife

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Mrs Margo McGurk
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Date	1 April 2021
Your Ref	
Our Ref	LD/GW
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Email	gillian.westbrook@nhs.scot

Dear Margo

GOVERNANCE STATEMENT 2020/2021

As per SGHSCD guidance on the Governance Statement, which requires the Accountable Officer to receive formal assurance from senior managers that adequate and effective internal controls and risk management have been in place across their areas of responsibility, and that any breaches of Standing Orders or Standing Financial Instructions have been reported, in addition to all significant failures of internal control and Audit Reports rated as giving 'Limited or No Assurance', I can confirm that there were adequate and effective internal controls and risk management in place, for the areas under my direct responsibility, for FY2020/21, to 31 March 2021.

In particular, I can confirm that:

- There were no known failures or weaknesses in the systems of internal control during the above period, and that the minor audit action points resultant from Internal Audits conducted have been addressed (or plans are in place to address);
- There were no known breaches of the Code of Corporate Governance during the above period;
- There was no known non-compliance with relevant legislation or guidance, including the Scottish Public Finance Manual (SPFM), during the above period;
- There were no significant projects owned or overseen during this period, however should such projects be initiated the Project Management guidelines will be followed; and
- All known or new risks for the organisation have been appropriately reported on for the areas I am responsible for.

The COVID-19 pandemic has had a particular and significant impact on the delivery of services provided by the Workforce Directorate (Occupational Health and Wellbeing, Recruitment, Advisory Services [incl. Policy and Guidance], Leadership and Development, and

HR Administration and Systems), but with positive outcomes achieved. Significant change to service delivery was positively led and managed. The increased volume of activity was unprecedented, however team member rose to the challenge and delivered great results. Systems of work and organisational processes were created or revised at pace and successfully adopted to respond to the demands presented by a global pandemic. This included; how we deployed staff, how we recruited and onboarded new staff into the organisation, how we delivered learning and up/reskilled ourselves and our colleagues, how we communicated and engaged with our colleagues and stakeholders, and probably most significantly, how we enhanced and developed support to staff to sustain and enhance their wellbeing and resilience.

Yours sincerely

Linda Douglas
Director of Workforce
NHS Fife

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Mrs Carol Potter
Chief Executive
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Date	1 April 2021
Your Ref	MM/LS YE Letter
Our Ref	
Enquiries to	Margo McGurk
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Direct Line	
Email	Margo.McGurk@nhs.scot

Dear Carol

GOVERNANCE STATEMENT 2020/2021

As per SGHSCD guidance on the Governance Statement, which requires the Accountable Officer to receive formal assurance from senior managers that adequate and effective internal controls and risk management have been in place across their areas of responsibility, and that any breaches of Standing Orders or Standing Financial Instructions have been reported, in addition to all significant failures of internal control and Audit Reports rated as giving 'Limited or No Assurance', I can confirm that there were adequate and effective internal controls and risk management in place, for the areas under my direct responsibility, for FY2020/21, to 31 March 2021.

In particular I can confirm that:

- There were no known failures or weaknesses in the systems of internal control during the above period;
- There were no known breaches of the Code of Corporate Governance during the above period;
- There was no known non-compliance with relevant legislation or guidance, including the SPFM, during the above period however a significant delay was experienced in relation to the completion of the statutory annual accounts as described in this report;
- All significant projects have followed Project Management guidelines; and
- All known or new risks for the organisation have been appropriately reported on for the areas I am responsible for.

Financial Planning and Reporting

As a consequence of the pandemic the AOP process for 2020/21 was paused and replaced with initial COVID Response Mobilisation and Remobilisation Planning. This included a requirement to determine the financial impact of COVID in-year. The first iteration of the COVID Local Mobilisation Plan (LMP) was submitted to Scottish Government in April 2020 and during the year there were a number of formal updates to the plan. Initial funding was

confirmed in October 2020 and a final allocation was confirmed in January 2021. The funding received delivered full financial cover for the additional COVID and remobilisation costs incurred in-year and for the level of undelivered efficiency savings which arose as a consequence of the pandemic. Whilst NHS Board and Governance Committee meetings and agendas were reduced to essential COVID and local governance matters, full disclosure and reporting on the financial position was maintained throughout the year. The complexity of financial reporting increased during 2020/21 as a result of maintaining the core and COVID financial monitoring and reporting arrangements. The financial management team also experienced a significant capacity issue with a number of departures and vacancies during the year. Work is underway to recruit to a new deputy post in 2021/22 and to complete a full review of the financial management senior team roles and responsibilities going forward. In addition there was a significant investment of time across the team as we engaged with ARCUS Consulting to help shape the focus of our Finance Business Partnering arrangements going forward.

Senior Information Risk Officer (SIRO)
I have fulfilled the role of Senior Information Risk Owner (SIRO) throughout 2020/21. I can confirm that during that period I have not taken on a role or a task that could have resulted in a conflict of interest with the SIRO role.

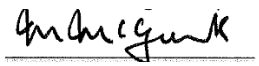
Procurement and PPE Silver Command
A Silver Command was established in April 2020 to monitor, manage and deliver effective governance of the emerging situation in relation to availability of PPE during the pandemic. This group was very effective in aligning with NSS, National Procurement supply management and local Board ongoing assessment of demand issues. The group met until the end of August 2020 when an assessment and lessons learned report confirmed that the management of PPE could be passed back as a business as usual matter. I maintained the SPOC position for the Board and attended regular national briefing sessions and also engaged direct support from NHS Lothian to ensure ongoing peer support for the local procurement team.

Annual Accounts Process 2019/20 – Financial Services Staffing Capacity Issues
It became apparent that the local capacity and capability to deliver the annual statutory accounts was limited as a result of the departure of 2 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 and no significant audit issues were raised however it was critical to address the capacity issues as quickly as possible. Recruitment commenced for a new Head of Financial Services and an appointment was made in December 2020. The new Head of Financial Services commenced employment in March 2021 and planning has commenced for the 2020/21 annual accounts and audit process.

Internal Audit Reports and Progress with Implementation of Recommendations
During 2020/21 EDG refreshed oversight of this area with quarterly reviews on progress against Internal Audit Recommendations. Progress has been made in-year however continued efforts are required to deliver full closure in a number of areas during 2021/22.

Strategic Planning and Resource Allocation
During 2020/21 the new Strategic Planning and Resource Allocation (SPRA) process was launched to deliver the RMP3 for 2021/22 and to begin the process of creating the new Health and Well-being Strategy for Fife. Good progress was made in the initial phase of this work with plans agreed to progress this work during 2021/22.

Yours sincerely



Margo McGurk
Director of Finance & Strategy
NHS Fife

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Estates, Facilities & Capital Services

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Mrs M McGurk
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Date 1 April 2021
Your Ref
Our Ref NMcC/AB

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Email neil.mccormick@nhs.scot

Dear Margo

GOVERNANCE STATEMENT 2020/2021

As per SGHSCD guidance on the Governance Statement, which requires the Accountable Officer to receive formal assurance from senior managers that adequate and effective internal controls and risk management have been in place across their areas of responsibility, and that any breeches of Standing Orders or Standing Financial Instructions have been reported, in addition to all significant failures of internal control and Audit Reports rated as giving 'Limited or No Assurance', I can confirm that there were adequate and effective internal controls and risk management in place, for the areas under my direct responsibility, for FY2020/21, to 31 March 2021.

In particular I can confirm that:

- There were no known failures or weaknesses in the systems of internal control during the above period;
- There were no known breaches of the Code of Corporate Governance during the above period;
- There was no known non-compliance with relevant legislation or guidance, including the SPFM, during the above period;
- All significant projects have followed Project Management guidelines; and
- All known or new risks for the organisation have been appropriately reported on for the areas I am responsible for.

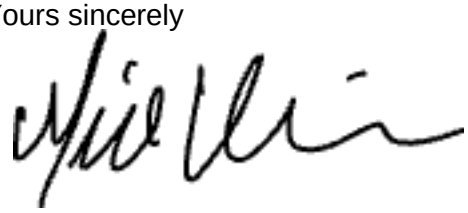
Mrs Margo McGurk

1 April 2021

- In November 2020, NHS Fife received a COVID Management ‘spot check’ visit from two Health & Safety Executive (HSE) inspectors. This visit was conducted on the Victoria Hospital Kirkcaldy site. The visit resulted in a ‘Notice of Contravention’ being issued to the organisation with a requirement for actions to be taken. The December 2020 Health & Safety sub-committee meeting was therefore given over to discussion on the detail of the Notice to ensure that actions were being addressed and that appropriate managers and staff were involved in this work. The Health & Safety Manager was advised that a number of actions identified had already been actioned and that support was being received from the Deputy Chief Operating Officer, Hospital Control Team and relevant departments. The issues raised by the HSE centred mainly on application of physical distancing (especially in rest / break areas), records management and training with regards to face fit testing and fit testers and concerns with changing and locker facilities. The Health & Safety Manager has subsequently been advised by the HSE that they are satisfied that no further action is required.

This has been a particularly challenging year for our workforce who have responded admirably through changing circumstances following mounting Covid-19 restrictions both in the workplace and in their personal lives. I am grateful for the loyalty and support they have shown to NHS Fife.

Yours sincerely



Neil McCormick
Director of Property & Asset Management

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Mrs Margo McGurk
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Date	21 April 2021
Your Ref	NC/L1/wja
Our Ref	
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Dear Margo

GOVERNANCE STATEMENT 2020/2021

As per SGHSCD guidance on the Governance Statement, which requires the Accountable Officer to receive formal assurance from senior managers that adequate and effective internal controls and risk management have been in place across their areas of responsibility, and that any breaches of Standing Orders or Standing Financial Instructions have been reported, in addition to all significant failures of internal control and Audit Reports rated as giving 'Limited or No Assurance', I can confirm that there were adequate and effective internal controls and risk management in place, for the areas under my direct responsibility, for FY2020/21, to 31 March 2021.

In particular I can confirm that:

- There were no known failures or weaknesses in the systems of internal control during the above period;
- There were no known breaches of the Code of Corporate Governance during the above period;
- There was no known non-compliance with relevant legislation or guidance, including the SPFM, during the above period;
- All significant projects have followed Project Management guidelines' including:-.
  - MH In-Patient Capital Project – confirming this has been taken forward in line with Scottish Capital Investment Manual (SCIM) guidelines.
  - Transformation Programmes – Integrated Transformation Programme Board and associated projects suspended due to prioritisation of COVID response.

- External reviews of Mental Health Services have continued and actions identified have been addressed or are in progress. Reports continue to Clinical and Care Governance Committee on progress.

- The Kincardine and Lochgelly Health Centres will be subject to an application for capital funding from the Scottish Government. The applications will be presented in the form of business cases developed to conform to the Scottish Capital Investment Manual. Internal and external governance approvals of the business cases will be required at key gateway stages before full funding can be committed.

- All known or new risks for the organisation have been appropriately reported on for the areas I am responsible for.

  - 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.

  - For the last year, 2020/21, this risk has been maintained at a moderate level scoring 3 for likelihood (Possible, may occur occasionally – reasonable chance) and 4 for Consequence (Major), giving a score of 12.

  - During the Integration review scheme process consideration was given to increasing the score, however, in light of the ongoing considerable work and focus, regular discussions with and feedback from colleagues and ongoing dialogue with the Scottish Government it was agreed the risk scoring would be maintained.

  - Obviously there are a number of audit actions ongoing which reference the review of the Integration Scheme and these may be delayed, however, the instruction from Scottish Government was that the current Scheme will stand until such time as a new Scheme is approved.

<u>Summary of Inspections which where carried out and Action Plan Recommendation are as follows:</u>

1. On 7 and 8 July 2020 Health Improvement Scotland (HIS) carried out an unannounced inspection at Wards 1&2 of Glenrothes Hospital. This was the first inspection in Scotland by HIS following the outbreak of the COVID 19 pandemic. This inspection focussed on the impact of COVID-19 and the care older people receive whilst in hospital. Ward 1 is a 17 bedded GP managed ward and Ward 2 is a 17 bedded MOE consultant led ward serving Glenrothes and the surrounding communities. This inspection resulted in four areas of good practice and five requirements.

   The areas of good practice included good standard of hospital cleanliness and excellent infection control support.

   The five requirements were as follows:

   - 4 requirements in relation to people's health and wellbeing being supported and safeguarded during the COVID-19 pandemic.

- 1 requirement relates to the condition of patient equipment.

A robust Improvement Action Plan was implemented which outlined the prioritisation of actions implemented aligned with each of the five requirements to ensure compliance with national standards, guidance and best practice in healthcare and nursing.

2. On Tuesday the 28 October 2020, HIS carried out an unannounced inspection at Tarvit Ward Adamson Hospital, the second visit to a Community Hospital in Fife within 4 months. This inspection focussed the impact of COVID-19 and the care older people receive whilst in hospital. Tarvit Ward is a 2 bedded community hospital ward serving Cupar and surrounding areas. The ward is a mixture of 19 GP managed beds and 4 palliative care beds.

   This inspection resulted in three areas of good practice and eight requirements.

   The areas of good practice included good standard of hospital cleanliness and thorough completion of assessment such falls, oral care and pressure ulcers prevention.

   The eight requirements were as follows:

   - 6 requirements in relation to people's health and wellbeing being supported and safeguarded during the COVID-19 pandemic
   - 2 requirements in relation to infection control practices supporting a safe environment for both people experiencing care and staff

   A robust Improvement Action Plan was implemented on the 28 October 2020 which outlined the prioritisation of actions implemented aligned with each of the eight requirements to ensure compliance with national standards, guidance and best practice in healthcare and nursing

Yours sincerely

Nicky Connor
Director of Health & Social Care
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Date	1 April 2021
Your Ref	
Our Ref	SG/gw
Enquiries to	Scott Garden
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Direct Line	01592 643355 Ext 21050
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Dear Margo

GOVERNANCE STATEMENT 2020/2021

As per SGHSCD guidance on the Governance Statement, which requires the Accountable Officer to receive formal assurance from senior managers that adequate and effective internal controls and risk management have been in place across their areas of responsibility, and that any breaches of Standing Orders or Standing Financial Instructions have been reported, in addition to all significant failures of internal control and Audit Reports rated as giving 'Limited or No Assurance', I can confirm that there were adequate and effective internal controls and risk management in place, for the areas under my direct responsibility, for FY2020/21, to 31 March 2021.

In particular I can confirm that:

- There were no known failures or weaknesses in the systems of internal control during the above period;
- There were no known breaches of the Code of Corporate Governance during the above period;
- There was no known non-compliance with relevant legislation or guidance, including the SPFM, during the above period;
- All significant projects have followed Project Management guidelines; and
- All known or new risks for the organisation have been appropriately reported on for the areas I am responsible for.

Due to the Covid-19 pandemic, the Pharmacy and Medicines Directorate stood up a silver command, as part of NHS Fife's pandemic governance structure. This group had oversight and responsibility for decision making outside of routine business as usual structures. To ensure appropriate governance, decisions made by this group were recorded and logged by the Pharmacy Control Team. A full record of decisions made is available on request.

As Senior Responsible Officer for the Covid-19 Vaccination Programme, I have ensured decisions made with regard to the planning and operations of the programme have been made in line with NHS Fife's pandemic structure. The Executive Team, and Board of NHS Fife have been appraised and consulted throughout this process.

Yours sincerely

Scott Garden
Director of Pharmacy and Medicines
NHS Fife

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**16 September 2021**
Title:	**Internal Audit Annual Report**
Responsible Executive/Non-Executive:	**M McGurk, Director of Finance**
Report Author:	**T Gaskin, Chief Internal Auditor**

1 Purpose

This is presented to the Audit and Risk Committee for:

- Assurance

This report relates to a:

- Government policy/directive
- Legal requirement

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

- Effective

2 Report summary

2.1 Situation

The purpose of this report is to present the **FINAL** 2020/21 Annual Internal Audit Report to the NHS Fife Audit and Risk Committee. This report is for the Committee to consider as part of the wider portfolio of year end governance assurances.

2.2 Background

The Audit and Risk Committee is asked to approve this report with completed action plan as part of the portfolio of evidence provided in support of its evaluation of the internal control environment and the Governance Statement.

This annual report provides details on the outcomes of the 2020/21 internal audit and the Chief Internal Auditor's opinion on the Board's internal control framework for the financial year 2020/21.

2.3 Assessment

Based on work undertaken throughout the year we have concluded that:

- The Board has adequate and effective internal controls in place;
- The 2020/21 internal audit plan has been delivered in line with Public Sector Internal Audit Standards.

In addition, we have not advised management of any concerns around the following:

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

Therefore, **it is my opinion** that:

- The Board has adequate and effective internal controls in place
- The Accountable Officer has implemented a governance framework in line with required guidance sufficient to discharge the responsibilities of this role.

We noted the following key themes:

- As noted in the ICE, during the first part of the year the Board maintained and improved its governance arrangements and has performed well in exceptionally difficult circumstances, facing the unprecedented challenges created by Covid19. We welcome the progress with the Strategic Allocation and Resource Process which has informed the annual plan (RMP3).
- The development of the Health and Wellbeing Strategy, which will supersede the current Clinical Strategy, is due to be presented to the Board for approval in March 2022.
- Strong communication within the Board, in challenging times, with Staff Link providing a constant feed of news and a Weekly News Roundup via email, which provides Operational, Clinical, Workforce, Staff Health & Wellbeing and Research & Development updates, as well as a useful links and updates from the Health & Social Care Partnership (HSCP) Director.
- This report highlights changes to the risk environment in which the Board operates. There are opportunities now to enhance governance further through the application of assurance mapping principles and our report contains comments aimed at ensuring coherence between Governance Structures, Performance Management, Risk Management and Assurance. We note the progress with the update of the Digital and Information, Strategic Planning and Financial Sustainability BAFs. The Quality and Safety BAF is planned for review as part of ongoing with the Assurance Mapping work and we this report highlights a key clinical risk which should be considered for inclusion.
- There have been positive improvements in a number of areas but we would highlight, in particular, Information Security and Information Governance, where the Board's own systems have identified issues in addition to those highlighted by Internal Audit and made the improvements necessary to achieve the required standards.

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.

The audit highlights a number of areas for consideration in assessing risks and controls.

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 the Deputy Director of Finance.

2.3.8 Route to the Meeting

This paper has been produced by the Regional Audit Manager, reviewed by the Chief Internal Auditor and agreed by the Director of Finance and Deputy Director of Finance.

2.4 Recommendation

The Audit and Risk Committee is asked to:

- **APPROVE** this report as part of the portfolio of evidence provided in support of its evaluation of the internal control environment and the Governance Statement.

3 List of attachments

The following attachment is included:

- Annual Internal Audit Report 2020/21

FTF Internal Audit Service

Annual Internal Audit Report 2020/21

Report No. B06/22

Issued To: Carol Potter, Chief Executive
Margo McGurk, Director of Finance and Strategy
NHS Fife Executive Directors Group

Gillian MacIntosh, Head of Corporate Governance and Board Secretary

Audit & Risk Committee
External Audit

Contents

Draft Report Issued	30 August 2021
Management Responses Received	08 September 2021
Target Audit & Risk Committee Date	16 September 2021
Final Report Issued	09 September 2021

INTRODUCTION AND CONCLUSION

1. This annual report to the Audit and Risk Committee provides details on the outcomes of the 2020/21 internal audit and my opinion on the Board's internal control framework for the financial year 2020/21.

2. Based on work undertaken throughout the year we have concluded that:

- The Board has adequate and effective internal controls in place.
- The 2020/21 internal audit plan has been delivered in line with Public Sector Internal Audit Standards.

3. In addition, we have not advised management of any concerns around the following:

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

ACTION

4. The Audit and Risk Committee is asked to **note** this report in evaluating the internal control environment and **report** accordingly to the Board.

AUDIT SCOPE & OBJECTIVES

5. The Strategic and Annual Internal Audit Plans for 2020/21 incorporated the requirements of the NHSScotland Governance Statement and were based on a joint risk assessment by Internal Audit and the Director of Finance. The resultant audits range from risk based reviews of individual systems and controls through to the strategic governance and control environment.

6. The authority, role and objectives for Internal Audit are set out in Appendix 3 of the Board's Standing Financial Instructions and are consistent with Public Sector Internal Audit Standards.

7. Internal Audit is also required to provide the Audit and Risk Committee with an annual assurance statement on the adequacy and effectiveness of internal controls. The Audit & Assurance Committee Handbook states:

The Audit & Risk Committee should support the Accountable Officer and the Board by reviewing the comprehensiveness and reliability of assurances on governance, risk management, the control environment and the integrity of the financial statements and the annual report. The scope of the Committee's work should encompass all the assurance needs of the Accountable Officer and the Board. Within this the Committee should have particular engagement with the work of Internal Audit, risk management, the External Auditor, and financial management and reporting issues.

INTERNAL CONTROL

8. The Internal Control Evaluation (ICE), issued January 2021, was informed by detailed review of formal evidence sources including Board, Standing Committees, Executive Directors Group (EDG), and other papers. The ICE noted actions to enhance risk reporting and clinical governance arrangements, with progress in improvements in Information Governance arrangements. Internal Audit concluded that NHS Fife's assurance structures were adequate and effective and made 6 recommendations for improvement by year end. The status of previous recommendations is summarised in table 1 below.

9. During the year we worked with management to review and update outstanding internal audit recommendations to take account of Covid19, including those arising from the previous ICE report.

10. Throughout the year, our audits have provided assurance and made recommendations for improvements. Of these, the ICE was the most significant. We have undertaken detailed follow up of the agreed actions arising from that report as well as testing to identify any material changes to the control environment in the period from the issue of the ICE to the year-end. We have reflected on the impact of Covid19 and the governance arrangements in place during the year, taking into account developments since year-end where relevant. Some areas for further development were identified and will be followed up in the 2021/22 ICE and, where applicable, our detailed findings have been included in the NHS Fife 2020/21 Governance Statement.

11. Our assessment of the progress taken to address ICE recommendations is detailed in table 1 on page 11. NHS Fife has demonstrated good progress with only minor slippage on some actions, despite the continuing difficulties caused by Covid. Several of the more strategic actions are not yet due for completion but are progressing well. We will comment on the effectiveness of the action taken in the 2021/22 ICE.

12. For 2020/21, the Governance Statement format and guidance were included within the NHSScotland Annual Accounts Manual. Whilst Health and Social Care Integration is not specifically referenced, the guidance does make it clear that the Governance Statement applies to the consolidated financial statements as whole, which would therefore include activities under the direction of IJBs.

13. The Board has produced a Governance Statement which states that:

    'During the 2020/21 financial year, no other significant control weaknesses or issues have arisen, in the expected standards for good governance, risk management and control'.

14. Our audit work has provided evidence of compliance with the requirements of the Accountable Officer Memorandum and this, combined with a sound corporate governance framework in place within the Board throughout 2020/21, provides assurance for the Chief Executive as Accountable Officer.

15. Therefore, **it is my opinion** that:

    - The Board has adequate and effective internal controls in place.
    - The Accountable Officer has implemented a governance framework in line with required guidance sufficient to discharge the responsibilities of this role.

16. All Executive Directors and Senior Managers were required to provide a statement confirming that adequate and effective internal controls and risk management arrangements were in place throughout the year across all areas of responsibility and, this process has been enhanced with guidance on content provided by the Director of Finance and Strategy. These assurances have been reviewed and no control issues, breaches of Standing Orders / Standing Financial Instructions were identified.

17. The Governance Statement reflects the necessary changes to Board governance and operating arrangements due to Covid19 and the work to remobilise. The Governance Statement includes details of the Board performance and risk profile and future changes to Strategy Development and Strategic Planning and Resource Allocation. The risk management section of the Governance Statement is particularly helpful in describing the enhancements required to the risk arrangements and profile of the organisation. All elements of the Governance Statement have been considered by Internal Audit.

Key Themes

18. As noted in the ICE, during the first part of the year the Board maintained and improved its governance arrangements and has performed well in exceptionally difficult circumstances, facing the unprecedented challenges created by Covid19. We welcome the progress with the Strategic Allocation and Resource Process which has informed the annual plan (RMP3).

19. We are pleased to note that new Health and Wellbeing Strategy, which will supersede the current Clinical Strategy, is under development and due to be presented to the Board for approval in March 2022.

20. We highlight the strong communication within the Board, in these challenging times, with Staff Link providing a constant feed of news and a Weekly News Roundup via email, which provides Operational, Clinical, Workforce, Staff Health & Wellbeing and Research & Development updates, as well as a useful links and updates from the Health & Social Care Partnership (HSCP) Director.

21. This report contains a number of recommendations that reflect the changes to the risk environment in which the Board operates. There are opportunities now to enhance governance further through the application of assurance mapping principles and our report contains recommendations aimed at ensuring coherence between Governance Structures, Performance Management, Risk Management and Assurance. We note the progress with the update of the Digital and Information, Strategic Planning and Financial Sustainability BAFs. The Quality and Safety BAF is planned for review as part of the work ongoing with the Assurance Mapping Group.

22. Whilst there have been positive improvements in a number of areas, we would highlight in particular Information Security and Information Governance, where the Board's own systems have identified issues in addition to those highlighted by Internal Audit and made the improvements necessary to achieve minimum standards.

Key developments since the issue of the ICE included:

- The third iteration of the Remobilisation Plan, RMP3 covering the period April 2021 – March 2022, was submitted to the Scottish Government on 26 February 2021 and presented to the Board, as soon as possible, in May 2021.
- Corporate Objectives have been developed and were approved at the 27 July 2021 Board Meeting.

- Overall, there has been good progress on recommendations from the ICE. Where action is still to be concluded, the Board has been informed of the planned approach and timescales, as well as associated improvement plans.
- The development of the Health and Wellbeing Strategy and timetable agreed.

23. During 2020/21 we delivered 28 audit products to the NHS Fife Audit and Risk Committee (May 2020 to June 2021 meetings). These audits reviewed the systems of financial and management control operating within the Board and provided opinions on the adequacy of controls in these areas. Summarised findings or the full report for each review were presented to the Audit and Risk Committee throughout the year.

24. A number of our reports, including the ICE and Sustainability work, have been wide ranging and complex audits which have relevance to a wide range of areas within Fife. These should provide the basis for discussion around how NHS Fife can best build on the very good work already being done to improve and sustain service provision.

25. Board management continue to respond positively to our findings and action plans have been agreed to improve the systems of control. Internal Audit have maintained a system for the follow-up of audit recommendations and reporting of results to the Audit and Risk Committee. In March 2021, Internal Audit carried out a review of outstanding recommendations and removing from the Audit Follow Up system actions which had been completed, or were consolidated and superseded by recent audit products. As reported to the 17 June 2021 Audit and Risk Committee, of the 49 audit actions remaining, 33 had date extensions, 6 were overdue and 10 were not yet due.

ADDED VALUE

26. The Internal Audit Service has been responsive to the needs of the Board and has assisted the Board and added value by:

    - Examining a wide range of controls in place across the organisation.
    - In conjunction with Local Authority Internal Auditors, providing advice and support during 2020/21.
    - Providing opinion on and evidence in support of the Governance Statement at year-end and conducting an extensive Internal Control Evaluation which permitted remedial action to be taken in-year. This review made recommendations focused on enhancements to ensure NHS Fife has in place appropriate and proportionate governance, which supports and monitors the delivery of objectives and is commensurate with the challenging environment within which it is operating.
    - Continuing to liaise with management and providing ad-hoc advice on a wide-range of governance and control issues.
    - Provision of Committee Assurance principles and risk guidance which were considered and endorsed by the Audit and Risk Committee for adoption by Standing Committees. We continue to engage with national groups to ensure that our approach is congruent with forthcoming SGHSCD developments.
    - Assurance mapping and risk advice, in particular on Digital and Information risks.
    - Consideration of how best to provide Directors' assurances required under the Scottish Public Finance Manual and production of a potential template for use in future years.

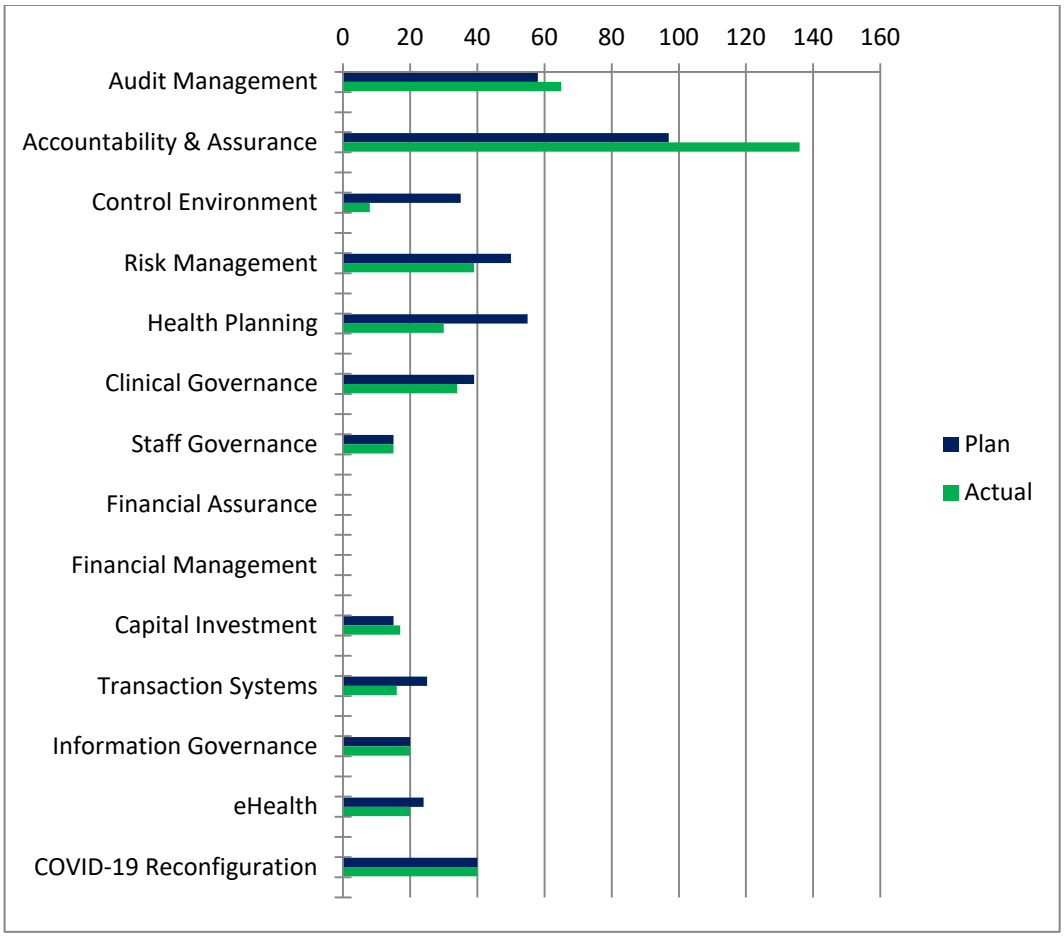
- Advice provided to the process maps for agency nurses and authorisation of invoices, etc.
- Initial review of NHS Fife's proposed approach to strategic planning and resource allocation.
- Advice on the revised Terms of Reference for the Digital Information Board, Information Governance and Security Steering and Operational Groups and attendance at their meetings.
- Suggested amendments to the draft Integration Scheme and preparation for assumption of the Chief Internal Auditor role for Fife IJB from April 2021 onwards.

27. Internal Audit have also used any time made available by necessary senior management prioritisation of Covid19 duties to reflect on our working practices, both to build on action taken in response to previous External Quality Reviews and to adapt to a post Covid19 environment. This has included:

- Revision of the internal audit reporting protocol and flowchart.
- Development of a revised client quality questionnaire.
- Update and enhancement of the FTF Intelligence Library.
- Review of internal documentation and processes including analytical review and performance review, again to ensure we add value wherever possible.
- Review and update of our risk assessment categorisation.
- Ongoing development of the FTF website.
- Review and update of the FTF self assessment against the Public Sector Internal Audit Standards.

INTERNAL AUDIT COVER

28. **Figure 1: Internal Audit Cover 2020/21**



29. Figure 1 summarises the 2020/21 outturn position against the planned internal audit cover. The initial Annual Internal Audit Plan was approved by the Audit and Risk Committee at its meeting on 13 July 2020. It was agreed at that time that the plan would be revised as changes to the risk profile and other factors became better known, and the Audit and Risk Committee approved amendments in March 2021. We have delivered 439 days against the available 473 days.

30. Following a recommendation from the External Quality Assessment (EQA) carried out on Internal Audit in 2018/19, we continue with the agreed process of risk assessing outstanding 2020/21 audits for inclusion in the 2021/22 plan.

31. A summary of 2020/21 performance is shown in Section 3.

PERFORMANCE AGAINST THE SERVICE SPECIFICATION AND PUBLIC SECTOR INTERNAL AUDIT STANDARDS (PSIAS)

32. Due to prioritisation of Covid19 duties, the FTF Partnership Board met only once in 2020/21. The Partnership Board is chaired by the NHS Tayside Director of Finance and the FTF Client Directors of Finance are members. The FTF Management Team attends all meetings. During the year the Partnership Board reviewed the Internal Audit Shared Service Agreement 2018-2023 and the Internal Audit Service Specification, as well as approving the 2020/21 budget. The Partnership Board also approved revised risk assessment definitions for internal audit reporting.

33. We have designed protocols for the proper conduct of the audit work at the Board to ensure compliance with the specification and the Public Sector Internal Audit Standards (PSIAS).

34. Internal Audit is compliant with PSIAS, and has organisational independence as defined by PSIAS, except that, in common with many NHSScotland bodies, the Chief Internal Auditor reports through the Director of Finance rather than the Accountable Officer. There are no impairments to independence or objectivity.

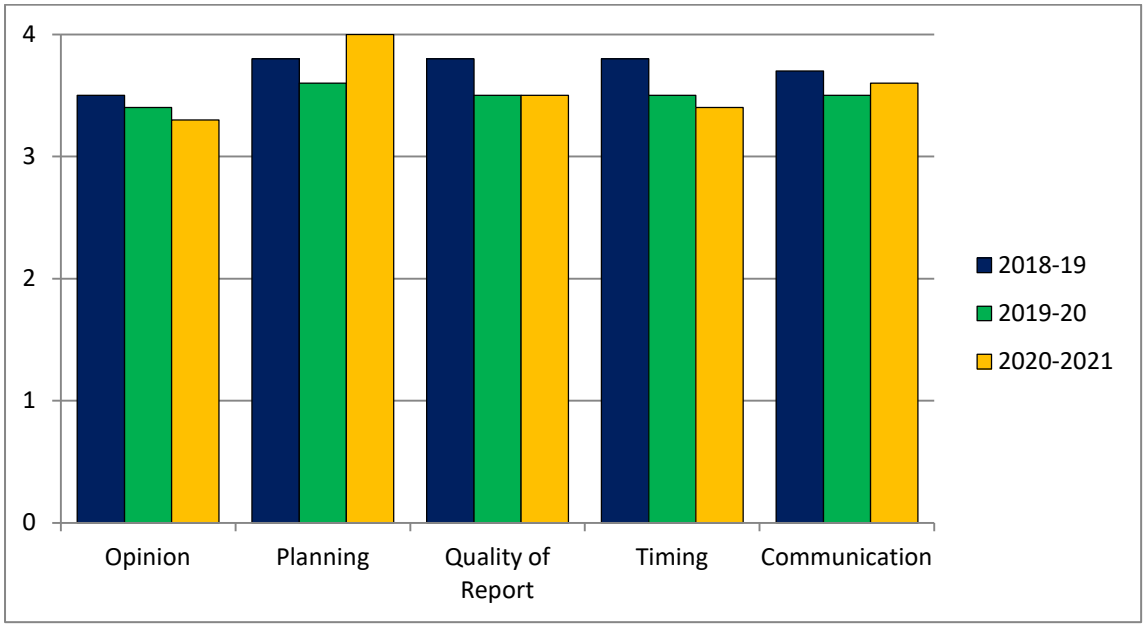
35. Internal and External Audit liaise closely to ensure that the audit work undertaken in the Board fulfils both regulatory and legislative requirements. Both sets of auditors are committed to avoiding duplication and securing the maximum value from the Board's investment in audit.

36. Public Sector Internal Audit Standards (PSIAS) require an independent external assessment of internal audit functions once every five years. The most recent External Quality Assessment (EQA) of the NHS Fife Internal Audit Service in 2018/19, concluded that *'it is my opinion that the FTF Internal Audit service for Fife and Forth Valley generally conforms with the PSIAS.'* FTF has updated its self assessment and this will be reported to the NHS Fife Audit and Risk Committee in early 2021/22.

37. A key measure of the quality and effectiveness of the audits is the Board responses to our client satisfaction surveys, which are sent to line managers following the issue of each audit report. Figure 2 shows that, overall, our audits have been perceived as good or very good by the report recipients.

38. **Figure 2: Summary of Client Satisfaction Surveys**

Scoring: 1 = poor, 2 = fair, 3= good, 4 = very good.



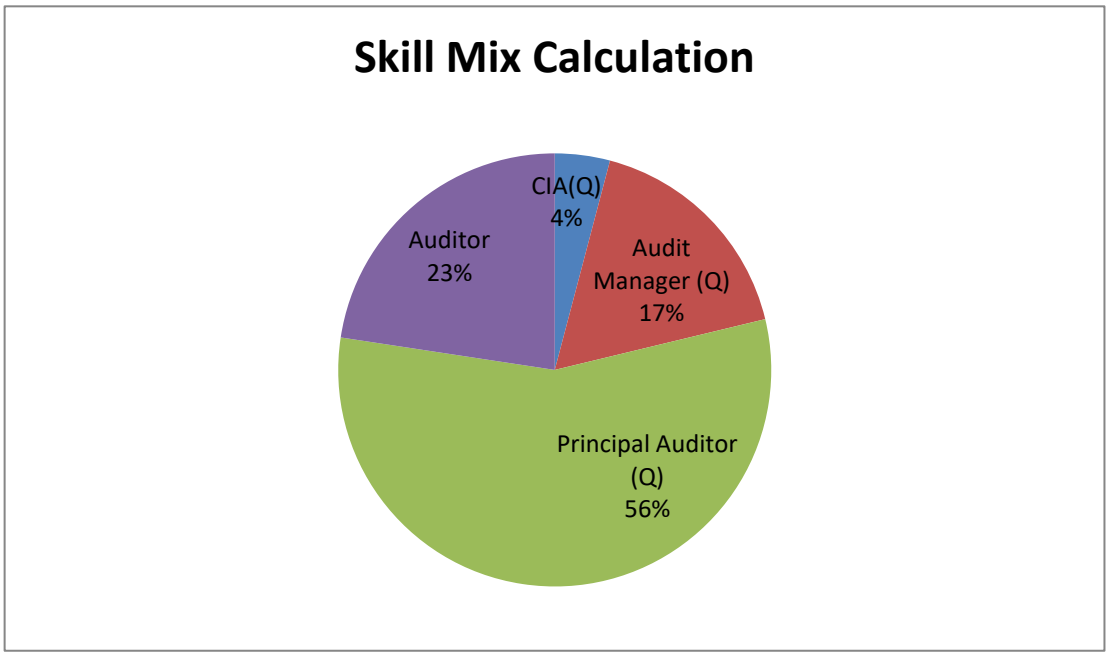
39. Other detailed performance statistics are shown in Section 3.

STAFFING AND SKILL MIX

40. Figure 3 below provides an analysis, by staff grade and qualification, of our time. In 2020/21 the audit was delivered with a skill mix of 77%, which substantially exceeds the minimum service specification requirement of 50% and reflects the complexities of the work undertaken during the year.

41. **Figure 3: Audit Staff Skill Mix 2020/21**

Audit Staff Inputs in 2020/21 [days] Q= qualified input.



ACKNOWLEDGEMENT

42. On behalf of the Internal Audit Service I would like to take this opportunity to thank all members of staff within the Board for the help and co-operation extended to Internal Audit.

43. My team and I have greatly appreciated the positive support of the Chief Executive, Director of Finance and Strategy, the Board Secretary, EDG and the Audit and Risk Committee.

A Gaskin, BSc. ACA
Chief Internal Auditor

TABLE 1 - ICE 2020/21 (B08/21) - Update of Progress Against Actions		
Agreed Management Actions with Dates	**Management Actions Updates with Dates**	**Assurance Against Progress**
1. Long term Strategy • The EDG should jointly agree how the various strands of work to inform and deliver the long term strategy for NHS Fife will be analysed and translated into a co-ordinated programme, building on the progress already made through the SPRA as well as remobilisation planning, considering how best use can be made of existing expertise and data and understanding constraints on resources. • This review should also consider how best to ensure effective governance and oversight of this key area in advance of the Board Development Session • A timetable for development of the new Strategy and supporting strategies should be reported to the NHS Board. Reporting on progress should be clearly assigned to an Assurance Committee or the NHS Board and should include a broad overview of whether Recovery, Remobilisation and strategy development is on track, key achievements, challenges and risks and any significant implications for strategy and priorities. ***Action Owner: Chief Executive***	• The Board noted and approved the RMP 3 at the May 2021 Board meeting. • The Board has been kept informed of the development of the Strategy through a number of updates including a Board Development Session on the progress of the Population Wellbeing Strategy for Fife on 27 April and an update on Strategy Development on 29 June 2021. • An update on the Strategic Planning & Resource Allocation Process (SPRA) was presented to the 12 January 2021 meeting of the Finance Performance & Resources Committee (FP&RC). The SPRA process was planned to support the development of an organisational strategy and 3 year financial and strategic plan. However, disruption caused by Covid has necessitated a more fluid and agile approach to planning this year. The Remobilisation plan RMP3 has been informed by the SPRA process and was approved by the Board in May 2021. A Remobilisation Forum has been established to update the tracker for the RMP3. This will also be used to track progress with RMP4, which is due to be submitted to the Scottish Government in September 2021. • The update on SPRA presented to the 12 January 2021 FP&RC meeting included a timetable the submission of directorate templates by 31 March 2021. • The SBAR to the FP&RC meeting held on 16 March 2021 stated 'the *output from the SPRA process will*	 **On track**

	be part of the development of the new Health and Wellbeing Strategy following on from the Clinical Strategy. This is due to be presented to the Board in March 2022'. The reporting on progress of the RMP3, is through a Tracker which will be monitored by the EDG and Remobilisation Forum. The FP&R Committee receive updates on the SPRA. The RMP3 is also monitored through the ESIPQR performance reporting to the Board.	
2. Governance and Year end Assurances Coordination of the year-end governance reports and statements of assurance is well underway. This will conclude in the normal timeframes – **June 2021,** specifically • Adoption of Assurance Mapping principles **– June 2021** *Action Owner: Director of Finance and Strategy*	• Templates were produced for year end assurances and governance reports and statements have been provided. • Year End Review shows significant progress, with workplans for Standing Committees being reviewed, to ensure that they are fit for purpose in a covid related environment. • Year-end governance reports and statements were comprehensive and meaningful. • Significant progress has been made with the implementation of Assurance Mapping principles. The Committee Assurance Principles for best practice, produced by Internal Audit were presented to the March 2021 meeting of the Audit and Risk Committee and were considered and endorsed. The Environmental Sustainability & IJB BAFs require an update on narrative and Covid risks.	 **On track**
3. Clinical Governance Framework Development of the Clinical Governance Strategy and Clinical Governance Assurance Framework with a focus on risk, informed by Committee Assurance and Integration Principles. ***Action Owner: Medical Director***	• As per internal audit report B19/21 the Clinical Governance Strategy and Framework are being revised. A consultation process, including evaluation of the current governance reporting lines, is underway and an outline timetable is in place with a final version of the revised strategy scheduled to be presented to the CGC and Fife NHS	 **On track**

	Board towards the end of 2021/22. • The approach to presentation of the BAFs and corporate risks are currently being reviewed by the Director of Finance & Strategy (Executive Lead for RM) with full involvement of EDG.	
4. Whistle Blowing • An annual report from the Whistleblowing Champion (WBC) cannot be provided until a WBC is appointed to NHS Fife. In the absence of a WBC a report is being presented to the Board which includes whistleblowing data. The SGC action plan 2021/22 will include the reporting requirement from the Whistleblowing Champion – **March 2021** ***Action Owner: Director of Human Resources***	• The Whistleblowing Champion Non-Executive resigned from Fife NHS Board during 2020/21 and their replacement attended their first Staff Governance meeting as a member on 1 July 2021 and provided an update to the Staff Governance Committee on the role of the Whistleblowing Champion at the September meeting. • Fife NHS Board was updated, on 31 March 2021, regarding the new Whistleblowing Standards, which came into effect on 1 April 2021 and provided the 2020/21 annual report. The update stated that that no Whistleblowing concerns had been raised in the financial year to 31 March 2021. Future reports will facilitate discussion around whether this indicates whether staff are sufficiently encouraged/facilitated staff to raise concerns. • The SGC Workplan for 2021/22 includes 'Whistleblowing – Reporting of Incidents/Data' will be reported quarterly to the SGC which started September 2021 with the first quarter 1 April to 30 June 2021. • The report template of annual and quarterly assurance reports is being further developed to include the statistical information, analysis and conclusions required by the standard in order to allow a conclusion on the adequacy and effectiveness of whistleblowing arrangements.	 On track

5. Property Management Strategy • Property and Asset Management Strategy (PAMS) is on the Agenda for the NHS Board in March 2021. • We anticipate that there will be a requirement for an East Regional PAMS report in the near future. The data in this document represents NHS Fife position as at 1 April 2020. • The 2020 PAMS document is largely retrospective and represents the pre-Covid19 landscape, the Impact of Covid19 will be further considered as part of the 2021 full PAMS which will be compiled between April and July 2021 by NHS Fife and likely submitted as part of an East Regional PAMS report – August 2021 ***Action Owner: Director of Property and Asset Management***	• The interim PAMS for 2020 was presented to the FP&RC in March 2021 and reflected the position from 1 April 2020 to March 2021. Currently the target for approval of the NHS Fife PAMS document by the NHS Board is November 2021 following scrutiny by EDG, FCIG and FP&RC. NHS Fife is currently reviewing any requirement for a regional component of PAMS going forward.	 On track
6. Information Governance and Security • Establishment of IG&S Operational Group and Steering Group ToR • Digital and Information Board to provide additional support and assurance to IG&S and its alignment to strategy and operational performance **– April 2021** • IG&S Assurance Report and Framework – **March 2021** • Assurance report will be made available for consideration at the next Clinical Governance Meeting, following the IG&S Steering Group meeting on 23 March 2021. • Risk associated with resources and requirement for business cases when delivering the Digital and	• Annual Assurances were received by the CGC from the Information Governance & Security Steering Group and the Digital and Information Board. The IG&SSG statement recognised the requirement to '*further enhance and develop suitable controls in some areas*'. This is consistent with our report on D&I Governance Arrangements (B28/21) which followed up this ICE recommendation. • Additional assurance reporting has been included in the Clinical Governance Committee Annual Workplan with IG&S reporting to the Committee in July 2021 with a follow up to be agreed later in the year. • The risk regarding affordability of the NHS Fife D&I Strategy was reflected in the most recent iteration of the D&I BAF and	 On track

Information Strategy will be documented within the related BAF – **April 2021** ***Action Owner: Associate Director of Digital***	included in the D&I Strategy Update provided to the June Clinical Governance Committee meeting.	

Corporate Governance

BAF Risks:

- **Risk 1675 – Strategic Planning - There is a risk that the development and the delivery of the new NHS Fife Population Health and Wellbeing strategy is not adequately supported by the required planning and programme management capacity, capability and governance arrangements.**
- **Risk 1676 – Integration Joint Board - 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.**

Strategy

The ICE report highlighted the opportunity to build on the strong foundation of existing reconfiguration and remobilisation processes, in order to produce an overarching strategy which allows effective prioritisation and creates sustainable services allowing for the changes to demand, resources and modes of operation created by Covid19.

The Strategic Planning Resource Allocation (SPRA) Framework was created to inform both a medium term strategy and support the development of a longer term organisational strategy. The Directors discussed and agreed the output of the SPRA process on 22 February 2021, where three key objectives were identified. The output of the SPRA process was presented to the March 2021 meeting of the Finance, Performance and Resources Committee:

- Minimise transmission of Covid19 and support health protection
- Improve whole system capacity and flow to ensure timely and appropriate access to health care when required
- Support the actions required to reduce health inequalities

The SPRA process also informed the key objectives for NHS Fife for 2021/22. An EDG workshop was held in March 2021 where key Strategic Priorities for the organisation were agreed, prior to Board approval on 27 July 2021 and represent the key objectives for delivery in 2021/22. These priorities, each aligned to a Executive Director, will be used as the framework to provide assurance to the Board on delivery of the Corporate Objectives:

1. To Improve Health and Wellbeing
2. To Improve the Quality of Health and Care Services
3. To Improve Staff Experience and Wellbeing
4. To Deliver Value and Sustainability

The SBAR presented to the July 2021 meeting of the CGC provided assurance that the objectives for 2021/22 are aligned to NHS Fife Strategic Priorities and will be aligned to the 'in development' Population and Wellbeing Strategy which is due to be presented to the Board in March 2022, with progress monitored by the EDG and the recently established Population Health and Wellbeing Committee.

Covid19 & Governance

NHS Fife has continued to monitor and adapt governance arrangements whilst taking account of the pressures on management and the need to free operational staff to prioritise the response to Covid19. Covid reporting to the Board has continued and covers: Covid19

Vaccination, Test and Protect and Covid19 Testing in Fife.

A revised Code of Corporate Governance was approved by the Board in May 2021, which includes the recently revised remits of the Board Committees. The SBAR presented to the Board noted that further changes to the Code are likely to be required to reflect the work underway for the implementation of the NHS Scotland Blueprint for Good Governance.

Assurance Mapping

The Chief Internal Auditor, working with officers from NHS Fife and other Client Health Boards, developed a set of Committee Assurance Principles, together with a series of questions which would help Standing Committees assess the assurances they receive on risks delegated to them. These were recommended for use by Standing Committees at the May 2021 Audit and Risk Committee. B12/21 Assurance Framework, provided assistance to the Board in developing an assurance map for key aspects of the Digital and Information Governance BAF.

Remobilisation

The draft NHS Fife Remobilisation Plan - April 2021 to March 2022 (RMP3) was submitted to Scottish Government (SG) on 26 February 2021. Feedback and sign off from SG was received on 2 April 2021 and the RMP3 was presented to the Board for formal approval at the May 2021 Board Meeting which was the earliest opportunity following the Scottish elections.

The ICE 2020/21 report recommended establishing greater formality of reporting of remobilisation progress through governance structures. An action tracker has been developed by the Executive Directors Team (EDG). A Remobilisation Plan Forum has been re-established to review the Action Tracker, which will be updated every 2 months, in preparation for presentation to the EDG. The update on RMP3 due in July was not taken through the EDG and Standing Committees but we have been informed that subsequent updates will be presented to the EDG and on to the Standing Committees of the Board. The RMP3 activity template is an integral part of the performance reporting to the Board and is included within the Fife Integrated Performance & Quality Report Executive Summary. The Associate Director of Strategic Planning has advised that the Remobilisation Plan Forum will meet every two weeks in preparation for the submission of the RMP4 to the Scottish Government for 30 September 2021. The RMP4 is planned for presentation to the Board in November 2021. We note the extremely challenging ambition within Fife's response to RMP4 guidance and the intention to increase elective output above pre-covid levels.

Risk Management

As reported within the B08/21 ICE 2020/21 report, a number of BAFs have been updated for Covid19; however the Board has not received an overall Covid19 risk or been informed on how these will be incorporated into the BAF. The Quality and Safety BAF will be reviewed as part of B11/22 Assurance Framework. As noted previously, the IJB BAF and the Environmental Sustainability BAF still require review and update to reflect the current risks and mitigating actions.

The risk profile remained largely static throughout the year, again as noted within the ICE, with the exception of both the Financial Sustainability and Strategic Planning BAFs risk ratings which were updated appropriately.

During the year, a high level covid risk register of the highest organisational risks was developed via the Emergency Command structures which were considered by the EDG, although they were not presented to the Board or a Standing Committee nor were they incorporated into the BAF. Standing Committees and the full Board were however presented with regular updates on the activities and risks included in the ongoing response to the

Covid pandemic.

The SBAR presented to the June 2021 Audit and Risk Committee advised that the Corporate Risk Register (CRR) will be presented to the EDG, where all escalated active high risks or operational risks will be considered for inclusion on the CRR and/or as a linked risk on the BAF; this is still ongoing. Draft Internal Audit report B13/21 - Risk Management Strategy Standards and Operations Phase 1 identified key areas for improvement for the revised Risk Management Framework. We were pleased to note that the Executive Lead for Risk Management has agreed to secure a short-term resource to undertake a risk maturity assessment of the organisation and review and improve risk management arrangements, priorities and risk structures including the development of detailed improvement plans and focussed reporting.

Performance

The Board was presented with the Integrated Performance Quality Report Executive Summary (ESIPQR) at the July 2021 meeting.

Highlights include that NHS Fife has continued to exceed the Cancer 31-day Diagnostic Decision to first Treatment (DTT) target and inpatient falls with harm. Drug and Alcohol Treatment Waiting Times are also above target performance.

The Patient Treatment Time Guarantee (TTG), New Outpatients and Diagnostics are all performing below target, although they are all well above the Scotland average.

There are continued challenges with meeting targets for the following key indicators: 4 Hour Emergency Access, where current performance is 3.1% under the target of 91.9% although over the Scotland average of 88.7%; Complaints (stage 2 closure rate) where current performance is 21.6% with a target of 65%; 18 weeks RTT where current level is 69.2%, slightly below the Scotland average of 75.9%; the Sickness Absence rate is currently 5.07% with a target of 4.0%. It was noted that Covid19 related absence affected approximately 1.52% of the NHS Fife workforce in March and 0.62% in May.

NHS Fife are successfully delivering against the remobilisation plan for TTG Inpatient/Daycase Activity; New OP Activity; Elective Imaging Activity; A&E Attendance; Emergency Admissions; Urgent Suspicion of Cancer; CAMHS and Psychological Therapies. The Board has been less successful meeting the projected targets for Elective Scope Activity and 31 Day Cancer – First Treatment and the challenges are likely to increase given the ambitions around elective activity and the likely backlog of unrecognised need and higher case mix in relation to both targets.

Integration

An update on the review of the Integration Scheme was presented to the March 2021 Board meeting. The Scottish Government indicated that due to the constraints placed on Boards caused by the Pandemic, they are content that local reviews are concluded with an indicative timescale provided on the planned conclusion. The revised Scheme will be considered for approval by the Board in September 2021, before being submitted to Scottish Government for final sign-off.

Clinical Governance

BAF Risks:

- **Risk 1674 – Quality and Safety - 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.**

Annual Report

The Clinical Governance Committee (CGC) annual report provided a reflective and nuanced conclusion that the Committee had fulfilled its remit and that adequate and effective clinical governance arrangements were in place throughout NHS Fife during the year. The narrative in the report includes detailed reflection on key areas including nosocomial covid infection, the risk based approach taken to service pause during the pandemic and mitigating action taken to minimise the impact of this on patient treatment and diagnosis.

Pandemic

The CGC received reports on Shielding, Testing, Care Homes, PPE, Medicines Availability, Remobilisation of Clinical Services, Nosocomial Related infections and the Covid Vaccination Programme during 2020/21.

During the year, the Board experienced significant challenges initially in delivering the seasonal flu programme. The Chief Executive commissioned an independent review which made 9 recommendations. The CGC in January 2021 was informed that 4 actions had been completed and the remainder were on track, although no subsequent reports were produced to provide assurance that the remaining actions were complete.

An external review of all immunisation programmes in NHS Fife subsequently made recommendations to allow NHS Fife to meet the increasing demands and expectations for childhood and adult immunisation programmes. Recommendations were approved by the EDG at their 6 May 2021 meeting and are due to be presented to an extraordinary meeting of CGC in September 2021, which will consider the forthcoming flu and Covid19 booster immunisation programmes.

Clinical and Care Governance Strategy and Framework

A revised Clinical Governance Strategy, now to be referred to as the Clinical Governance Framework, is in development. This will contain reference to the integration framework which is also in development. An engagement process has been established with the finalised strategy scheduled to be presented to the NHS Fife Clinical Governance Committee and Fife NHS Board by January 2022. There are also a number of contributing Workstreams underway which will enable and inform the Framework development including:

- Adverse Event Process and Policy Review
- Development of an Organisational Learning Group
- Review of Internal Audit Findings
- Review of the Risk Management Framework.

Internal audit report B19/21 followed up previous internal audit reports on Clinical Governance Strategy and Assurance. Most recommendations had been implemented or superseded although there is still a need to ensure that the revised strategy and framework provide a clear vision of responsibility for clinical governance across NHS Fife's span of

responsibility including clinical areas delegated to the Integration Joint Board. Clearly, the Clinical Governance Framework will need to align with the development of other NHS Fife strategies including the Population Health and Wellbeing Strategy for NHS Fife.

CGC Governance and Assurance

The workplan is reviewed following each meeting to assure the committee that key business has been covered and to track any delayed items.

The work being undertaken to develop the new Clinical Governance Framework will consider all groups and committees in the framework to ensure that appropriate assurance reporting and scrutiny is provided as efficiently as possible. The committee and integration assurance principles prepared by Internal Audit will be used as a guide in this process.

Risk Management

The scoring and information on the 3 BAFs considered by the CGC (Strategic planning, Quality and Safety, and Digital and Information) did not significantly change during 2020/21, despite enormous changes to the risk environment and to the application of a number of key controls. A complete review of all BAFs and corporate risks is underway being led by the Executive Director for Risk Management (Director of Finance and Strategy) and will include integrating risk management in the strategic planning process. A commitment was made at CGC to specifically consider combining remobilisation, transformation and strategic planning into one BAF and responsibility for this BAF has transferred from the Medical Director to the Director of Finance and Strategy.

Our work in internal audit B11/22 will include providing guidance regarding assurance mapping and will specifically consider the Quality and Safety BAF.

Risk management arrangements are continuing to evolve, with dedicated senior Leadership from the Risk Manager and Adverse Events now managed separately.

Pandemic related risks were considered via the Bronze, Silver and Gold command structure. However the risk associated with interruptions to treatment and diagnostic services and resultant patient harm were not recorded overtly even though it has the potential to be one of, if not the most significant threat to the wellbeing of patients. Whilst we are aware that some controls are in place, it is of concern that this key risk has not been included within the risk register nor discussed with the CGC, which would provide the opportunity to assess and assure the adequacy and effectiveness of these key controls.

We recommend the development of a specific risk, delegated to the CGC, to capture the clinical implications of Covid19 on waiting times and the associated impact on patient safety, clinical effectiveness and strategic prioritisation. This would allow the CGC to understand the quantum of the risk and also to monitor the controls already in place to mitigate it, for example, the clinical prioritisation and remobilisation framework developed in line with Scottish Government guidance.

External Review

The NHS Fife CGC Annual Assurance Report now includes reference to the External Reports related to NHS Fife Clinical Governance that have been published during the year and high level assurances on action being taken to address issues identified. We previously highlighted the need to triangulate data and information from different sources in order to assess the reliability of internal assurances; this has not yet been implemented but will be considered as part of the revised internal control framework for Clinical Governance and developed further through the Organisational Learning Group.

Significant Adverse Events

A full review is currently being undertaken of the processes associated with recording and investigating adverse events and for ensuring the required actions are implemented in all areas of the organisation they apply to. A Short Life Working Group (SLWG) is being established to take this forward and will consider the overall process, the triggers for LAERs and SAERs and the education, learning and communication required related to the process. The SLWG is to commence its work in September 2021 and will report to the Adverse Events & Duty of Candour Group and the Clinical Governance Oversight Group with a paper detailing the outcome to be presented to the Clinical Governance Committee when the work is complete.

Organisational Duty of Candour

The Organisational Duty of Candour Annual Report for 2020/21 is on the Clinical Governance Workplan for November 2021. In future a short summary report should be provided to the CGC at year-end for consideration when concluding on its Annual Assurance Report and Statement.

Clinical Policies and Procedures

The latest report to the Clinical Governance Oversight Group in April 2021 indicated that 100% of Clinical Policies and Procedures had been reviewed by their scheduled review date.

Other Areas

Inpatient falls with harm have increased during the pandemic. Improvement work has been undertaken in those areas that have seen the largest spike in numbers and the Inpatient Falls Steering group are refreshing their workplan to include learning from experiences during Covid and how care needs to adapt.

Efforts are underway to address the backlog of complaints caused by the pandemic and to bring response timescales back in line with legislative timescales.

Action Point Reference 1 - Increased Risk of Harm

Finding:

Pandemic related risks were considered via the Bronze, Silver and Gold command structure. However there are major risks associated with SGHSCD mandated interruptions to treatment and diagnostic services. These have the potential for significant resultant patient harm which have not been recorded overtly even though they have the potential to be one of, if not the most significant threats to the wellbeing of patients. Whilst we are aware that some controls are in place, it is of concern that this key risk has not been included within the risk register nor discussed overtly as a risk with the CGC, which would provide the opportunity to assess and assure the adequacy and effectiveness of these key controls.

Audit Recommendation:

A specific risk should be recorded, delegated to the CGC, to capture the clinical implications of Covid19 on waiting times and the associated impact on patient safety, clinical effectiveness and strategic prioritisation. This would allow the CGC to understand the quantum of the risk and also to monitor the controls already in place to mitigate it, for example, the clinical prioritisation and remobilisation framework developed in line with Scottish Government guidance.

The risk should include clear controls and assurance sources looking at reducing avoidable harm caused by delays in diagnoses and treatment and should reflect:

- The key priorities and aims for 2021/22 within the current remobilisation plan.
- Other relevant controls, such as implementation of RCS guidelines
- A description of controls to address the current pressure on scheduled care as a result of imbalance in demand and capacity; additional pressures due to Covid19; possible pent up demand due to reduction in referral rates.
- Identified requirements to redesign services.

Assessment of Risk:

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

Management Response/Action:

The development of a risk as recommended above will form part of the review and update of the Quality & Safety BAF. This review will take account of the short, medium and longer term impact of the pandemic on service provision and consider the corresponding controls and assurances that require to be in place, linking to the evolving Population Health and wellbeing Strategy.

Action by:	Date of expected completion:
Head of Quality and Clinical Governance	**November 2021**

Staff Governance

BAF Risks:

- **Risk 1673 - Workforce sustainability - 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.**

Governance

The April 2021 Staff Governance Committee (SGC) received a self-assessment by members of the operation of the committee together with improvement actions including number of attendees, role and contribution; agenda management; and report content and related actions.

The SGC Annual Statement of Assurance concluded that the Staff Governance Committee fulfilled its remit and that adequate planning and monitoring arrangements were in place.

Pandemic

Regular updates on Staff Health and Wellbeing were presented to SGC in 2020/21 which included assurances regarding staff resourcing, induction and learning, communications & guidance, staff wellbeing hubs and psychological support for staff but no information on PPE, Social Distancing or Home Working, which were key risks at that time. The HSE issued a 'Notice of Contravention' following their spotcheck of Covid Management at Victoria Hospital in November 2020. This was considered by the December 2020 Health and Safety Sub Committee (and reported to the January 2021 SGC) with assurance that an official response would be provided to HSE by the end of January 2021 by which time most actions would have been implemented. The HSE closed the Contravention Notice on 31 March 2021. It is not clear that the committee received comprehensive, overt internal assurances on the impact of Covid19 on staff throughout the year.

Risk Management

The Workforce Sustainability BAF was considered at SGC meetings other than 4 March 2021.

The content of the Workforce Sustainability BAF has not altered significantly during 2020/21 and the current risk rating remains high. The Director of Workforce informed the July 2021 SGC that the development of the Workforce Strategy 2022-2025 will provide the opportunity for a thorough review of the BAF.

Staff Governance Action Plan

No specific year-end assurance provided to SGC on the Staff Governance Action Plan as work on this was paused due to the pandemic. The SGC Annual Statement of Assurance states that '*A particular strand of the Staff Governance standards is reviewed at each meeting, ensuring full coverage over the year's meeting schedule'.* Although papers relating to each strand of the Staff Governance were discussed throughout the year, their strand to which they relate was not always highlighted in the papers, agenda or minutes and there was no year-end summary to demonstrate coverage achieved. However, it is included in the 2021/22 workplan going forward and will be made overt in future papers.

The action lists from SGC meetings held in 2020/21 record the pausing of the Staff

Governance Action Plan.

Staff Governance Standard Annual Monitoring Return 2020/21

Scottish Government has requested returns from all Boards by 24 September 2021. The NHS Fife return, which focuses on the five individual strands of Staff Governance as well as staff experience and culture, has been developed and presented to Executive Directors Group, Area Partnership Forum, and the Staff Governance Committee. The Return will be signed by the Chair of Staff Governance Committee and the Employee Director will endorse the Return in September 2021 prior to being submitted to Scottish Government.

Workforce Strategy, Planning and Delivery

SGC were updated at their 1 July 2021 meeting that the NHS Fife Workforce strategy refresh will be completed in conjunction with the development NHS Fife Population Health & Wellbeing strategy. Consultation and engagement timescales for the Workforce Strategy development will therefore progress in parallel.

The Operational Workforce Planning Group, with oversight from the Strategic Workforce Planning Group, is in the process of reviewing the extant Workforce Strategy and associated action plans prior to March 2022. Service leads have been asked to update action plans produced as part of the 2019-2022 Workforce Strategy, confirming the status of each commitment, the results of which will be summarised at a future Staff Governance Committee. The review is being led by the development of the new NHS Fife Population and Wellbeing Strategy and is considering short term issues such as current capacity and staffing requirements as well as longer term prognoses for need and provision.

A draft Interim Joint Workforce Plan 2021/2022 was presented to SGC on 29 April 2021 prior to submission to the Scottish Government. The plan includes an emphasis on the staff wellbeing agenda, focusing on the ongoing implications of Covid delivery in terms of test and protect, staff and patient testing, vaccination, occupational health and infection control.

Whistleblowing

The Whistleblowing Champion Non-Executive resigned from Fife NHS Board during 2020/21 and the newly appointed Whistleblowing Champion attended her first Staff Governance meeting as a member on 1 July 2021.

The March 2021 Board was informed of the implementation of the Whistleblowing Standards, which came into effect on 1 April 2021 and the June Audit and Risk Committee was informed that regular Whistleblowing reports would be provided in future. No Whistleblowing concerns were raised in first quarter of 2021/22. A report on implementation of the standards has been presented to the SGC and future reports will contain the data required by the new national standards as they evolve.

Performance Development Plans

The SGC was updated regarding the completion of Performance Development Plan Reviews at its September 2020 and January 2021 meetings. To reflect the impact of the pandemic, the target was reduced from 80% completion target to 55%. However, year-end completion was only 36% as noted in the Staff Governance Annual Report.

Medical Revalidation and Appraisal

The General Medical Council deferred revalidation for a year for all those due 16 March 2020 - 31 March 2021 and medical appraisal was paused across Scotland from 16 March 2020 - 1 October 2020. In Fife there was an additional pause at the beginning of January 2021 for 6 weeks. Many medical staff were given exemptions for 2020/21 as a result. It is

anticipated that 2021-22 will see a partial return to normal practice, although there are likely to be some technical difficulties with some aspects of required experience.

Attendance Management

Papers to SGC in 2020/21 indicate that efforts continue to be made to reduce staff absences including staff wellbeing activity such as mindfulness sessions, staff wellbeing hubs and access to psychological support.

The average percentage of staff absent in 2020/21 was 5.06% which is an improvement on the 2019/20 figure of 5.85% but still significantly higher than the notional national target of 4%.

Covid19 related absences are not included in the absence data quoted above and for 2020/21; the average percentage of hours lost due to Covid19 related absences within NHS Fife was 2.27%.

Remuneration Committee

The Remuneration Committee met on 5 occasions in 2020/21. The self assessment also considered that the operation of the committee during the pandemic had continued without interruption and that assurance could continue to be given to the Board on the areas under its remit.

Staff Governance

BAF Risks:

- **Risk 1673 - Workforce sustainability - 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.**

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Staff Governance Monitoring Return 2020/21

Scottish Government has requested returns from all Boards by 24 September 2021. The NHS Fife return, which focuses on the five individual strands of Staff Governance as well as staff experience and culture, will be completed and presented to Area Partnership Forum for approval in September 2021 prior to being submitted to Scottish Government.

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An action plan to underpin the strategy is being developed by the Operational Workforce Planning Group which will include commitments within the Joint Interim Workforce Plan for 2021/2022, the Remobilisation Plan and other service review programmes.

Workforce Planning

A draft Interim Joint Workforce Plan 2021/2022 was presented to SGC on 29 April 2021 prior to submission to the Scottish Government. The plan includes an emphasis on the staff wellbeing agenda, focusing on the ongoing implications of Covid delivery in terms of test and protect, staff and patient testing, vaccination, occupational health and infection control.

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The Whistleblowing Champion Non-Executive resigned from Fife NHS Board during 2020/21 and their replacement attended their first Staff Governance meeting as a member on 1 July

2021.

The March 2021 Board was informed of Whistleblowing standards, which came into effect on 1 April 2021 and the June Audit and Risk Committee was informed that regular whistleblowing reports would be provided to the NHS Fife Board in future. No whistleblowing concerns were raised in first quarter of 2021/22 and no report was provided to the Board. A draft quarterly whistleblowing report template was presented to the EDG on 5 August 2021 but Internal Audit have noted that it did not contain provision for recording much of the information required by the new standards.

Performance Development Plans

The SGC was updated regarding the completion of Performance Development Plan Reviews at its September 2020 and January 2021 meetings. To reflect the impact of the pandemic, the target was reduced from 80% completion target to 55%. However, year-end completion was only 36% as noted in the Staff Governance Annual Report.

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Remuneration Committee

The Remuneration Committee met on 5 occasions in 2020/21. The self assessment also considered that the operation of the committee during the pandemic had continued without interruption and that assurance could continue to be given to the Board on the areas under its remit.

Financial Governance

BAF Risk:

- **Risk 1671 – Financial Sustainability - 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 not match costs incurred. 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.**
- **Risk 1672 – Environmental sustainability - 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**

Financial Targets and Savings

As reported to the 27 July 2021 Board, the draft financial outturn position to 31 March 2021 subject to external audit review, was:

- A surplus of £0.377m against a Revenue Resource Limit of £870.979m.
- 99.98% of total capital allocation spent against Capital Resources of £17.315m.
- 2020/21 savings delivered of £11.766m, of which £5.430m (46%) are recurring. Also received £8.3m support from Scottish Government in relation to Covid19 savings delays.

Financial Planning 2020/21

NHS Fife considered the Financial Plan as part of its draft Annual Operational Plan for 2020/21 – 2022/23 at the March 2020 meeting of the FP&RC, noting that plans will be subject to constant review. The Plan set out a position to deliver financial balance, and the savings requirements, over the next 3 year period. The plan was based on NHS Fife's continuing response to the pandemic, recovery and remobilisation priorities.

The Financial Plan for 2021/22 is a part of the RMP3 for Health and Care services delivered by NHS Fife and Fife Health and Social Care Partnership, with this plan to be the Annual Operational Plan for 2021/22. Key financial assumptions were included as part of the overall financial plan.

Savings

Initial savings targets were set out in the 2020/21 financial plan. Savings in 2020/21 have come largely from unsustainable non-recurring sources which will increase the financial gap in future years. The gap in plan before efficiencies for 2021/22 is £21.837m with planned savings of £8.181m, which will make achieving financial balance in 2021/22 extremely difficult. In the longer term, financial sustainability will only be achieved through a combination of securing full NRAC parity, review of external commissioning costs and levels and the redesign of services with very clear priorities, which should arise from the new Health and well-being Strategy and the SPRA process.

Financial Reporting

Finance reporting to Board and FP&RC has been transparent and the Director of Finance has consistently and clearly articulated financial challenges, including the need for confirmation

of allocations to cover Covid19 costs and the delay in delivering anticipated savings in 2020/21. We are aware of the ongoing discussions on potential IJB risk share options with Scottish Government and respective partners.

Capital Plan and Property Strategy

An Interim Property & Asset Management Strategy (PAMS) update for 2020 was provided to the March 2021 PRC. This followed Scottish Government reporting requirements and forms part of a 'state of the nation' report. An update was also provided to the July 2021 PRC around the production of the PAMS report for the year to 31 March 2021. This report is not mandatory but NHS Fife have decided to produce. Delays have been experienced due to the late release of the templates by the Scottish Government with the target for approval of the NHS Fife PAMS document by the NHS Fife Board in November 2021. It would be beneficial for the PAMS produced to have clear links to the Health and Wellbeing Strategy development.

The FP&RC receive regular updates on current major capital projects and property transactions including the impact of Covid19. The Business Case for the Orthopaedic Centre was approved by the FP&RC in November 2020.

Best Value

Internal Audit has previously recommended application of the Audit Scotland Best Value Tool Kit. However, given the pressures on officers due to Covid19 response, we do not consider this a priority for the Board at this time, especially as best value and effective allocation of resources are a key element of the new SPRA process.

BAF – Financial Sustainability

The Financial Sustainability BAF, as reported to the FP&RC during 2020/21, recognised the ongoing financial challenges facing Acute Services, the pressures within Health & Social Care Partnership, specifically in relation to social care budgets and the ongoing work to review the risk share arrangement and the impact of Covid19 in delivering savings.

Information Governance

BAF Risk:

- **Risk 1677 – Digital and Information - There is a risk that the organisation will fail to recognise and afford the financial investment necessary to deliver its D&I Strategy and enable transformation across Health and Social care to deliver sustainable and integrated services that are safe, secure and compliant with governance frameworks and associated legislation.**

Governance Arrangements and Assurance Reporting

During 2020/21 the governance arrangements for Digital and Information Governance have been reviewed and revised with newly formed Information Governance & Security Steering and Operational Groups and the evolvement of the eHealth Board into the Digital and Information Board. Annual Assurance reports from Digital and Information Board and the Information Governance & Security Steering Group were presented to the CGC and included assurance on the key activities of both groups.

Recently issued audit report B28/21 - Digital and Information Governance Arrangements concluded that '*although the IG&S Operational Group has only recently started to meet, and much of the time at the meetings of the IG&S Steering Group held to date has necessarily been taken up with agreeing the new governance arrangements, assurance reporting has begun and is anticipated to evolve in 2021/22*'. The most recent report presented to IG&SSG on 1 June 2021 (IG&S Activity Tracker 2021-22) and the update provided to the Clinical Governance Committee on 7 July 2021 show an improving position regarding the quality of assurance provided with plans to further enhance.

B08/21 ICE 2020/21 notes that the work plan for the Clinical Governance Committee presented to its 30 April 2021 meeting, did not include provision for regular assurance reporting on Information Governance.

Pandemic

Several projects and programmes of work were accelerated to allow remote working and new projects added regarding the management of Covid19. All work was undertaken at pace with high level risk assessments taking the place of documented Data Protection Impact Assessments, Information Sharing Agreements and System Security Policies which are now being addressed retrospectively.

Digital and Information Strategy

The Digital and Information Strategy 2019-24 was approved by Fife NHS Board on 30 September 2020 and updates on the impact of the pandemic on the Digital and Information Strategy Delivery Plan were provided to CGC on 7 September 2020 and 7 July 2021. The later update considered the strategy's robustness and highlighted areas of reprioritisation.

The latest Digital and Information BAF presented to CGC on 7 July 2021 includes a revised risk description which recognises the risk to D&I Strategy implementation posed by lack of financial investment. This addresses a previous internal audit recommendation on this topic.

A paper on the funding challenges facing Digital and Information was presented to the Digital and Information Board on 21 July 2021 and highlighted areas of operating costs that require further consideration by NHS Fife. A financial plan is in development to address the significant challenges and we will consider this as part of our 2021/22 Internal Control

Evaluation work.

Risk Management

Internal Audit have continued to work with the lead for eHealth around improvements to the Digital and Information BAF. Initial changes were made and a full risk review within Digital and Information was undertaken and an improved Digital and Information BAF was presented to CGC on 7 July 2021.

Improvement to risk reporting to IG&SSG and Digital and Information Board have been made progressively throughout 2020/21 with the latest Risk Report presented to Digital and Information Board on 21 July 2021 including a new risk categorisation model and a new format of reporting including detailed analysis of one high risk and introducing the concept of 'risk velocity'.

The CGC Annual Assurance Report recognises that further work is required on Digital and Information risks and those related to transformation programmes noting that work on strategy development will bring an overall focus and direction to individual strands of work.

External Review

The Competent Authority NISR Audit Report was published 26 April 2021, with Compliance in 2021 audit at 69% (compared to 53% in 2020) which was recognised as 'a significant achievement especially in the midst of a pandemic'.

Internal Audit note the commitment made within the Medical Director's Annual Assurance letter that states *'the outcome and subsequent action plan will be considered by the IG&SSG in 2021/22, with intention to share, where appropriate, updates on the delivery of this plan with the Clinical Governance Committee*'.

Information Governance Incidents

During the financial year 2020/2021, 11 incidents were reported to the Information Commissioner's Office (ICO), with no further action required for 9 of the incidents. The ICO has since responded regarding the other 2 incidents reported in March 2021 indicating that no further action is required.

Key Performance Indicators – Performance against Service Specification

	Planning	Target	2019/20	2020/21
1	Strategic/Annual Plan presented to Audit & Risk Committee by April 30th	Yes	No (June 20)	No (July 21)
2	Annual Internal Audit Report presented to Audit & Risk Committee by June	Yes	Yes	No
3	Audit assignment plans for planned audits issued to the responsible Director at least 2 weeks before commencement of audit	75%	95%	79%
4	Draft reports issued by target date	75%	76%	59%
5	Responses received from client within timescale defined in reporting protocol	75%	57%	68%
6	Final reports presented to target Audit & Risk Committee	75%	76%	47%
7	Number of days delivered against plan	100% at year-end	101% at year-end	93%
8	Number of audits delivered to planned number of days (within 10%)	75%	76%	77%
9	Skill mix	50%	72%	77%
10	Staff provision by category	As per SSA/Spec	Pie chart	
	Effectiveness			
11	Client satisfaction surveys	Average score of 3	Bar chart	

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.**	None
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.**	One
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.**	None
Merits attention		There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**	None

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**16 September 2021**
Title:	**Review of Property Transactions**
Responsible Executive:	**Tony Gaskin, Chief Internal Auditor**
Report Author:	**Barry Hudson, Regional Audit Manager**

1 Purpose

This is presented to the Audit and Risk Committee for:

- Assurance

This report relates to a:

Government Directive

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

- Safe
- Effective
- Efficient

2 Report summary

2.1 Situation

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

2.2 Background

The purpose of this report is to advise the Audit and Risk Committee of the internal audit of the property transaction completed in 2020/21, which provides assurance that the required procedures have been followed.

2.3 Assessment

Under the PTH regulations, the Audit and Risk Committee is charged with oversight of the monitoring of the process of property transactions. The monitoring process is a cyclical exercise and Internal Audit reviewed the only transaction completed in 2020/21 to ensure the requirements of the PTH were followed.

The audit report assessed this transaction at grade A, i.e. transaction is properly completed, with two recommendations risk assessed as 'merits attention' which management have accepted.

A clean property transaction return in respect of 2020/21 can therefore be submitted to the SGHSCD by the 30 October 2021 deadline.

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.

2.3.3 Financial

The PTH is intended to ensure that NHS property is bought, sold and leased at a price and on other conditions which are the best obtainable for the public interest at that time. This post transaction monitoring process considers compliance with the PTH including the requirements associated with finance.

2.3.4 Risk Assessment/Management

The post transaction monitoring process considers the control objectives and processes in place to mitigate against the risk of non compliance with the PTH.

2.3.5 Equality and Diversity, including health inequalities

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

2.3.6 Other impact

Not applicable

2.3.7 Communication, involvement, engagement and consultation

The content of the report was discussed with the Chief Internal Auditor, Director of Finance and Director of Property and Asset Management ahead of submission to the Audit and Risk Committee.

2.3.8 Route to the Meeting

Not applicable

2.4 Recommendation

The Audit and Risk Committee is requested to note that:

1. The requirements of the PTH have been complied with;
2. The internal audit report is attached at Appendix 1, and
3. Arrangements are in place to issue the Board's Annual Property Transactions Return to SGHSCD by the deadline of 30 October 2021, and that the return be submitted with no significant issues identified.

3 List of Attachments

The following attachment is included with this report:

- Internal Audit Report B19/22 – Post Transaction Monitoring

Report Contact

Tony Gaskin
Chief Internal Auditor
Email tony.gaskin@nhs.scot

FTF Internal Audit Service

Post Transaction Monitoring

Report No. B19/22

Issued To: **Carol Potter, Chief Executive**
Margo McGurk, Director of Finance

Neil McCormick, Director of Property and Asset Management
Nicola Swan, Projects & Property Administration Manager

Gillian MacIntosh, Head of Corporate Governance/Board Secretary
Hazel Thomson, Board Committee Support Officer

Audit and Risk Committee
External Audit

Contents

Draft Report Issued	30 August 2021
Management Responses Received	31 August 2021
Target Audit & Risk Committee Date	16 September 2021
Final Report Issued	**31 August 2021**

CONTEXT AND SCOPE

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

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

3. The following transactions meet the criteria set out in the NHS Property Transaction Handbook for 2020/21.

Acquisition by Lease	**Lease P/A**
Land at Smeaton Road Kirkcaldy	£7,500

4. The Audit and Risk Committee meeting on 13 May 2021 agreed the Internal Audit Annual Plan for 2021/22 which included Post Transaction Monitoring. We agreed with client management that the above transaction would be included in our audit.

5. Transaction files were examined to ensure that:

   ◊ Property needs are appropriately identified and suitable action taken

   ◊ Transactions are properly managed

   ◊ Certificates are completed as required.

AUDIT OPINION

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

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

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

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

   A Transaction has been properly conducted, or

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

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

   The audit opinions for the transaction concluded in 2020/21 are:

Transaction	Lease P/A	Category
Land at Smeaton Road, Kirkcaldy	£7,500 20 year lease	**A**

10. A review of the procedures followed for the 2020/21 transaction, confirmed that it was concluded in accordance with the Handbook albeit improvements can be made regarding the timing of certification sign off and to clearly document where handbook requirements have not been followed and the reasons for this. We examined evidence which confirms that appropriate advice and guidance was sought and received from the Central Legal Office (CLO) and the appointed external Property Advisers.

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

12. Internal Audit Post Transaction Monitoring Reviews B27/19, B26/20 and B25/21 previously recommended that, in line with Section C1.18 of the Handbook, certification is required to be signed at the point where an offer for property is to be submitted or accepted. The transaction certification was signed off following final settlement but not at the point where initial offer was accepted.

13. Section C5.28 of the Handbook states '*Once a final decision is taken to acquire a property a formal offer should be submitted by the Legal Adviser on behalf of the Holding Body. The Legal Adviser is responsible for investigating the seller's title and carrying out the conveyancing. The Holding Body's payment in settlement of the transaction should be passed to the Legal Adviser for transmission to the seller. However it is the Holding Body which is ultimately responsible for protecting the Scottish Ministers' interests.* ***Certification should also be completed at this point***'. The Certification for the transaction was signed off significantly after the date of entry (14 weeks). The final settlement of transaction for the lease of land at Smeaton Road, Kirkcaldy was on 01/02/2021 and certification wasn't signed off fully until 10/05/2021.

14. We are advised that approval to proceed with the lease was on the basis of an SBAR approved by the Executive Directors' Group (EDG) on 21 January 2020. The SBAR provided a level of detail around the background for the lease and funding (met from existing Estates Capital and Revenue budget) but did not explain why a business case with options appraisal was not required, why a lease rather than purchase was the preferred option and did not append the initial Heads of Terms for the lease which is dated 8 January 2020 (ie prior to the date of the SBAR – 21 January 2020). We recommend that, for future transactions either a business case with options appraisal be completed or the reasons for not doing so be clearly documented, and consideration given to the approval route and decision made from a Governance Committee in addition to the EDG. The Property Team should be reminded of these requirements so that they are complied with for any future acquisitions by lease.

ACTION

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

ACKNOWLEDGEMENT

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

Barry Hudson BAcc CA
Regional Audit Manager

Action Point Reference 1

Finding:

We have previously reported issues around the following requirements of the Handbook in Internal Audit Post Transaction Monitoring Reviews B27/19, B26/20 and B25/21:

- Section C - 1.18 of the Handbook states that '*Certification should be signed at the point where an offer is to be accepted or submitted*'.
- Section C - C5.28 of the Handbook states *'Once a final decision is taken to acquire a property a formal offer should be submitted by the Legal Adviser on behalf of the Holding Body. The Legal Adviser is responsible for investigating the seller's title and carrying out the conveyancing. The Holding Body's payment in settlement of the transaction should be passed to the Legal Adviser for transmission to the seller. However it is the Holding Body which is ultimately responsible for protecting the Scottish Ministers' interests.* ***Certification should also be completed at this point***'. [This is the requirement for acquisitions – our previous findings related to sales transactions and the equivalent requirement included at section C2.37]

We found the same issues previously identified in the transaction for the lease of land at Smeaton Road, Kirkcaldy:

- The transaction certification was signed off following final settlement but not at the point where initial offer was accepted.
- The Certification for the transaction was signed off significantly after the date of entry (14 weeks). The final settlement of was on 01/02/2021 and certification wasn't signed off fully until 10/05/2021.

Audit Recommendation:

NHS Fife should comply with the requirements of the Property Transaction Handbook included at sections C1.18 & C5.28 which require:

- Certification to be signed at the point where an offer is accepted or submitted
- Final certification to be completed by the Chief Executive on the date of settlement of the transaction.

Assessment of Risk:

Merits attention

There are generally areas of good practice.

Action may be advised to enhance control or improve operational efficiency.

Management Response/Action:

The recommendation is accepted and prompt certification sign off at acceptance or submission of an offer and at the date of settlement will be pursued for future property transactions.

Action by:	Date of expected completion:
Nicola Swan, Projects & Property Administration Manager	Immediate Effect

Action Point Reference 2	
Finding:	
The SBAR, used as the basis of approval for this transaction when presented to EDG on 21 January 2021, did not explain why a business case with options appraisal was not required, why a lease rather than purchase was the preferred option and did not append the initial Heads of Terms for the lease which is dated 8 January 2020 (ie prior to the date of the SBAR – 21 January 2020).	
Audit Recommendation:	
For future transactions of this type, either a business case with options appraisal be completed or the reasons for not doing so be clearly documented, and consideration given to the approval route and decision made from a Governance Committee in addition to the EDG. The Property Team should be reminded of these requirements so that they are complied with for any future acquisitions.	
Assessment of Risk:	
Merits attention 	There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**
Management Response/Action:	
The recommendation is accepted and we will work with Internal Audit to develop checklists for each type of transaction to allow compliance with the Property Transaction Handbook to be readily evidenced. The checklist will then be referred to and appended to papers associated with the transaction as it progresses through approval stages.	
Action by:	**Date of expected completion:**
Neil McCormick, Director of Property and Asset Management	30 November 2021

Section 3 Definition of Assurance and Recommendation Priorities

Assessment of Risk

To assist management in assessing each audit finding and recommendation, we have assessed the risk of each of the weaknesses identified and categorised each finding according to the following criteria:

Risk Assessment		Definition	Total
Fundamental		Non Compliance with key controls or evidence of material loss or error. **Action is imperative to ensure that the objectives for the area under review are met.**	None
Significant		Weaknesses in 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.**	None
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.**	None
Merits attention		There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**	Two

Board Assurance Framework (BAF)
A report on the BAF is provided separately to the Committee.

Risk Management Key Performance Indicators (KPIs)
A report on the KPIs is provided separately to the Committee.

RISK MANAGEMENT ACTIVITY
A review of risk management arrangements is underway; this is being supported by the Head of Risk and Resilience, NHS 24. The review includes obtaining a baseline assessment of risk maturity using an industry recognised methodology. Risk appetite will be revisited in the context of the organisation's priorities and decisions, and there will also be related discussions around accountability and assurance.

A formal presentation will be provided to the EDG on 23 September 2021; this will be followed by discussions with the NHS Board at the November Development Session. The outcome of this review will inform a proposed approach to define the short, medium and long term priorities which will inform the development of a work plan and a detailed project plan.

Assurance Arrangements
As reported previously, Internal Audit selected the Digital & Information (D&I) BAF as a pilot for an assurance mapping exercise. This activity is ongoing and continues to make progress across the respective areas of Digital and Information Strategy and Operations and Information Governance and Security.

The Quality & Safety BAF is scheduled for review as part of Internal Audit B19/21. In parallel, it has been agreed that the BAF submission to the Clinical Governance Committee in November 2021, will present a detailed review and update of that BAF in line with assurance mapping principles. Importantly, the BAF will reflect the quantum of risk associated with the short, medium and longer term impact of the pandemic; and align with the Scottish Government's clinical prioritisation and remobilisation framework.

Developments
A proposal to elevate the profile of risk management through integration with the strategic planning process and deliver the risk management portfolio was approved in May 2021. A key element of the proposal was to release the Risk Manager to provide dedicated leadership in taking forward the Risk Management Framework. This is now in place.

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
Good 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 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 resources.

2.3.4 Risk Assessment/Management

The paper relates directly to activities intended to provide appropriate assurance to the NHS Board on the management of risk.

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

The Head of Quality and Clinical Governance and the Director of Finance and Strategy on 8 September 2021.

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 2021 - 2022 to NHS Fife Audit and Risk Committee on 160921

Report Contact
Author Name: Pauline Cumming
Author's Job Title: Risk Manager
Email pauline.cumming@nhs.scot

Appendix 1

RISK MANAGEMENT WORK PLAN 2021 - 2022

REPORTING TO THE AUDIT & RISK COMMITTEE			
ACTION	**TARGET DATE**	**STATUS**	**REVISED DATE**
Quarterly report on Corporate Risk Register	March 2021,Sept 2021, Dec 2021, March 2022	Deferred from March 2021. Reported on 17/06/21 and submitted for meeting on16/09/21.	
Quarterly report on Board Assurance Framework	March 2021, Sept 2021, Dec 2021, March 2022	Reported on 13/05/21 and 17/06/21 and submitted for meeting on16/09/21.	
Quarterly report on Risk Management Key Performance Indicators	March 2021, Sept 2021, Dec 2021, March 2022	Deferred from March 2021. Reported on 13/05/21 and submitted for meeting on16/09/21.	
Quarterly report against Risk Management Work Plan	March 2021, Sept 2021, Dec 2021, March 2022	Deferred from March 2021. Reported on 13/05/21 and submitted for meeting on16/09/21.	
Risk Management Annual Report 2020-21	June 2021	Reported on 17/06/21.	

RISK MANAGEMENT ACTIVITY

ACTION	**TARGET DATE**	**STATUS**	**REVISED DATE**
Develop Risk Management Framework launch programme and implement.	End Oct 2020	A Board wide review of risk management arrangements is underway*.	December 2021
Review the governance infrastructure and processes, including the accountability arrangements that support risk management across the organisation.	End Nov 2020	As above*	December 2021
Undertake a wholesale review of the organisation's risk registers and current risk profile.	End Nov 2020	As above*. Conversations initiated with Directors, senior managers and other risk owners.	December 2021

Review and update the risk appetite statement.	End Dec 2020	As above*	December 2021
Embed risk appetite and tolerance across the organisation.	March 2021	As above*	December 2021
Strengthen assurance arrangements and specifically the structure, content and governance arrangements associated with the Board Assurance Framework.	March 2021	As above*	December 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	Work in progress	December 2021
Overhaul Datix Risk Register Module incl BAF structure.	End Nov 2020	Work in progress	March 2022
Transfer Legal Services Claims activity from Datix Rich Client to DatixWeb.	End Dec 2020	Completed 31/03/21	N/A
Complete the transfer of Complaints module to DatixWeb.	End Dec 2020	Completed 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	The upgrade path for the Datix Risk Management system is under consideration. This will be informed by national procurement decisions around risk management systems; these are pending.	To be confirmed
Further develop the management and learning from adverse events in line with national framework & local policy.	N/A	A review of the adverse events policy and process is underway and is due to be completed by November 2021.	November 2021
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	In development	November 2021

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**17 September 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 the organisation's success against a range of targets and objectives, to monitor progress and offer insights to inform decision making. This report provides an update on performance against the NHS Fife Risk Management KPIs since the last report to the Committee on 13 May 2021.

2.2 Background

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

- KPIs 1 - 3 relate to risk registers and are intended to show overall organisational performance on the effectiveness of current management actions and controls, and overall governance arrangements.
- KPI 4 relates to BAF reports submitted to the governance committees to which they are aligned.
- KPI s 5 - 7 relate to adverse events and are intended to show overall organisational performance on the effectiveness of arrangements for managing adverse events in line with national guidance and local policy.

2.3 Assessment

Appendix 1 provides an assessment of compliance against the KPIs. It is clear that significant improvement is required across each area of focus to demonstrate that risk management processes are working effectively.

Since the last meeting of the Committee, arrangements have been put in place to enable the Risk Manager to have a full time focus on risk management to ensure delivery of some essential improvements. We have also secured the input of a Risk Management lead from another Board to provide support with the initial phases.

A first step will be to take the opportunity to assess our risk management maturity against a recognised framework. In the first instance, this will enable the EDG to have a discussion on the current level of maturity, and the steps required across all Executive areas in NHS Fife to enhance current arrangements. The methodology to be used is an industry recognised approach that will review 6 elements:

- Leadership
- Risk Strategy & Policy
- People
- Processes
- Risk Handling
- Outcomes

The maturity assessment will include a review of existing KPIs to determine if they are meaningful, relate to our strategic priorities and objectives, and in line with the organisation's risk appetite.

Of note, a significant proportion of the current risk management KPIs relate to adverse events; the review will consider if this is appropriate going forward.

A report will then be produced with recommendations for the Chief Executive and Executive Lead for Risk to discuss with EDG and inform an appropriate improvement programme.

In parallel, a detailed project plan will be developed, a component of which will involve the Risk Manager undertaking a wholesale review of risks across the organisation in

collaboration with directors, senior managers and risk owners, to establish the reasons for the current performance and to identify opportunities for improvement, in particular in relation to:

- review of risks within stated timescales
- review dates set commensurate with the assessed risk level
- the control of very high and high risks

The Risk Manager will also work with the service to compile a summary risk profile for defined organisational areas and break down risks by:

- initial risk and current risk level
- age of the risk
- improvement or deterioration in risk level over time
- number of risks that have a risk level that matches the target (planned) level
- categorisation
- risk within each category by risk level
- speed at which the risk will impact NHS Fife
- whether the risk is still active or has materialised into an issue
- root cause (s)
- related management actions
- status of the actions e.g. underway/planned and timescale

This work will provide a baseline of the organisational risk profile, inform our assessment of its alignment or otherwise to the strategic planning agenda, and make recommendations for next steps

2.3.1 Quality/ Patient Care

Effective risk management can identify opportunities for improvement and innovation, e.g. by highlighting gaps in capacity, procedures or service delivery, actions to change or enhance service delivery and avoid, prevent and reduce harm

2.3.2 Workforce

All staff require to have an awareness of risk management and to assess emerging risks, take action to mitigate or anticipate, and monitor and review progress to reduce or eliminate the 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 inherent and

new risks. 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

All KPI s were shared with the Director of Finance & Strategy and the Medical Director on 13 August 2021.

KPIs 1- 3 (Adverse Events) data will be shared virtually with the NHS Fife Adverse Events & Duty of Candour Group and discussed at its next meeting on 5 October 2021.The information will also inform the review of the Adverse Events Policy and processes.

2.3.8 Route to the Meeting

EDG

2.4 Recommendation

Discussion – Examine and consider the implications of a matter.

3 List of appendices

Appendix 1, Risk Management Key Performance Indicator Report to the Audit & Risk Committee, 170921

Report Contact
Author Name: Pauline Cumming
Author's Job Title: Risk Manager, NHS Fife
Email Pauline.Cumming@nhs.scot

Risk Management KPIs
Report to the Audit & Risk Committee on 16 September 2021

Report Criteria

Risks - KPI 1 to 3 - All Active Risks as at 10/08/2021
Risks - KPI 4 - BAF reports to Committees as at 10/08/2021
Adverse Events - KPI 5 - where event reported 01/08/2020 to 31/07/2021
Adverse Events - KPI 6a / 6b / 6c - where event closed 01/08/2020 to 31/07/2021
Adverse Events - KPI 7 - where event reported 01/04/2018 to 11/08/2021

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	537	378	70(63)	100

1. **Note:** Previously 577 risks at 64% compliance
A slight improvement in performance is noted from May 2021, but concerted action and support is required to achieve sustained and meaningful improvement. An assessment of risk management arrangements and information and education needs in place across the organisation is essential. This will form part of a detailed work plan going forward Performance continues to be affected in part due to the impact of the pandemic on activity and workload.

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
			Risk Level (Rating)	Number	Each Level		Overall		%
					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	537	Very High (25)	3	0	0	264	49	100
			High (15-20)	85	46	54			
			Moderate (8-12)	328	142	43			
			Low (4-6)	111	69	62			
			Very Low (1-3)	10	7	70			

2**. Note:** Previously 577 at 51% compliance.
As per 1 above. Concerted action and support is required to achieve sustained and meaningful improvement.

KPI 3:
Length of time 'Very High' level risks have been at that level:

KPI	KPI Descriptor	Number of risks at each level		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)	3	Number of risks open <= 1 year	2	67	Very High (25)	2	100	100
				Number of risks open >1 year	1	33	Very High (25)	1	100	100
3b	Length of time 'High' level risks have been at that level	High (15-20)	85	Number of risks open <= 1 year	44	52	High (15-20)	42	95	100
				Number of risks open >1 year	41	48	High (15-20)	34	83	100

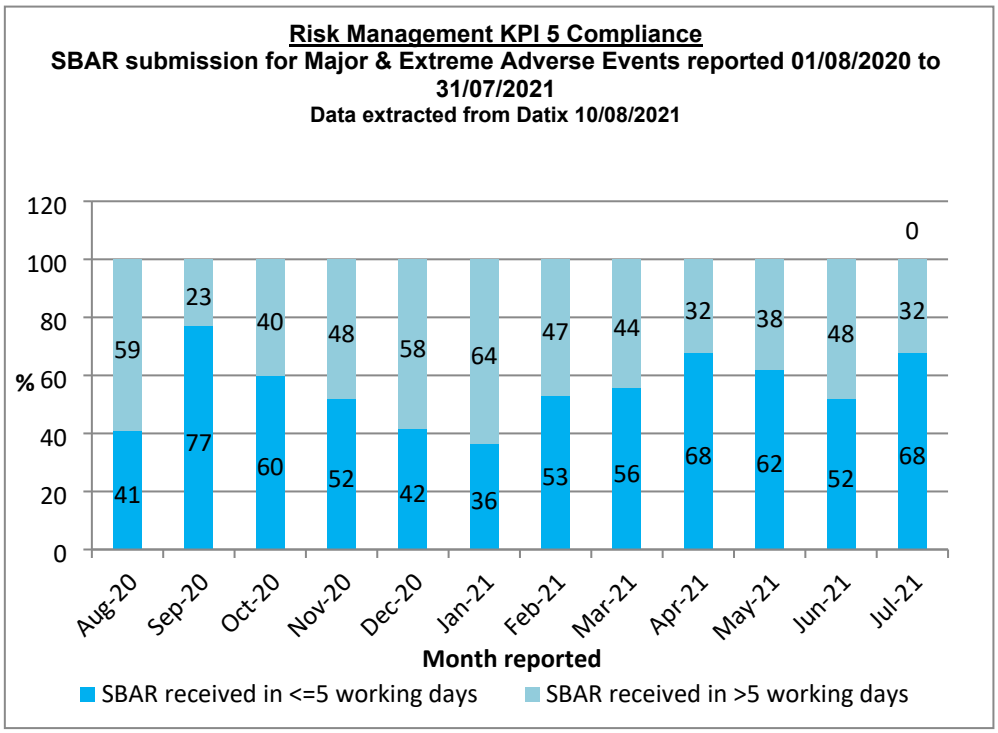
3. KPI 3 needs to be redefined. As it stands, it is not a true KPI. In this context, use of a 'target' % is misleading and redundant.

KPI 4:
A Board Assurance Framework (BAF) report is required to be submitted bi monthly to the aligned governance committee. Since the last report to the Committee, 100% of reports have been submitted as required.

Committee		Sep-20	Nov-20	Jan-21	Mar-21	Apr-21	May-21	Jul-21
Finance, Performance & Resources								
BAF	Financial Sustainability	√	√	√	*	N/A	√	√
	Environmental Sustainability	√	√	√	*	N/A	√	√
	Strategic Planning	√	√	√	*	N/A	√	√
Clinical Governance								
BAF	Quality & Safety	x	√	√	*	√	N/A	√
	Digital & information	√	√	√	*	√	N/A	√
	Strategic Planning	√	√	√	*	√	N/A	√
Staff Governance								
BAF	Workforce Sustainability	√	√	√	*	√	N/A	√

The BAFs were not considered at the March 2021 committees as it was decided, that due to the pressures of COVID, the agendas were shortened and confined to items of high importance or which required decision by the Committees.

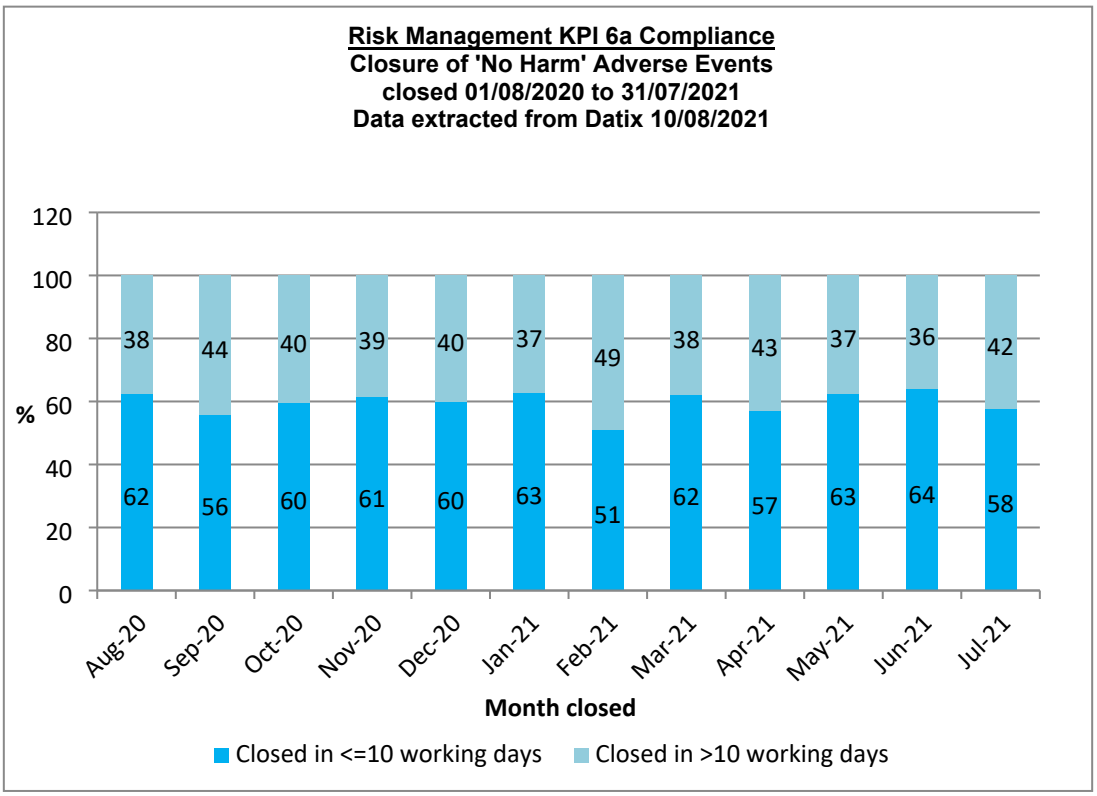
KPI 5:
A Decision Making SBAR for Major and Extreme Adverse Events should be submitted in line with Adverse Events Policy GP/I9 - within 5 working days of reported date (or upgraded if applicable)



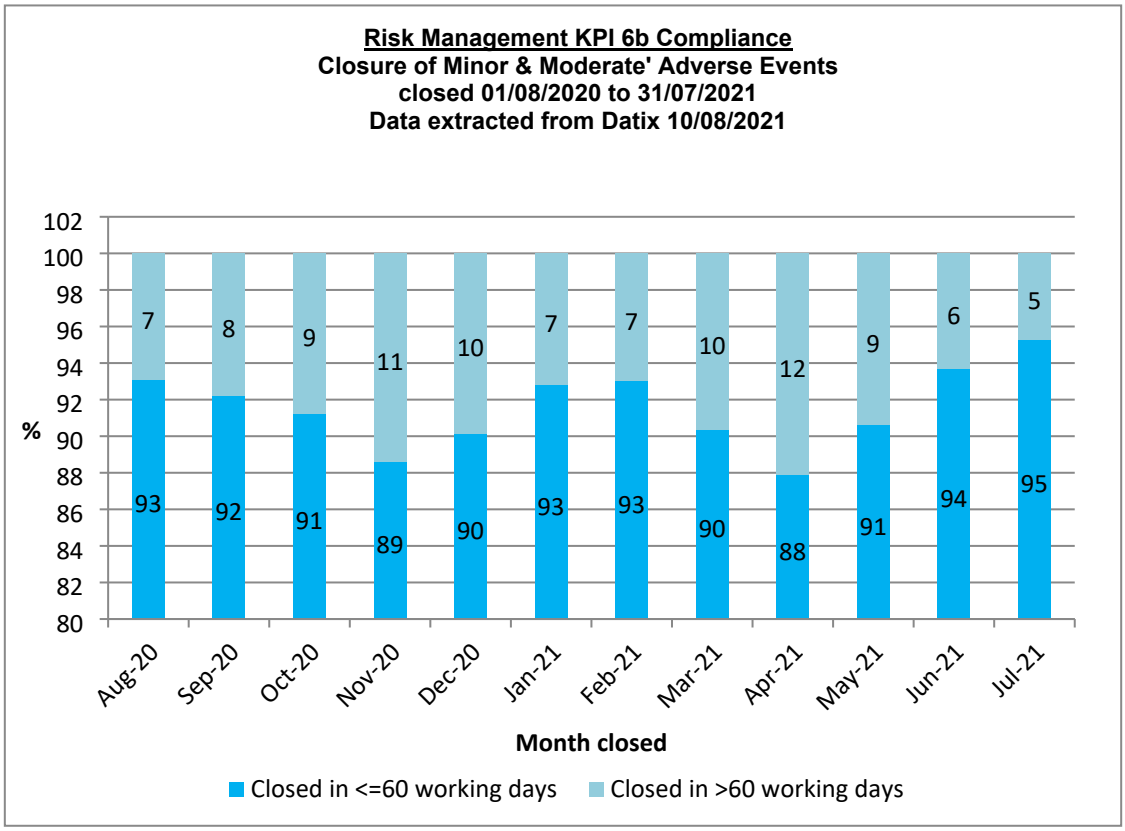
Notwithstanding a dip in June 2021, the previously reported recovery in submission timeliness has continued in the last quarter. This remains far short of what is required in terms of policy compliance. As before, the specific reasons for sub optimal performance have not been investigated but it is recognised that this may be attributable in part to activity and workload.

The NHS Fife Adverse Events Group has considered the performance data over time. The Adverse Events KPIs will be reviewed as part of the Adverse Events process review which is currently underway. It has been agreed that in future it may be beneficial to put in place an improvement action plan when performance is noted to be falling.

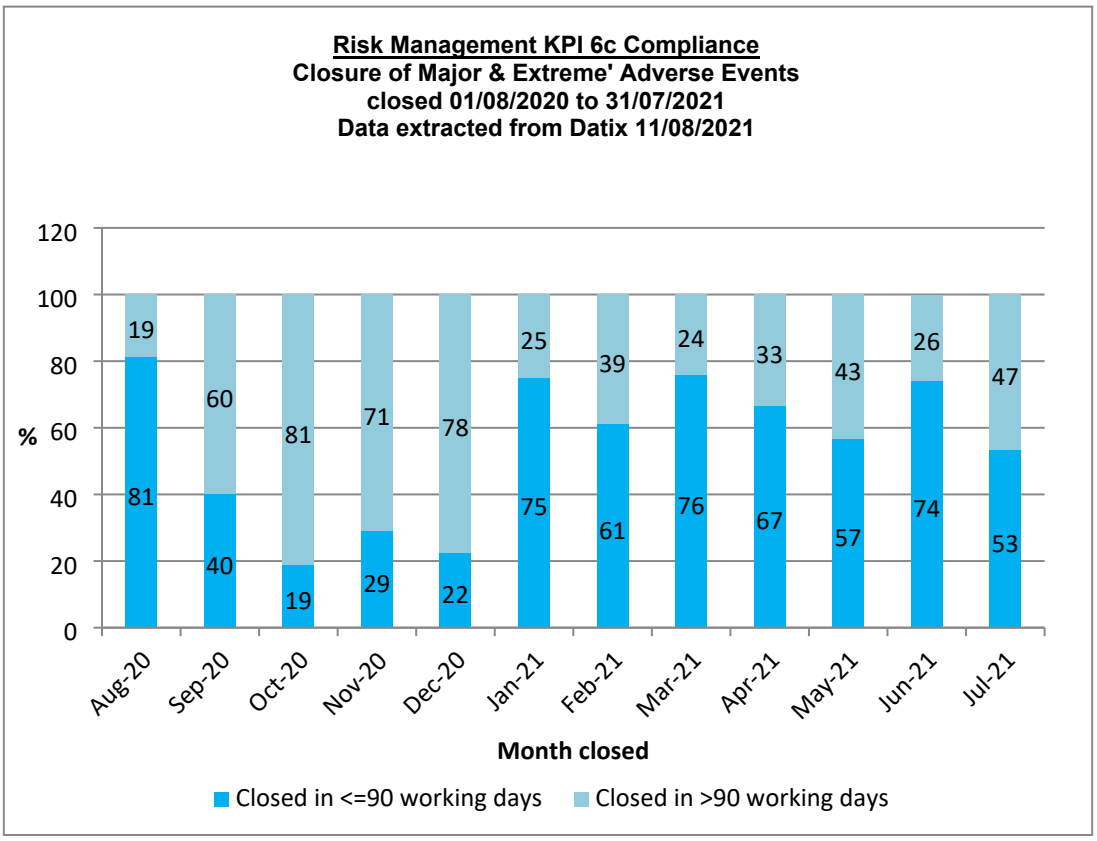
KPI 6a:
Adverse Events with severity reported as 'No Harm' should be closed within 10 working days of reported date



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

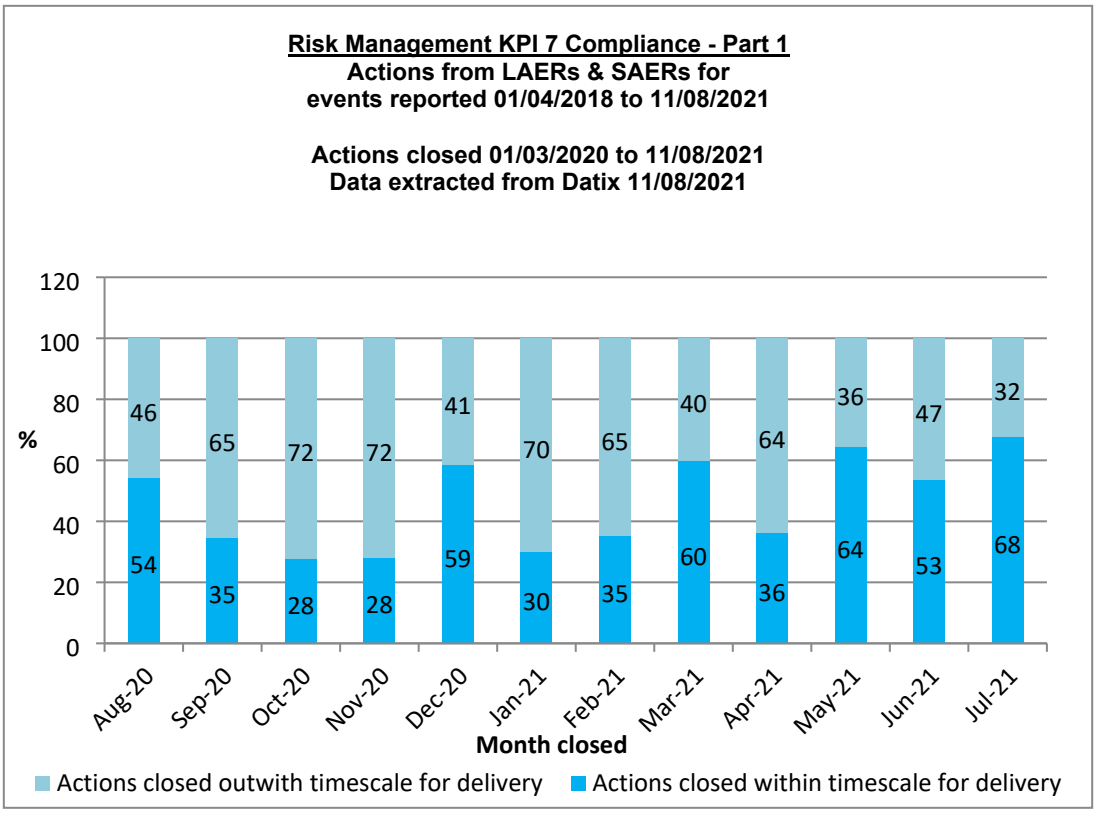


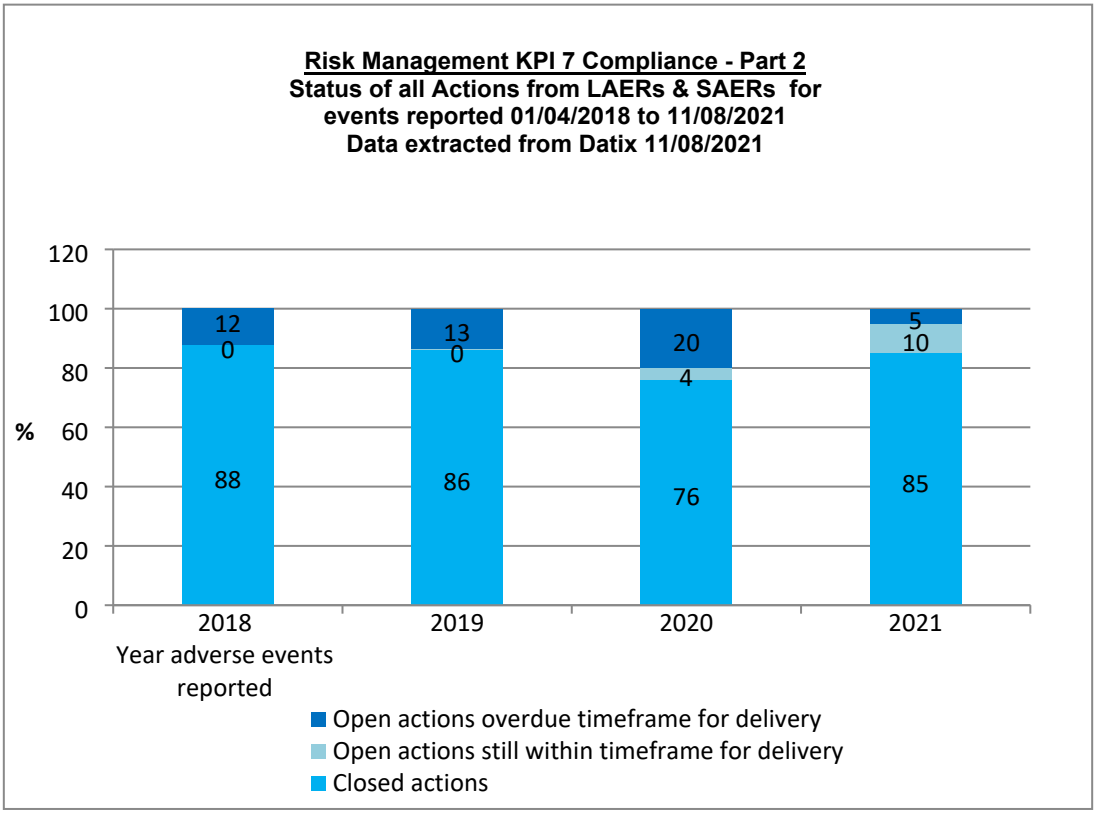
KPI 6c:
Adverse Events with severity reported as 'Major' or 'Extreme' should be closed within 90 working days of commissioned date



6a, 6b.& 6c
The expectation that all adverse events will have timely reviews, action completion and closure, in accordance with local policy and the national framework for adverse event management is well understood. Oversight and monitoring of performance continues at operational and divisional level. The Adverse Events & Duty of Candour Group provides organisational oversight. A full review of the adverse event process and update of the Policy is underway and will be completed by October 2021. The new policy will be submitted through governance routes in November 2021.

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)





7. As above, the NHS Fife Adverse Events Group receive and review reports on performance against these indicators. The KPIs will be considered as part of the Adverse Events process review in terms of their relevance, the need for alternative indicators and interventions to drive improvement. In the interim, following engagement with Associate Nurse, Midwifery and Medical Directors and other managers and staff, it has been agreed that a highlight report will be developed for services. This will include information such as overdue SBAR submissions, SAER / LAER status and actions. It is thought this will help services to have clearer oversight of what is happening within their dept.

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**16 September 2021**
Title:	**Update on Corporate Risk Register Arrangements**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Author:	**Pauline Cumming, Risk Manager**

1 Purpose

This is presented to the Committee for:

- Discussion

This report relates to an:

- Local Framework & Policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This paper provides an update on developments related to the Corporate Risk Register (CRR) since the last report to the Committee on 17 June 2021.

2.2 Background

The Executive Directors' Group (EDG) is currently sighted on risks linked to the BAF before these are submitted to the governance committees, and also receive a monthly report on COVID - 19 related high risks.

It has been agreed that going forward, EDG will also consider **all** active high risks, or operational risks which have been escalated e.g. can no longer be managed by a service or require senior ownership and support to mitigate, and agree any risks for inclusion on the CRR and / or as a linked risk on the BAF, or decide on another course of action.

2.3 Assessment

The CRR is unchanged from the previous report to the Committee. It currently contains 5 risks; 3 high and 2 moderate. See Appendix 1.

This is partly as a result of ongoing discussion on the overall approach to risk management arrangements. In accordance with the EDG Annual Work plan, a report has been submitted to EDG recommending the priority review and update of the CRR to ensure it:

- accurately reflects the current risk profile for NHS Fife in the context of the strategic priorities, the corporate objectives and the developing Population Health and Wellbeing Strategy; and
- can provide assurance to governance committees and the Board

The report contains details of the extant CRR, **all** active high risks, and moderate and low risks with a consequence rating of 5 (extreme). The paper includes a proposal that EDG agree an approach for a preliminary review of those risks in order to identify any that require to be de-escalated from, or included in the CRR, or other action e.g.

- immediate mitigation
- add as linked risk to the BAF
- seek further details from risk owner to inform decision making
- other

In parallel, there is a need to establish a baseline organisational risk profile.

It has been recommended to EDG, that the Risk Manager carries out a wholesale risks review with senior management teams and risk owners in the ASD, HSCP, and Corporate Directorates in order to:

- confirm all active risks
- review risks for clarity, consistency, appropriateness of risk scoring
- assess alignment of risks to objectives
- consider if risks reflect the impact of the remobilisation phase of the pandemic
- identify new and emerging risks to the achievement of objectives

The outputs will be collated and reported to EDG for consideration and a decision on action.

EDG and Board discussions are required to confirm the structures and processes governing the CRR, including the reporting mechanism, frequency and effectiveness. Further developments and improvements will be informed by the outcome of the EDG workshop on 23 September 2021 and a subsequent Board Development session in November 2021; these will provide the opportunity to examine risks in relation to our risk appetite and to ensure our reporting delivers the assurance which committees require.

An update on the CRR will be provided to the next meeting of the Committee on 9 December 2021.

2.3.1 Quality/ Patient Care

Our risk management systems and processes support the delivery of safe, effective, person centred care. Healthcare is safe for every person, every time; (Safe); best use is made of available resource (Effective); and everyone has a positive experience of healthcare (Person Centred).

2.3.2 Workforce

Good risk management empowers staff to identify and address risks, make improvements, protect health and wellbeing and reduce exposure to risk.

2.3.3 Financial

Proportionate management of risk supports the efficient and effective use of resources.

2.3.4 Risk Assessment/Management

The appendices provide details of the risks, their analyses, and mitigating actions.

2.3.5 Equality and Diversity, including health inequalities

This paper does not raise any specific issues relating to the above.

2.3.6 Other impact

Not applicable.

2.3.7 Communication, involvement, engagement and consultation

Appropriate communication, involvement, engagement and consultation with EDG and key stakeholders within the organisation.

2.3.8 Route to the Meeting

Via Margo McGurk, Director of Finance and Strategy on 6 September 2021, and EDG on 9 September 2021

2.4 Recommendation

- **Discussion** – Examine and consider the implications of a matter.

3 List of appendices

The following appendix is included with this report:
Appendix 1, Corporate Risk Register as at 270821

Report Contact
Pauline Cumming
Risk Manager
Email pauline.cumming@nhs.scot

ID	1296	529
Position of Risk (Risk Register)	CORPORATE RISK REGISTER, Corporate Directorate - Estates Risk Register	CORPORATE RISK REGISTER, NHSFBD - Digital and Information Directorate Risk Register
Opened	22/08/2016	02/10/2012
Title	Emergency Evacuation, VHK Phase 2 Tower Block	Information Security Risk
Description	There is a risk that a second stage fire evacuation, or complete emergency evacuation, of the upper floors of Phase 2 VHK, may cause further injury to frail and elderly patients, and/or to staff members from both clinical and non-clinical floors.	There is a risk that NHS Fife's information or data assets including patient data, commercially sensitive data or personal data may be compromised through deliberate or accidental misuse of IT Systems, malicious attack designed to damage or steal electronic data, affect essential services, loss theft or misuse of paper based records during transportation, clinical processes or storage. This risk relates to the Networking and Information Systems(NIS)Regulations.
Likelihood (initial)	4 - Likely - Strong possibility this could occur	5 - Almost Certain - Expected to occur frequently - more likely than not
Consequence (initial)	5 - Extreme	3 - Moderate
Risk level (initial)	High Risk	High Risk
Rating (initial)	20	15
Current Management Actions	JR - 22/06/2021 - Current management actions still apply. The fire safety advisors have visited ward 10 and all staff have completed recent fire training. An exercise to upgrade/repair all the compartment doors is underway and a survey to check for any breaches in compartmentation is also underway. This risk remains high. NHS Fife is taking steps to identify, and risk assess data assets using the DPIA Template and the creation of an Information asset register, but this involves significant effort to retrospectively complete, this is work in progress. There has been discussion between the ISM (Information Security Manager) and the Head of Information Governance as to the formulation of a work flow for DPIA's to progress through to streamline the process, this will be raised within the IG&S Ops meeting once regular meetings are established. The NIS regulations audit has been carried out and we as a board improved by 16%, this report has been used to build an action plan of progression towards addressing the information security objectives. ISM and Cyber Security Manager (once appointed), will develop a framework of baseline acceptable standards and documentary requirements that will address information and cyber security objectives across the organisation if adopted. Note that this risk is underpinned by the following risks: 217,220,221,225, 226,233,234,537,538,541,542,1410,1569,2109.
Likelihood (current)	4 - Likely - Strong possibility this could occur	4 - Likely - Strong possibility this could occur
Consequence (current)	5 - Extreme	4 - Major
Risk level (current)	High Risk	High Risk
Rating (current)	20	16
Likelihood (Target)	1 - Remote - Can't believe this event would happen	1 - Remote - Can't believe this event would happen
Consequence (Target)	5 - Extreme	4 - Major
Risk level (Target)	Low Risk	Low Risk
Rating (Target)	5	4
Risk Owner	McCormick, Neil	McGurk, Margo
Handler	Ramsay, Jimmy	Irving, Kevin
Previous Review Date	22/07/2021	18/08/2021
Next Review	30/09/2021	27/10/2021

1500	522
CORPORATE RISK REGISTER, NHSFBD - Digital and Information Directorate Risk Register	CORPORATE RISK REGISTER, NHSFBD - Prescribing & Medicines Management Risk Register
04/12/2018	30/03/2006
Cyber Resilience Risk	Prescribing and Medicines Management - Prescribing Budget
There is a risk that NHS Fife will be overcome by a targeted and sustained attack because of a lack of Cyber Resilience, resulting in our inability to resist, respond and recover from cyber attacks that may impact the availability or integrity of information we require to operate a full Health Service.	Prescribing and Medicines Management - Prescribing Budget: There is a risk that NHS Fife will be unable to control the prescribing budget.
3 - Possible - May occur occasionally - reasonable chance	3 - Possible - May occur occasionally - reasonable chance
4 - Major	3 - Moderate
Moderate Risk	Moderate Risk
12	9
29/12/2019 - Work continues to develop and improve the Cyber Security Plan and strengthen NHS Fifes overall cyber security posture. This includes work to improve staff awareness of common threats. However, due to the response to COVID-19 and an ongoing heightened state of Threats & Vulnerabilities; progress has been slower than anticipated. The Cyber Security Team has also sufferec some retention issues during 2020.	30/4/21 - The GP prescribing position for 20/21 is an underspend of £24k (0.03%), on an annual budget of £70.7m. £1.891m recharged to COVID costs, based on final national guidance and local analysis. The analysis and basis of recharge to COVID funding focused on price impact, drug switch requirements (primarily to minimise healthcare contacts)and increased usage, full analysis is available. Hospital prescribing budget is overspent by £1.26m (3.7%), on a budget of £33.77m Medicines efficiency target for 21/22 is £500k for both HSCP and Acute Services (combined £1m). The first meeting of the Fife Prescribing Forum took place on 23 April.
3 - Possible - May occur occasionally - reasonable chance	5 - Almost Certain - Expected to occur frequently - more likely than not
4 - Major	3 - Moderate
Moderate Risk	High Risk
12	15
2 - Unlikely - Not expected to happen - potential exists	3 - Possible - May occur occasionally - reasonable chance
3 - Moderate	3 - Moderate
Low Risk	Moderate Risk
6	9
Potter, Carol	McKenna, Christopher
Young, Allan	Reid, Euan
01/12/2020	29/07/2021
01/12/2021	13/10/2021

527	
CORPORATE RISK REGISTER	
09/12/2008	
Staff Governance - Sickness Absence	
Staff Governance - Sickness Absence: Sickness absence rates are a HEAT standard and there is a risk that NHS Fife will not meet the target of 4%.	May 2021 - The sickness absence rate for the 12 months ending May 2021 was 5.11%, a decrease of 0.34% when compared with the previous 12 months ending May 2020. During the 2020/2021 financial year, the average sickness absence rate was 5.04%, a decrease of 0.53% when compared with the 2019/2020 financial year. Although sickness absence levels have fallen during the COVID-19 pandemic, it is difficult to draw any specific conclusions from this due to the continuing pandemic. A range of actions continue to be undertaken to improve absence rates within NHS Fife, with focussed activity being undertaken within all areas of the Board. NHS Fife's Promoting Attendance Group and Review and Improvement panels continue to meet, along with local Attendance Management Groups. December 2020 - The sickness absence rate for the 12 months ending December 2020 was 5.21%, a decrease of 0.42% when compared with the previous 12 months ending December 2019. During the first nine months of the 2020/21 financial year, the average sickness absence rate was 5.11%, a decrease of 0.49%
4 - Likely - Strong possibility this could occur	
3 - Moderate	
Moderate Risk	
12	
July 2020 - The sickness absence rate for the 12 months ending July 2020 was 5.34%, a decrease of 0.27% when compared with the previous12 months ending July 2019. During this first four months of the 2020/21 financial year, the average sickness absence rate was 4.90%, a decrease of 0.70% when compared with the equivalent period of the 2019/20 financial year. Although sickness absence levels have fallen in the first four months of the COVID-19 pandemic, it is difficult to draw any specific conclusions from this due to the current pandemic. The situation will continue to be monitored as we return to "normal" and restart various Promoting Attendance activities. In the meantime, a range of actions continue to be undertaken to improve absence rates within NHS Fife, with focussed activity being undertaken within all areas of the Board. Promoting Attendance Review and Improvement Panels, Promoting Attendance Groups and local Management Team meetings had been paused during the COVID-19 pandemic, however, activity re-commenced in earnest from July 2020.	
4 - Likely - Strong possibility this could occur	
3 - Moderate	
Moderate Risk	
12	
3 - Possible - May occur occasionally - reasonable chance	
3 - Moderate	
Moderate Risk	
9	
Douglas, Linda	
Cummings, Karen	
13/07/2021	
11/01/2022	

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**17 September 2021**
Title:	**NHS Fife Board Assurance Framework Update**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Report Author:	**Pauline Cumming, Risk Manager**

1 Purpose

This is presented to the Committee for:

- Assurance

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 is an update to the Committee since the last report on 17 June 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 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 Dec2020-/Jan2021	Current Level & Rating Jan/Feb 2021	Current Level & Rating April / May 2021	Current Level & Rating June / July 201
1671	**Financial Sustainability**	High 16	Likely 4	Major 4	16 (4x 4) High	16 (4x 4) High	12 (3x 4) Mod	16 (4x 4) High
1672	**Environmental Sustainability**	High 20	Likely 4	Extreme 5	20 (4x 5) High	20 (4x 5) High	20 (4x 5) High	20 (4x 5) High
1673	**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
1674	**Quality & Safety**	High 20	Likely 4	Extreme 5	15 (3x 5) High	15 (3x 5) High	15 (3x 5) High	15 (3x 5) High
1675	**Strategic Planning**	High 16	Likely 4	Major 4	16 (4 x 4) High	16 (4 x 4) High	12 (3x 4) Mod	12 (3x 4) Mod
1676	**Integration Joint Board**	High 16	Likely 4	Major 4	12 (3 x 4) Mod	12 (3x4)) Mod	12 (3x4)) Mod	12 (3x4)) Mod
1677	**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 reported to and considered by the appropriate committees in July 2021. This update summarises the key points from those reports. The BAF risks are provided separately in appendices.

Financial Sustainability BAF

The Director of Finance and Strategy reported on the BAF to the Finance, Performance & Resources (FP&R) Committee on 13 July 2021. The BAF current score has reverted from Moderate to High.

The increased in risk level reflected the position where Scottish Government had indicated that Covid-19 funding; treatment of offsetting cost reductions; and any potential funding of 'long covid' unachieved efficiency savings, would be considered following a formal Quarter 1 review of Boards' financial performance. To that end, Scottish Government support for our financial gap was at that point uncertain, hence the increased high risk rating.

Changes in linked operational risks since the last report to the Committee:

- Risk 1363: Financial (Health & Social Care Integration) - reduced from high 20 to 16
- Risk 1364: Efficiency Savings - reduced from high 20 to high 16
- Risk 1784: Finance (Short Term / Immediate HSCP) re COVID 19. Following confirmation of funding from Scottish Government on unachieved savings, the risk level reduced to moderate and was removed from the BAF.

Environmental Sustainability BAF
The Director of Property and Asset Management reported on the above to the FP&R Committee on 13 July 2021. Property & Asset Management continue to mitigate the risks in this area. There has been no significant change to this BAF since the previous report to the Committee.

Workforce Sustainability BAF
The Director of Workforce reported on the above to the Staff Governance (SG) Committee on 1 July 2021; there were no significant changes to the BAF and linked operational risks remain around the National Shortage of Radiologists, Medical Staff Recruitment and Retention, and Lack of Medical Capacity in Community Paediatric Service.

Quality & Safety BAF
The Medical Director reported on the above to the Clinical Governance Committee (CGC) on 7 July 2021. There had been no substantive change to the BAF.

Changes in linked operational risks since the last report to the Committee:
Risk 1515: Impact of the UK's withdrawal from the EU on Nuclear Medicine and the ability to provide diagnostic and treatment service(s) had been closed. Post BREXIT, there were no immediate issues with the supply chain, apart from the supply of therapy capsules from General Electric (GE); these were due to changes in paperwork, but did not affect NHS Fife directly.

Developments:
The Medical Director, the Director of Nursing, the Head of Quality & Clinical Governance and the Risk Manager will carry out a full review of the Quality & Safety component of the BAF, assess the extent to which it reflects the impact of the COVID 19 pandemic and plan to ensure that its future development aligns with the evolving Population Health and Wellbeing Strategy. The review findings will be presented to the November CGC.

Strategic Planning BAF
The Director of Finance & Strategy reported on the above to the CGC on 7 July 2021 and to FP&R on 13 July 2021.This BAF had been updated to reflect the changes over the COVID period, the work underway to develop our strategic planning capacity and capability, and also the development of the new Population Health and Wellbeing Strategy for NHS Fife. The risk level remains at moderate.

Digital and Information BAF
The Medical Director reported on the above risk to the CGC on 07 July 2021. The risk level and target level remained high and moderate respectively.

Changes in linked operational risks since the last report to the Committee:

- Risk 885: Digital and Information Financial Position. The risk had been reassessed following the financial allocations for 2021-22 and rated as High.
- Risk 1338: NHS Fife is at increased risk to a targeted cyber intrusion. The description had been revised to provide a clearer indication of the risk. This risk represents the threat landscape for public sector organisations and the weakness that legacy systems present at the current time.
- Risk 1996: Office 365 - Unknown Financial Consequences. Assessed as a high risk and now linked to the BAF. This risk relates to the new nationally negotiated deal with Microsoft, the details of which are still to be formally communicated and implications to financial provision for licence access and other associated programme costs.

Two linked risks had been re-assessed as moderate and removed from the BAF:

- Risk 226: Security of data being transferred off/on site.
- Risk 1746: O365 may cause disruptive network overhead.

As reported previously, Internal Audit continues to make progress with the assurance mapping exercise on this BAF across the respective areas of Digital and Information Strategy and Operations, and Information Governance and Security.

Integration Joint Board (IJB) BAF
Following the submission to Scottish Government and the discussions that have taken place with the Chief Officer of the IJB and the Chief Executives of Fife Council and NHS Fife, there is a commitment to conclude the review of the Integration Scheme through both Fife Council and NHS Fife governance structures by September 2021. Confirmation has been received from both NHS Fife and Fife Council that they are on track to meet this deadline. In view of ongoing dialogue with Scottish Government and a commitment with partners to conclude by September 2021, the risk remains moderate.

Developments
An EDG workshop has been arranged for September 2021 to be followed by a Board Development Session in November 2021; these will provide opportunities to examine the baseline of the BAF and consider improvements, including how to overtly connect it to the strategic priorities, and ensure that the approach, presentation and associated reporting are effective and deliver the assurance which Committees require.

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 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, Integration Joint Board, and Digital & Information.

2.3.7 Communication, involvement, engagement and consultation

This report reflects the engagement of Executive Directors, Non Executives and other key stakeholders.

2.3.8 Route to the Meeting

Via Margo McGurk, Director of Finance and Strategy on 12 August 2021

2.4 Recommendation

The paper is presented for members' information.

3 List of appendices

The following appendices are included with this report:

- Appendix 1, NHS Fife BAF Financial Sustainability - FP& RC 130721
- Appendix 2, NHS Fife BAF Environmental Sustainability - FP& RC 130721
- Appendix 3, NHS Fife BAF Workforce Sustainability - SGC 010721
- Appendix 4, NHS Fife BAF Quality & Safety - CGC 070721
- Appendix 5, NHS Fife BAF Strategic Planning - CGC 070721 & FP&RC 130721
- Appendix 6, NHS Fife BAF Integration Joint Board (IJB) at 070621
- Appendix 7, NHS Fife BAF Digital and Information - CGC 070721

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	04/06/2021	31 August 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 not match costs incurred. 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.	Likely	Major	16	High Risk	Likely	Major	16	High Risk	2021/22 Covid-19 funding will be assessed post formal Quarter 1 review of Boards' financial performance. Hence this uncertainty impacts the risk rating and moves it to high risk.	Margo McGurk Director of Finance	Finance, Performance & Resources (F,P&R) Rona Laing	*Ongoing actions designed to mitigate the risk including:* SG has indicated that: Covid-19 funding; treatment of offsetting cost reductions; and any potential funding of 'long covid' unachieved efficiency savings will be considered following a formal Quarter 1 review of Boards' financial performance. To that end, SG support for our financial gap is at this point uncertain and our BAF risk reverts to high risk rating level.	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.	Whilst full Covid-19 funding was received for 2020/21 and we delivered a small underspend £0.440m subject to external audit review; funding for 2021/22 will be determined post formal quarter 1 review of Boards' financial performance.	Possible	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
1513	Financial and Economic impact of Brexit	Active Risk	High Risk	20	McGurk, Margo
1364	Efficiency Savings	Active Risk	High Risk	16	McGurk, Margo
1363	Health and Social Care Integration	Active Risk	High Risk	16	McGurk, Margo
522	Prescribing and Medicines Management - Prescribing Budget	Active Risk	High Risk	15	McKenna, Christopher
1784	Finance (Short Term/Immediate)	Closed Risk	Moderate	8	Connor, Nicky

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
1357	Financial Planning, Management and Performance	Active Risk	Moderate	12	McGurk, Margo
1846	Test and Protect/Covid Vaccination	Active 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	03/06/2021	6 August 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.	Likely	Extreme	20	High risk	Likely	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.	Neil McCormick Director of Property & Asset Management	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.	Remote	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	McCormick, Neil
1252	Flexible PEX hoses in PHASE 3 VHK	Active Risk	High Risk	15	McCormick, Neil
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 faiure	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																										
1646	Excellent Staff Governance	04/13		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.	Almost Certain	Major	20	High	Likely	Major	16	High	Failure in this area has a direct impact on patients' health. NHS Fife has an ageing workforce with recruitment challenges in key specialities. Failure to ensure the right composition of workforce with the right skills and competencies gives rise to a number of organisational risks including: reputational and financial risk; a potential adverse impact on the safety and quality of care provision; and staff engagement and morale. Failure would also adversely impact on the implementation of the Clinical strategy. The current score reflects the existing controls and mitigating actions in place.	Lisa Stacey	Staff Governance	*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 have now progressed to offers to the students who will graduate in the summer of 2021. 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 and strengthening links with the Psychology 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. • Development of the Learning and Development Framework strand of the Workforce Strategy. 14. • Leadership and Management development provision is constantly under review and updated as appropriate to ensure continuing relevance to support leaders at all levels. 15. • Improvement to be achieved in Core Skills compliance to ensure NHS Fife meets its statutory obligations. 16. • 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. 17. • Continue to address the risk of non compliance relating to TURAS Appraisal. 18. • 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. 19. • 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 United Kingdom Visas and Immigration Sponsor Licence and successful application for 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. (7-8) Strengthen workforce planning infrastructure ensuring a co-ordinated and cohesive approach is taken to advance key workforce strategies, including those generated by the current COVID-19 pandemic. This now includes employment of independent contractors, student workforce (medical, N&M etc) to support the COVID-19 Test and Protect and Vaccination Programmes. The Director of Workforce has now convened a Strategic Workforce Planning Group which has been complemented by the establishment of an Operational Workforce Planning Group. A COVID-19 Silver Workforce Group was also stood up and down to support workforce demand and supply. These groups will take account of recent and anticipated Scottish Government guidance on Integrated Workforce Planning and are reflected in the recent Interim Joint Workforce Template for NHS Fife and HSCP, based on an integrated approach. (9-10) 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. (11) 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.	1. Regular performance monitoring and reports to Executive Directors Group, Area Partnership Forum, Local Partnership Forums and 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 future Population Health and Wellbeing Strategy for Fife and the implementation of eESS, should provide appropriate levels of control.	Unlikely	Major	4	Low	Continuing improvement in current controls and full implementation of mitigating actions will reduce both the likelihood and consequence of the risk from moderate to low.

																		(12) Continue to implement and promote Staff Governance Action Plans and staff engagement, through the Pulse Survey results in 2021. (14) Implementation of the Learning and Development Framework strand of the Workforce Strategy. Increased utilisation of virtual learning opportunities. (15-16 & 19) Review of L&D processes, planning and resources to ensure alignment to priorities. (17) Full roll out of Learning Management self service (18) Continuing implementation of the TURAS Appraisal Improvement and Recovery Plan throughout the Board, led by EDG. Responsible Person: Director of Workforce / Partnership Responsible Person: Director of Workforce									

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	Dobson, Claire
1324	Medical staff recruitment and retention	Active Risk	High Risk	16	Kennedy, John
90	National Shortage of Radiologists	Active Risk	High Risk	16	Dobson, Claire

Previously Linked Operational Risk(s)

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

NHS Fife Board Assurance Framework (BAF)

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Board Assurance Framework (BAF) - Quality & Safety																											
1674	Clinically Excellent, Person Centred	30/04/21	07/07/21	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 Christina Cooper	*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 but 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 best practice guidance 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	Dobson, Claire
1296	Emergency Evacuation, VHK Phase 2 Tower Block	Active Risk	High Risk	20	McCormick, Neil
43	Vascular access for haematology/Oncology	Active Risk	High Risk	20	Savage, Shirley-Anne
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
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
1667	Infusion pumps, volumisers and Syringe Divers in Paediatrics and Neonatal Units	Closed Risk			
1514	Impact of the UK's withdrawal from the EU on the availability and cost of medicines and medical devices	Closed Risk			
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			
1515	Impact of the UK's withdrawal from the EU on Nuclear Medicine and the ability to provide diagnostic and treatment service(s	Closed Risk			

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Board Assurance Framework (BAF) - Strategic Planning																											
1675	Clinically Excellent, Exemplar Employer, Person Centred, Sustainable	20/6/21	1 September 2021	Proposed New Risk There is a risk that the development and the delivery of the new NHS Fife Population Health and Wellbeing strategy is not adequately supported by the required planning and programme management capacity, capability and governance arrangements. Key Risks from previous BAFs will remain until committees are content they are covered in renewed PHW Strategy. 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.	Likely	Major	16	High risk	Unlikely	Major	12	Meduim risk	The Board remains under the direction of Scottish Government will clear priorities established for 2021/22. The RMP3 sets out those priorities and is likely to be reviewed in September 2021.	Margo McGurk Director of Finance	Clinical Governance. Christina Cooper.	*Ongoing actions designed to mitigate the risk including:* 1. Progress has been made in development of strategy and will progress shared at Board Development session in June 2021 2. Corporate Objectives for 2021/22 to be agreed throuhg committees in June 2021. 1.	EDG Strategy meetings will provide the required leadership and executive support to enable strategy development.	EDG will engage in monthly sessions to ensure the ongoing development of the new strategy. The NHS Fife Board and Governance Committees will be fully engaged in this process throughout 2021/22 and will be responsbile for approval of the emerging strategy. Work is ongoing to develop clarity on the system-wide governance arrangements in terms of the developing strategy. Joint sesssion with NHS Fife and Fife Council Executive Teams in May 2021. Responsible Person: Director of Finance Timescale: 31/03/2022	1. Minutes of meetings record attendance, agenda and outcomes. 2. Reporting of key priorities to governance groups from the SPRA process.	1. Internal Audit Report on Strategic Planning (no. B10/17) 2. Governance Committeee scrutiny and reporting.	Governance of new arrangements will be agreed to deliver the required assurance.	Work is ongoing to agree the corporate objectives through SPRA process and the development of the Population Health and Wellbeing Strategy. This will be supported by the corporate PMO.	Unlikely	Moderate	9	Low risk	

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																											
1	S	2	8	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.	L	L	M	1	1	P	M	1	2	The level of risk has been actively reviewed and, following feedback from colleagues, 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	N	NHS Fife Board	*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, was 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. 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. Feedback on the revisions to the IS was received from NHS Fife and Fife Council in February 2021. These have mostly been agreed and concluded with the exception of an element of the Finance Section.	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.	R	E	M	A	4	3	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..

9. A review letter from the Chief Executives of Fife Council and NHS Fife was sent to the Scottish Government on 24 March 2021 advising on the progress being made in Fife and highlighting the revised timeframes in line with the impact of the pandemic. The current scheme remains in place until the updated scheme is formally submitted.
10. An update on this position was taken to a private session of NHS Fife Board on 31 March 2021.
11. Following the submission to Scottish Government active discussions have taken place with the Chief Officer of the IJB and the Chief Executives of Fife Council and NHS Fife. There is a commitment to conclude the review of the Integration Scheme through both Fife Council and NHS Fife governance structures by September 2021
12. In view of the fact there is ongoing dialogue with Scottish Government and a commitment with partners to conclude by September, the risk remains at a moderate level.

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) - Digital & Information																											
1677	Clinically Excellent, Exemplar Employer, Person Centred, Sustainable	09/04/2021	2 July 2021	There is a risk that the organisation will fail to recognise and afford the financial investment necessary to deliver its D&I Strategy and current operational lifecycle commitment to enable transformation across Health and Social care to deliver sustainable and integrated services that are safe, secure and compliant with governance frameworks and associated legislation.	Likely	Extreme	20	High risk	Possible	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.	CMK Medical Director	Clinical Governance, Finance Performance & Resources (FP&R) Christina Cooper (CGC), Rona Laing (FP&R)	*Ongoing actions designed to mitigate the risk including:* 1. Consistent alignment of the D&I Strategy with the NHS Fife Corporate Objectives and developing Health & Wellbeing Strategy 2. Digital & Information Board Governance improvement with ongoing review 3. Information Governance & Security Governance improvement with assurance activity plans reviewed by Steering Group and Improvement measures agreed 4. Caldicott - register maintained and reviewed 5. Review of financial impact of D&I Strategy as part of annual deliver planning and areas of exposure quantified 6. Operational governance lead through SLT focusing on operation controls (finance & resource), lifecycle management, policy/procedure implementation a workforce development 7. Risk management arrangements underpinned by: Policy & Process, Adverse event management, Asset Management Controls, Monitoring and Detection, Defence in Depth security measures and technology; all of which are receiving a higher percentage of budget allocation. 8. Directive on security of network and information systems (NIS) & Cyber Essentials Compliance – Action Plan developed prioritising a series of Cyber workshops informing technical controls and organisational response to Cyber attacks 9. Additional resilience planning and disaster recovery work underway to update alignment to current operating priorities 10. FOI, records management, DPA improvements being lead through IG&S Steering and Operational Groups 11. Senior Management Team consideration of policy and procedure impact and associated implementation 12. Monthly risk reviews with Operational Leads and escalation/reporting to Governance Groups as necessary 13. Performance Review 14. Participation in national and local audit e.g. NISD Audit 15. Commitment to ensure appropriate implementation of Cyber Defence Measures, including support of national centralised cyber incident reporting and coordination protocols. 16. Staff Learning & Development, both Digital staff and the wider organisation including leadership skills. 17. Business Case development to include costed resilience by design and ongoing support activities. 18. Enhancing monitoring of our digital systems.	Lack of formal quantification of the financial impact of the Digital Strategy, inline with the current baseline of D&I Operating Costs Lack of long term financial, lifecycle and workforce planning. Lack of systems to maintain ongoing monitoring of compliance with the key controls: GDPR/DPA 2018 - Improvements noted in IG&S Assurance Report (Target June 2021) Lack of consideration and commitment to unification of business process on strategic applications and the associated remove of duplicate or legacy systems Lack of training and education resource to ensure our staff and patients are digitally ready - Business Case in consideration Lack of resilience of key digital systems and technical recovery procedures and regular failover (DR) testing. - Plan to address agreed with EDG - April 2021- project now in initiation – Oct 2021 Governance and procedures do not fully follow ITIL professional standards - Internal Audit Findings being considered	1. Improving and maintaining strong governance, risk management and operating procedures following Information Technology Infrastructure Library (ITIL) professional standards within early adoption of continuous improvement assessment. (Governance and Risk plan to conclude September 2021. ITIL implementation - TBC) 2. Updated baseline of current operating financial commitments and assessment of financial implementation of Digital Strategy. (Target completion October 2021) 3. Develop long term financial, lifecycle and workforce planning - plan to address is in development (Target completion October 2021) 4. Ensure existing systems are considered first, prior to new systems introduced resulting in additional financial commitment to implementation and maintenance. The continual use of business case development and governance of digital requests by D&I Board will support this mitigation (Target completion February 2021) 5. Work to become fully compliant with GDPR, DPA 2018, NIS Directive, Information Security Policy Framework and thereafter maintain compliance. (Target completion February 2022)	Second line of Assurance: 1. Reporting to D&I SLT, D&I Board, Information Governance & Security Steering Group (IG&SG), EDG & Clinical Governance groups and committees. 2. Annual Assurance Statements for the D&I Board and IG&S Steering Group. 3. Locally designed subject specific audits. 4. Compliance and monitoring of policies & procedures to ensure these are up to date via D&I Senior Management Team. 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. External Assurance on Delivery Plan by Scottish Government 12. Update to Assessment following June 2019- Digital Maturity Assessment 13 Periodic Benchmarking for areas of focus	Third line of Assurance : 1. Internal Audit reviews and reports on controls and process; including annual assurance and 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. 6. Benchmarking with NHS Scotland's Boards	1. The D&I Strategy has not undergone a financial assessment against delivery. This work is now being progressed - target completion October 2021 2. Continual development of data assured performance is ongoing across all D&I Domains. Development of workplans aligned to risk continue to be developed. 3. Assurance reports are consistently provided to D&I SLT monthly and development of data/KPI reports to Governance Groups continue to be developed. These reports will ensure trend and analysis to 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). 4. Implementation of improvements as recommended in Internal and external ongoing. Adverse Events review to be included 5. Improvements to SLA's (in line with 'affordable performance')is that output still awaited from 4 to provide assurance or otherwise 6. Assurance on patients' readiness/equality impact in the adopt ion of digital care provision 6. Assurance on organisational readiness for further Digital Adoption	Overall, NHS Fife Digital has in place a sound systems of 1. Governance - agreed ToR and reporting 2. Improving 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. 5. Clear articulation of digital aspiration via the Digital Strategy 2019-2024 5. Extended corporate governance including EDG attendance 6. Meeting visibility through provision of minutes and delivery plans to EDG/CGC	Unlikely	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
885	Digital & Information Financial Position	Active Risk	High Risk	20	Graham, Alistair
1504	Lack of a central IT location to store guidance documents	Active Risk	High Risk	20	McKenna, Christopher
1338	NHS Fife is at increased risk to a targeted cyber intrusion - due to legacy systems	Active Risk	High Risk	20	Young, Allan
1996	Office 365 - Unknown Financial Consequence and so risk to licence availability	Active Risk	High Risk	20	Graham, Alistair
1422	Unable to meet NIS & Cyber Essentials compliance	Active Risk	High Risk	20	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
1934	Loss of Email & Collaboration Services	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
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
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			
226	Security of data being transferred off/on site	Active Risk	Moderate Risk	12	Graham, Alistair
1746	O365 May Cause Disruptive Network Overhead	Active Risk	Moderate Risk	12	Young, Allan

Meeting:	**Audit and Risk Committee**
Meeting date:	**16 September 2021**
Title:	**Internal Audit Report - Information Technology Infrastructure Library (ITIL) Audit**
Responsible Executive:	**Dr Chris McKenna – Medical Director**
Report Author:	**Allan Young – Head of Digital Operations**

1 Purpose

This is presented to the Committee for:

- Assurance

This report relates to a:

- Annual Operational Plan

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

Alignment to the best practices defined within the Information Technology Infrastructure Library (ITIL) is one of Digital & Information's key dependencies for achieving compliance with the Network & Information Systems Directive (NISD) and delivering the 2019-2024 Digital Strategy. At present, NHS Fife is loosely aligned to many parts of ITIL but advocates an old version and does not have acceptable levels of formal process documentation or a measured maturity framework.

2.2 Background

The D&I department recently supported an internal audit investigation (B23-21) of current ITIL process, to bring heightened focus onto the improvements that are required, and the effort needed to achieve those improvements.

The audit was carried out in May 2021 and has detailed D&I management responses and actions within the full internal audit report.

The scope of the audit was agreed and looked to confirm if: -

- There are extant arrangements for maintaining ITIL processes and keeping these up to date
- The effectiveness of processes within Digital & Information for monitoring the adherence to ITIL processes
- ITIL processes are being complied with within Digital & Information Operations

The review also considered their role as professional lead for ITIL to other areas of NHS Fife with Digital & Information service management responsibilities (e.g. Radiology and Laboratories) and the potential benefits of a move from the ITIL 3 framework to ITIL 4

There are 2 key areas of focus required:-

- Carry out the Management Actions that D&I have committed to in response to the Audit.
- Establish a D&I Operating Model which can establish good ITIL alignment and sustain continuous improvement.

The Committee are asked to note the encouragement, in the Internal Audit findings, to ensure management actions agreed extend to other areas of NHS Fife that undertake IT Service Management.

The existence of fully documented ITIL processes has slowly eroded due to the D&I department simply not having the capacity required to maintain them. NHS Fife started off well 15 years ago with ITILv2, but the old eHealth operating model was also forced to adopt to a period of austerity and under-investment, which meant some difficult prioritisation choices had to be made, including the loss of key roles associated with the delivery and maintenance of ITIL. Also, the transition to ITILv3 was not done effectively and the documented processes then became out of date and maturity levels fell.

2.3 Assessment

The first action will be to commission a cost/benefit exercise to determine how to move forward with ITIL. This cost/benefit exercise will outline the processes (now referred to as practices in v4) and prioritise them based on value and risk position. This exercise will also take the opportunity to successfully transition to ITILv4 and will use the new categories and updated practices. This approach will strive to select which ITILv4 practices will be adopted first and then set maturity levels accordingly.

There are 27 processes across 5 lifecycle stages in ITILv3 and 34 practices across 3 framework groups in ITILv4. The intention is to use a 5-tier maturity model: **Initial, Repeatable, Defined, Managed & Optimised.**

The formal costs/benefit exercise is due to be considered by the D&I Board on 19th October.

The high-level plan for carrying out the audit actions and improving the ITIL position is detailed in **Appendix 1** below.

Some of the key benefits of mature ITIL version 4 practices:

- Experience improved delivery of services through a more holistic view and value based look at the end to end delivery model.

- Reduce costs through efficient working practice and evidence backed value propositions.
- Obtain a clearer view of digital costs and the status of our assets.
- Increase the ability to manage operational risk and service disruption.
- Reduce redundant / re-working and improve resource utilisation.
- Maintain performance indicators for benchmarking and strategic/tactical direction.
- Support a much more agile approach to digital technology and transformation

High level timelines:

October 2021 – Agreement of cost/benefit paper.
December - January 2021 – Complete recruitment of delivery team.
February - March 2022 – Begin delivery of improvement plan (10 months)
December 2022 – Completion of improvements and ongoing maturity of ITIL practices.

2.3.1 Quality/ Patient Care

Will be more protected due to higher resilience to incidents and be better positioned to respond in a competent manner.

2.3.2 Workforce

Flexible and dynamic working practices, well informed workforce, consistently using practices that have measured levels of maturity. This help our workforce to be more efficient and effective, deliver better customer experiencers and be more motivated and fulfilled in our work.

A considered approach to training and education, for the IT Service Management workforce on the ITIL4 methods will be required, including an approach for Senior Leadership.

2.3.3 Financial

The cost benefit analysis will identify any investment plan required in support of the ITIL 4 introduction plan. Two of the items associated with completing the action plan will require funding. These are implementation and maintenance resources and staff training.

2.3.4 Risk Assessment/Management

The Risk Management position will be improved by completing the action plans committed to within the audit response.

2.3.5 Equality and Diversity, including health inequalities

N/A.

2.3.6 Communication, involvement, engagement and consultation

N/A

2.3.7 Route to the Meeting

This paper has been considered by the following groups as part of its development.

- Digital & Information Senior Leadership Team – 8 September 2021

2.4 Recommendation

- **Awareness** – For the committees' information and awareness.

3 List of appendices

The following appendices are included with this report:

- Appendix 1, High Level Plan for ITIL 4 delivery
- Appendix 2, Internal Audit Report B23/21 – ITIL Processes

Report Contact
Allan Young
Head of Digital Operations
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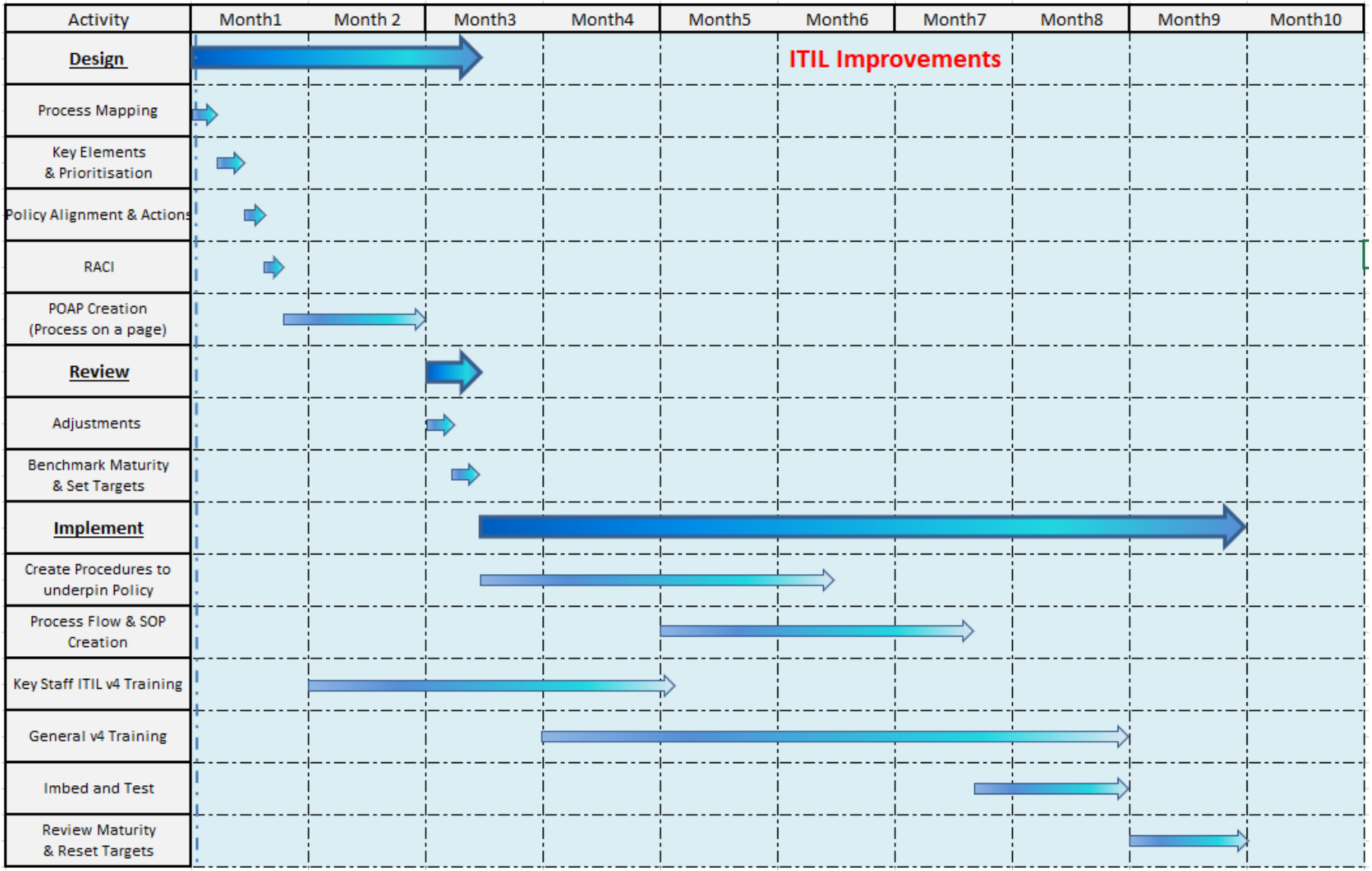
Appendix 1

High Level Plan for ITIL version 4 using a Design, Review, Implement approach.



FTF Internal Audit Service

ITIL Processes

Report No. B23/21

Issued To: **Carol Potter, Chief Executive**
Margo McGurk, Director of Finance & Strategy/SIRO
Chris McKenna, Medical Director/Caldicott Guardian

Alistair Graham, Associate Director – Digital and Information
Allan Young, Head of Digital Operations- Digital and Information
Brian Faichney, Change Manager
Stephen McGlashan, Microbiology Service Manager

Gillian MacIntosh, Head of Corporate Governance/Board Secretary
Hazel Thomson, Board Committee Support Officer

Audit and Risk Committee
Clinical Governance Committee
External Audit

Contents

Draft Report Issued	28 May 2021
Management Responses Received	28 June 2021
Target Audit & Risk Committee Date	16 September 2021
Final Report Issued	7 July 2021

CONTEXT AND SCOPE

1. The NHS Fife Strategic Framework includes key aspirations of providing services that are clinically excellent, person centred and sustainable and for NHS Fife to be an exemplar employer. The systems which protect the availability, integrity and confidentiality of patient and staff information and that ensure that the right information is available to the right people at the right time help NHS Fife achieve the objectives associated with these aspirations.

2. The revised NHS Fife Board Assurance Framework (BAF) for Digital and Information (D&I) describes the following risk which could threaten the achievement of these strategic objectives – '*There is a risk that the organisation will be unsustainable because of lack of financial underpinning to deliver its D&I Strategy to the full (staffing, procurement...) preventing necessary transformational change, stopping services from being delivered and exposing NHS Fife to the risk of prosecution and financial penalty for breaking data protection laws*'. The BAF also highlights the gap in control of *'Governance and procedures do not fully follow ITIL professional standards'*.

3. The current actions recorded in the BAF to mitigate this risk include:

    - '*Improving and maintaining strong governance and procedures following Information Technology Infrastructure Library (ITIL) professional standards*'.

4. D&I Service Management has been identified within the internal audit strategic planning process as **Low** and, although not specifically recorded on the Digital and Information directorate risk register, ITIL is the most widely recognised framework for IT and digitally enabled services in the world and provides comprehensive, practical and proven guidance for establishing an effective service management system. ITIL provides a robust framework for identifying, planning, delivering and supporting IT services that can be adapted and applied to all business and organizational environments. The main benefits of ITIL are improving the management of business risk and service disruption or failure and supporting business change whilst maintaining a stable service environment (further benefits are included at Appendix 3).

5. Discussions with the General Manager – Digital & Information, as part of B12/21 Assurance Mapping, highlighted concerns that due to resource limitations, ITIL processes were no longer always being fully followed in Digital and Information Operations.

6. Our audit evaluated the design and operation of ITIL processes *in Digital and Information* to confirm whether:

    - There are extant arrangements for maintaining ITIL processes and keeping these up to date
    - The effectiveness of processes within Digital and Information for monitoring the adherence to ITIL processes
    - ITIL processes are being complied with within Digital and Information Operations.

7. As part of this review we also considered how Digital and Information are discharging their role as professional lead for ITIL to other areas of NHS Fife with D&I service management responsibilities (eg Radiology and Laboratories) and the potential benefits to NHS Fife of moving from ITIL 3 to ITIL 4.

AUDIT OPINION

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

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

A description of all definitions of assurance and assessment of risks are given in Section 3 of this report.

Conclusion

9. Whilst there are elements of ITIL good practice in operation within NHS Fife's Digital and Information Directorate, few processes are properly documented and those intended to ensure adherence to ITIL lack rigour. When ITIL was introduced 15 years ago, NHS Fife introduced a structure of posts to ensure adherence to ITIL, but many of these posts are no longer in place.

10. NHS Fife is planning the move from its existing IT Service Management Software 'Cherwell' to a different application 'ServiceNow'. There is therefore an opportunity to refresh and re-establish ITIL compliance as part of the move to the new system. ITIL is best practice guidance and is intended to be used by organisations as needed for their own particular requirements. A summary of the purpose and benefits of commonly adopted ITIL management practices is included at appendix 3. A cost/benefit analysis should therefore be undertaken to determine whether investment in ITIL compliance will be justifiable in terms of the benefits it will bring. As stated above the D&I BAF highlights the gap in control of *'Governance and procedures do not fully follow ITIL professional standards'.* The conclusion of this analysis should therefore be clear regarding the risks being addressed by re-establishing ITIL processes and the extent to which these will be re-established.

Maintenance of ITIL Policies

11. Of the 27 separate processes included in ITIL only the Change Management process was documented in an NHS Fife policy document and this had a lapsed review date (June 2018) and is recognised by management as requiring significant revision to reflect current staffing roles and operational practices. There are other relevant documents (eg strategies/access request forms) that contain information and working practices in operation covering some of the ITIL processes in part (eg setting of Service Level targets and reporting on these) but these are not recorded in formal policies and are not all subject to regular review therefore some of the staffing roles and operational practices contained in these are out of date.

12. Overall there is not a documented process in place for reviewing and maintaining policies covering the ITIL processes to ensure that these are kept up to date.

Monitoring of Adherence to ITIL Processes

13. There is no specific checking of adherence with ITIL processes by front line business operational areas (first line of assurance), nor effective management information regarding adherence to ITIL processes by the second line of assurance (ie separate from

those responsible for delivery, but not independent of the organisation's management chain). Some independent, objective assurance (third line of assurance) may be derived (eg from the Network & Information Systems Regulations 2018 audits undertaken by the Scottish Health Competent Authority) but this is not comprehensive and has highlighted issues requiring to be resolved (eg regarding asset management).

14. Some indirect assurances are provided to management, for example compliance with service level agreements with performance against targets for system availability, service desk call resolution and others, but there is not specific assurance provided regarding adherence to ITIL processes. This also highlights a governance issue in that the appropriate group/committee was not informed that ITIL compliance had diminished since it was introduced in NHS Fife.

15. The latest version of the Digital and Information BAF, presented to NHS Fife Clinical Governance Committee on 30 April 2021, recognises that '*Governance and procedures do not fully follow ITIL professional standards*' and includes the aspiration to '*Improve and maintain strong governance and procedures following Information Technology Infrastructure Library (ITIL) professional standards within early adoption of continuous improvement assessment*'. The BAF also refers to several current controls that are relevant to the monitoring of adherence to ITIL best practice:

    - *'Operational governance lead through SLT focussing on operation controls, lifecycle management, policy/procedure implementation and adherence*
    - *Senior Management Team consideration of policy and procedure impact and associated implementation*
    - *Monthly risk reviews with Operational Leads and escalation/reporting to Governance Groups as necessary*
    - *Performance Review*
    - *Participation in national and local audit e.g. NISD Audit*'.

Compliance with ITIL Processes

16. The Change Management process seeks to minimise the risk associated with changes to ensure the stability of systems and IT infrastructure thereby minimising disruption to NHS Fife's operations and consequently improving the services and service levels provided to the organisation. Change management also acts as an enabler by supporting and facilitating the implementation and delivery of projects with IT dependencies driven by any NHS Fife Delivery programme. ITIL defines a change as '*the addition, modification of removal of anything that could have an effect on IT services*'. This includes Changes to the IT infrastructure, processes, documents, supplier interfaces. ITIL distinguishes between 3 types of changes:

    - '*Standard Changes: Pre-authorised, low-risk Changes that follow a well-known procedure.*
    - *Normal Changes: All other Changes that are not Standard Changes or Emergency Changes.'*
    - *Emergency Changes: Changes that must be implemented immediately, for example to resolve a Major Incident.*

17. We undertook a sample check of completed Standard and Normal changes over the last year to gauge compliance with NHS Fife's documented Change Management policy and procedure.

18. This identified some issues regarding the completeness of the information recorded regarding proposed changes, the setting and recording of change approvals and evidencing compliance with the emergency change procedure on the Cherwell IT Service Management system which should be considered as part of the impending changeover to the ServiceNow application.

19. The NHS Fife Emergency Change Procedure states that the procedure:

    - '*should only be used in an emergency,*
    - *it should not be used for planned work that has been overlooked*
    - *or has short notice changes*'.

20. Our check of 5 changes recorded as emergencies, identified two that did not appear to satisfy this or the 3 defined reasons for invoking the emergency change procedure outlined in the change management procedure. We have recommended a review of emergency changes made to identify reasons for inappropriate use of the process so that action can be taken to avoid this in future as inappropriate use of the Emergency Change Procedure results in unnecessary short notice use of Senior Management time and undermines the normal change management process.

21. We also noted that the Digital and Information BAF states a gap in control to be *'Governance and procedures do not fully follow ITIL professional standards'* but there is no related risk recorded regarding this in either the IT Operations risk register or D&I Directorate risk register.

Role of Digital and Information Directorate as Professional Lead for ITIL

22. There is a leadership role for the Digital and Information directorate advocates for ITIL processes for other areas which undertake IT service management roles such as Laboratories, Radiology, Theatres etc. We were advised by Laboratories' management that their IT processes are aligned to ISO 15189 and therefore may be broadly in line with ITIL but no mapping exercise has been undertaken to confirm this and to identify whether any additional benefits would be accrued from the introduction of further ITIL processes. Digital and Information should work with Laboratories management to assess ITIL compliance and to provide support and leadership to introduce the agreed NHS Fife ITIL processes. The timing of this will need to follow the cost benefit analysis and outcome referred to in paragraph 10 above and will also need to be sensitive to the impact the pandemic continues to have on the operation of Laboratory services.

23. Digital and Information should also engage with other services undertaking IT service management roles to assess their ITIL compliance and to offer assistance in introducing further ITIL processes.

Potential Benefits of Moving from ITIL 3 to ITIL 4

24. No assessment of ITIL v4 versus v3 has yet been undertaken but as the 'Service Now' service management application is to be implemented in NHS Fife it there is an opportunity to move practices to the latest ITIL version (v4).

25. ITIL 4 is a significant development from previous version in terms of philosophy, although much of the detailed 'practice' content remains in a recognisable form. The context and positioning of ITIL has however developed as a strategic and unifying element across the business and technology landscape. The approach has changed to ensure that ITIL meets the needs of a modern digital based service management workforce with an expectation that it be implemented across the organisation and not in silos. The adoption of relevant ITIL 4 General, Service and Technical Management

practices should act as an enabler for Digital and Information in its key role as part of the significant transformative strategic changes ahead for NHS Fife as part of remobilisation.

26. Therefore the cost/benefit analysis referred to in paragraph 10 above should include consideration of any changes to processes to align with the latest ITIL version (v4).

ACTION

27. The action plan at Section 2 of this report has been agreed with management to address the identified weaknesses. A follow-up of implementation of the agreed actions will be undertaken in accordance with the audit reporting protocol. Progress towards action implementation will also be monitored by regular reporting to the SIRO and the Digital and Information Board.

ACKNOWLEDGEMENT

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

Barry Hudson BAcc CA
Regional Audit Manager

Action Point Reference 1 – ITIL Alignment

Finding:

Whilst there are elements of ITIL good practice in operation within NHS Fife's Digital and Information Directorate, including many of the management practices listed at appendix 3, few processes are formally documented in policies and procedures and there is a general lack of rigour to ensure adherence to ITIL. When ITIL was introduced 15 years ago, NHS Fife introduced a structure of posts to ensure adherence to ITIL, but many of these posts are no longer in place and alignment to ITIL has diminished over this period. Examples of this are:

- Only one ITIL process is documented in a formal NHS Fife Policy and this policy has a lapsed review date and requires updating to reflect current roles and operational practices in respect of the Change Management process it covers. There are related documents covering some elements of a further 10 ITIL processes but these are also mainly out of date and no longer reflect the operational practices now in place.
- There is no specific checking of adherence with ITIL processes by front line business operational areas (first line of assurance) nor by provision of effective management information regarding adherence to ITIL processes by the second line of assurance (ie separate from those responsible for delivery, but not independent of the organisation's management chain). Some independent, objective assurance (third line of assurance) may be derived (eg from the Network & Information Systems Regulations 2018 audits undertaken by the Scottish Health Competent Authority) but this is not comprehensive. This also highlights a governance issue in that the appropriate group/committee was not informed that ITIL compliance had diminished since it was introduced in NHS Fife.

Audit Recommendation:

A summary of the purpose and benefits of commonly adopted ITIL management practices is included at appendix 3.

ITIL is best practice guidance and is intended to be used by organisations as needed for their own particular requirements. A cost/benefit analysis should therefore be undertaken to determine the ITIL processes that should be introduced or enhanced to bring the maximum benefit to NHS Fife for any investment required, in terms of acting as an enabler for Digital and Information in its key role as part of the significant transformative strategic changes ahead for NHS Fife as part of remobilisation.

The outcome of this cost/benefit analysis should be used to:

- Inform the prioritisation of action to update/write appropriate policies and procedures for the ITIL processes to be utilised by NHS Fife. This should include documenting a process for reviewing and maintaining policies covering the ITIL processes to ensure that these are kept up to date in future.
- Design and implement a compliance checking regime to monitor adherence to ITIL processes. This should include providing senior managers in Digital and Information and appropriate governance groups/committees with ITIL compliance management reports including relevant key performance indicators.

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

Management Response/Action:

Finding accepted: The existence of documented ITIL process has slowly eroded due to the department simply not having the headroom required to maintain them. NHS Fife started off well 15 years ago with ITILv2 but did not transition effectively to ITILv3, consequently the documented processes became out of date and maturity levels fell.

Recommendation accepted: The first action will be to commission a cost/benefit exercise to determine how to move forward with ITIL. This cost/benefit exercise will lay out the processes and prioritise them based on value. This exercise will take the opportunity to transition to ITILv4 and will use the new categories and updated processes. This approach will strive to select which ITILv4 processes will be adopted and then set maturity levels. The intention is to use a 5-tier maturity model using initial, repeatable, defined, managed & optimised.

Action: The carry cost/benefit exercise, document a report and take through D&I Senior Leadership for support and funding agreement. The report will show the time and resources required to create a foundation position using ITILv4. A foundation position will include: All adopted processes assessed for maturity level, prioritised for focus, documented to at least 'process on a page' level, owners agreed and RACI completed. A paper will be presented to the D&I Board recording the outcome of the cost/benefit analysis with options for approval.

Action by:	Date of expected completion:
Head of Digital Operations	31 October 2021

Action Point Reference 2 – Risk Management

Finding:

The Digital and Information BAF states a gap in control to be *'Governance and procedures do not fully follow ITIL professional standards'* but there is no related risk recorded regarding this in either the IT Operations risk register or D&I Directorate risk register.

The Digital and Information BAF includes an aspiration to '*Improve and maintain strong governance and procedures following Information Technology Infrastructure Library (ITIL) professional standards within early adoption of continuous improvement assessment*'.

There is no direct monitoring of whether this aspiration is being acted upon.

Audit Recommendation:

The actions required to fulfil the BAF aspiration of '*Improving and maintaining strong governance and procedures following Information Technology Infrastructure Library (ITIL) professional standards within early adoption of continuous improvement assessment*' should be documented and prioritised.

The implementation of these actions should be formally monitored by the Digital and Information Directorate in a manner which allows reporting within the BAF and to the Clinical Governance Committee.

Assessment of Risk:

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

Management Response/Action:

Finding accepted: No relevant risk exists to underpin the BAF aspiration therefore no vehicle in place to drive management.

Recommendation accepted: Actions to manage the risk will be placed upon the IT Operations Group and the D&I Senior Management Team. The development of ITILv4 will be added to the programmes list and progress reported to D&I Board and CGC through the regular highlight reports.

Action: Add an appropriate risk to the D&I directorate risk register and support the management of the risk with appropriate actions within the IT Ops and SLT.

Action by:	Date of expected completion:
Head of Digital Operations	30 June 2021

Action Point Reference 3 – Digital and Information Leadership Role	
Finding:	
There is a leadership role for the Digital and Information directorate advocates for ITIL processes for other areas which undertake IT service management roles such as Laboratories, Radiology, Theatres etc but the D&I Directorate are not currently actively engaged with areas/services outwith their own Directorate to promote the use of ITIL compliant processes for IT service management. We were advised by Laboratories' management that their IT processes are aligned to ISO 15189 and therefore may be broadly in line with ITIL but no mapping exercise has been undertaken to confirm this and to identify whether any additional benefits would be accrued from the introduction of further ITIL processes.	
Audit Recommendation:	
Digital and Information should engage with other services undertaking IT service management roles to assess their ITIL compliance and to offer assistance in introducing further ITIL processes to improve the efficiency of IT Service management in these areas. The timing of these actions will need to follow the cost benefit analysis and outcome referred to in action plan point 1 above and will also need to be sensitive to the impact the pandemic continues to have on the operation of other services.	
Assessment of Risk:	
Significant 	Weaknesses in control or design in some areas of established controls. **Requires action to avoid exposure to significant risks in achieving the objectives for area under review.**
Management Response/Action:	
Finding accepted: Attempts have been made in the past to include areas of shadow IT in ITIL process especially with Change Management, but with limited success. Full mapping and adoption to same level as D&I is required to attain best practice. **Recommendation accepted: The cost/benefit exercise should include adoption within Labs and Radiology to foundation level, taking into account the impact of the pandemic on these services.** **Action: Include shadow IT considerations in the cost/benefit exercise as a phase 2.**	
Action by:	**Date of expected completion:**
Head of Digital Operations	31 August 2021

Action Point Reference 4 – Completeness of Change Request Information

Finding:

From a random sample of 15 closed Standard and Normal changes checked the following issues were identified:

- The following were required on the RFC form but are not included as specific fields on Cherwell (and the information recorded on Cherwell for the changes sampled didn't include this information):
  - Benefits/Business Case
  - Prerequisites
  - Resources Required
  - Communication to Users/Stakeholders
- The statement of risks and scoring of these was inconsistent across the 15 changes sampled and 3 did not include any scoring of the risks recorded
- Two of the changes sampled related to server decommissioning. Only one of these included a server decommissioning checklist attachment and this had not been completed.

Audit Recommendation:

The NHS Fife Policy and Procedure for Change Management should be reviewed prior to the forthcoming change of IT Service Management software from Cherwell to ServiceNow. Part of this review should include determination of mandatory fields to be completed for all changes. This should include consideration of including the following information as mandatory (as these were identified as differences in the information required on the RFC forms in comparison to the information required on Cherwell):

- Benefits/Business Case
- Prerequisites
- Resources Required
- Communication to Users/Stakeholders

Recording of risks related to changes should be undertaken in a consistent manner and should always include scoring of the risks based on impact and likelihood.

The relevant staff should be reminded of the need to complete and attach the appropriate checklist for changes associated with server decommissioning.

Assessment of Risk:

Significant  Weaknesses in control or design in some areas of established controls.

Requires action to avoid exposure to significant risks in achieving the objectives for area under review.

Management Response/Action:

Finding accepted: The Change Manager post has not been available to D&I over the past 2 years, which has meant a reasonable endeavours approach towards policing some of the mandatory information with Change Requests. The priority has been around ensuring that changes are assessed at CAB level to reduce the risk of unplanned outage due to change.

Recommendation accepted: There is an opportunity imminent with moving to the Service Now ITSM tool and recruiting new resources, which will resolve this. **Action: Check that these issues addressed in the Service Now Change Process and progress recruitment of the Transition Specialist ASAP.**	
Action by:	**Date of expected completion:**
Service Delivery Manager	30 September 2021

Action Point Reference 5 – Approval of Changes

Finding:

The setting of the required approvals for each change is undertaken by the change requester which represents a potential conflict of interests (ie between the interests of having the proposed change approved quickly and having proper scrutiny over the proposed change).

Approval boxes that were not greyed out and had not been ticked in 13 of the 15 changes. The approval logs for these changes however did record appropriate authorisation of the changes.

Change Advisory Board (CAB) meetings are not formally recorded so we were unable to test to confirm that a quorum of 3 was present when decisions are made.

Audit Recommendation:

The setting of required approvals should not be undertaken by the change requester. This should be automated as far as possible based on the type of change and its impacts and where the change is exceptional the approval requirements should be set by another member of the Digital and Information Team (eg the Change Manager).

The move from Cherwell to ServiceNow should include determination of how approvals for changes are recorded so that this is clear and does not result in any doubt over whether the change has been appropriately authorised.

Brief minutes of each Change Advisory Board meeting held should be recorded including listing those in attendance and decisions made.

Assessment of Risk:

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

Management Response/Action:

Finding accepted: This is a 'feature' of the Cherwell Change Management module. The methodology to be used in ServiceNow for the setting of approval requirements for different types of changes will include automatically assigned approvers for specific types of change but will also offer the opportunity for further approval requirements to be added (eg CAB).

CAB admin is being carried with reasonable endeavours during a period where D&I are running without a Transition Specialist.

Recommendation accepted: Recommendations are already accepted and will be carried forward into Service Now and a return to full CAB admin capability is planned.

Action: Manage forward as part of Service Now delivery.

Action by:	Date of expected completion:
Service Delivery Manager	31 August 2021

Action Point Reference 6 – Emergency Change Process

Finding:

Of the 5 emergency changes checked 3 appeared to fit the criteria for being processed as emergency changes and two did not. Cherwell does not include a specific field to record the reason for a change being classified as an Emergency Change.

Two of the five emergency changes checked were recorded as being high risk which are required, by the Emergency Change Procedure, to be approved by the D&I General Manager or their Deputy. Neither of these changes specifically indicated this had taken place (one recorded approval by the Change Manager only and one recorded approval by the Change Advisory Board and the Change Manager).

Audit Recommendation:

A section should be added to the Service Management application (ServiceNow) to indicate whether the change falls into one or more of the 3 criteria listed in the Change Management Procedure as requiring the emergency change process to be invoked:

1. Delaying action will seriously affect the delivery of an essential service
2. There will be a serious impact on the business unless the change is made
3. There is a serious disruption to essential services and a change is needed to restore service

A review of changes processed as emergency changes should be undertaken to identify changes that have been processed as such but do not meet the criteria for invoking the emergency change procedure. The reasons for processing these changes as emergency changes should be determined and analysis of these reasons should be used to avoid the inappropriate use of the emergency change process in future.

The IT Service Management application (ServiceNow) should include provision for the recording of approval by the D&I General Manager or their Deputy for emergency changes classified as high risk.

Assessment of Risk:

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

Management Response/Action:

Finding accepted: Finding accepted: This is a 'feature' of the Cherwell Change Management module. The methodology to be used in ServiceNow for the approval of Emergency Changes will be Associate Director of D&I, their deputy or the On-Call Manager during out of hours or public holidays.

Recommendation accepted: Recommendations are already accepted and will be carried forward into Service Now.

Action: Manage forward as part of Service Now delivery.

Action by:	Date of expected completion:
Service Delivery Manager	31 August 2021

Section 3 Definition of Assurance and Recommendation Priorities

Definition of Assurance

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

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

Section 3 Definition of Assurance and Recommendation Priorities

Assessment of Risk

To assist management in assessing each audit finding and recommendation, we have assessed the risk of each of the weaknesses identified and categorised each finding according to the following criteria:

Risk Assessment		Definition	Total
Fundamental		Non Compliance with key controls or evidence of material loss or error. **Action is imperative to ensure that the objectives for the area under review are met.**	**None**
Significant		Weaknesses in control or design in some areas of established controls. **Requires action to avoid exposure to significant risks in achieving the objectives for area under review.**	**6** **(Ref 1 to 6)**
Merits attention		There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**	**None**

ITIL Version 3 Processes

The core of the ITIL v3 Framework revolves around the ITIL Service Lifecycle and a set of processes for each stage. The table below shows the 27 processes grouped by the lifecycle stage they relate to.

Stage	Process
Service Strategy	Strategy Generation
	Demand Management
	Service Portfolio Management
	IT Financial Management
Service Design	Service Catalogue Management
	Service Level Management
	Capacity Management
	Availability Management
	Service Continuity Management
	Information Security Management
	Supplier Management
Service Transition	Transition Planning and Support
	Change Management
	Service Asset and Configuration Management
	Release and Deployment Management
	Service Validation and Testing
	Evaluation
	Knowledge Management
Service Operation	Event Management
	Incident Management
	Request Fulfilment
	Problem Management
	Access Management
	Operation Management
Continual Service Improvement	Service Improvement
	Service Measurement
	Service Reporting

ITIL Version 4 Processes

The ITIL v4 Framework groups 34 practices by the management practice type they relate to as shown in the table below.

General Management Practices	Service Management Practices	Technical Management Practices
Architecture Management	Availability Management	Deployment Management
Continual Improvement	Business Analysis	Infrastructure And Platform Management
Information Security Management	Capacity And Performance Management	Software Development And Management
Knowledge Management	Change Enablement	
Measurement And Reporting	Incident Management	
Organizational Change Management	Service Request Management	
Portfolio Management	IT Asset Management	
Project Management	Monitoring And Event Management	
Relationship Management	Problem Management	
Risk Management	Release Management	
Service Financial Management	Service Catalogue Management	
Strategy Management	Service Configuration Management	
Supplier Management	Service Continuity Management	
Workforce And Talent Management	Service Validation And Testing	
	Service Design	
	Service Desk	
	Service Level Management	

Commonly Adopted ITIL Management Practices

The table below lists commonly adopted ITIL v3 processes together with the purpose/benefit as per ITIL v4.

Management Practice	Purpose/Benefit
Availability management	To ensure that services deliver agreed levels of availability to meet the needs of customers and users
Capacity and performance management	To ensure that services achieve agreed and expected performance, satisfying current and future demand in a cost-effective way
Change control	To maximize the number of successful changes by ensuring that risks have been properly assessed through to managing the change schedule
Continual improvement	To align practices and services with changing business needs through the ongoing improvement of products, services, and practices
Deployment management	To move new or changed hardware, software, documentation, processes, or any other component to live environments
Incident management	To minimize the negative impact of incidents by restoring normal service operation as quickly as possible
Knowledge management	To maintain and improve the effective, efficient, and convenient use of information and knowledge across the organization
Monitoring and event management	To systematically observe services and service components as well as record and report selected changes of state identified as events
Portfolio management	To ensure that the organization has the right mix of programs, projects, products, and services to execute the organization's strategy
Problem management	To reduce the likelihood and impact of incidents by identifying causes of incidents as well as managing workarounds and known errors
Release management	To make new and changed services and features available for use
Service catalogue management	To provide a single source of consistent information on all services and service offerings and to ensure that it is available to the relevant audience
Service configuration management	To ensure that accurate and reliable information about the configuration of services, and the configuration items that support them, is available
Service desk	To capture demand for incident resolution and service requests. It should also be the entry point and single point of contact for users
Service financial management	To support the organization's strategies and plans for service management by ensuring that financial resources and investments are used effectively
Service level management	To set clear business-based targets for service levels and to ensure that delivery of services is properly monitored and managed against them
Service request management	To support the agreed quality of a service by handling all pre-defined, user-initiated service requests in an effective and user-friendly manner

NHS Fife

Meeting: Audit & Risk Committee

Meeting date: 16 September 2021

Title: NHS Fife Population Health & Wellbeing Strategy Progress

Responsible Executive: Margo McGurk, Director of Finance and Strategy

Report Author: Susan Fraser, Associate Director of Planning and Performance

1 Purpose

This is presented to the committee for

- Assurance

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This is a progress paper regarding the initial work to support the NHS Fife Population Health and Wellbeing Strategy and Portfolio (PHWP) Board. This will cover both Portfolio work together with the co-ordination of the emerging 5 year strategy.

2.2 Background

NHS Fife is a complex organisation operating in a complex environment with many programme and project-related activities. A portfolio approach will facilitate an efficient, centralised management of the organisation's resources and investment whilst ensuring consistent Fife-wide governance and control standards.

A PHWP Board is being established to deliver the strategic co-ordination of the emerging strategy. It will also enable senior leadership to successfully deliver the entire range of programmes, projects and other related activities across Fife on an ongoing basis.

2.3 Assessment

The following gives a brief overview of the current work being undertaken.

Portfolio Approach to Population Health and Wellbeing
This approach will align existing programmes of work alongside the development of the Population Health and Wellbeing Strategy as well as providing leadership to new prioritised programmes of work.

A PHWP Board is being established to provide leadership and oversight of the programmes across health. The Terms of Reference are being agreed after discussion at the Executive Directors' Group. The first meeting of this Board is planned for September.

Alignment of Strategy and Portfolio to Care Programmes
The PHWP will align the existing key programmes and projects to the 4 national Care Programmes: Integrated Unscheduled Care, Integrated Planned Care, Place and Wellbeing and Preventative and Proactive Care.

In addition, the Fife PHW Strategic Framework will be designed using the 4 national care and wellbeing programmes and strategic direction will focus on these areas. Existing programmes in Fife will be aligned to these 4 programmes.

Proposal for Strategy Development
A detailed Programme Plan is currently being drafted for the development and delivery of the 5 year Strategy.

Given the current COVID restrictions, it is proposed to engage with staff virtually to develop the strategic framework initially to gather the current service position. Once the information is gathered, analysed and themed, the group will convene to agree gaps and recommendations.

EQIA
The EQIA Stage 1 form has been completed and signed off with the agreement to move to Stage 2 of the EQIA. NHS Fife's Equality and Human Rights Lead will lead stage 2 with input from staff, patients and the public engagement network.

Communications and Engagement Proposal to aid strategy development.
To start and maintain the NHS Fife strategy development "conversation" with our internal and external stakeholders, the following communications support is proposed. This work would also underpin and complement the EQIA Stage 2.

Branding for strategic plan and associated engagement campaign
To provide a visual identity for the project, which creates an instantly recognisable visual reference for the programme. This branding would be used across all communications material and across all channels.

Citizens Survey or Poll
NHS Fife is committed to engage with as many citizens living in Fife as we can to help direct and shape our strategic planning.

Given the limitations presented by COVID and the tight timescales we are working to, an online survey or poll might be the most effective way of reaching out to as many citizens across Fife via individuals, community groups and our partners to gain their thoughts and feedback.

There are 3 key strands the survey / poll could explore, which are:

1. What matters to the people in Fife in terms of accessing health care?
2. Capturing their current (including pre-COVID) experience of using our services
3. Building on the lessons learned from COVID and the unique opportunity to capitalise on some of the new ways of working we introduced - e.g. Near Me video consultations, how do they see the future of health care delivery across the kingdom of Fife.

In tandem with this we would look to run an equivalent internal staff survey to complement our citizens survey.

2.3.1 Quality/ Patient Care

PHW Portfolio Board and Strategy are aligned with providing high quality and good patient care.

2.3.2 Workforce

PHW Portfolio Board and Strategy are aligned with workforce development and support

2.3.3 Financial

PHW Portfolio Board and Strategy are aligned with financial implications

2.3.4 Risk Assessment/Management

PHW Portfolio Board and Strategy are aligned to risk management.

2.3.5 Equality and Diversity, including health inequalities

PHW Portfolio Board and Strategy are aligned with equality and diversity. An EQIA is being developed, as detailed above.

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

PHW Portfolio Board and Strategy are aligned with engagement and consultation. Further information on the proposed communications strategy is given above.

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 Gold Command, 9 August 2021
- EDG Strategy meeting, 19 August 2021
- All Board Committee meetings during September 2021

2.4 Recommendation

- **Assurance–** Members are asked to note the establishment of the Population Health and Wellbeing Portfolio Board and progress of the development of the strategy.

Report Contact
Susan Fraser
Associate Director of Planning and Performance
25 August 2021

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**16 September 2021**
Title:	**Joint Remobilisation Plan 2021/22 (RMP3/RMP4)**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Report Author:	**Susan Fraser, Associate Director of Planning and Performance**

1 Purpose

This is presented to the Committee for:

- Assurance

This report relates to the:

- Joint Remobilisation Plan 2021/22 (RMP3/RMP4)

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

- Safe
- Effective
- Person Centred

2 Report Summary

2.1 Situation

The third Joint Remobilisation Plan (RMP3) for Health and Care services delivered by NHS Fife and Fife Health and Social Care Partnership (HSCP) for the period 2021/22 was submitted and approved by the Scottish Government (SG). An update, known as RMP4, was requested on 20th July 2021 to reflect on progress to date and set out what is expected to be delivered over the remainder of 2020/21.

2.2 Background

The Scottish Government letter dated 20th July 2021 titled *Remobilisation Plans 2021/22: Mid-Year Update (RMP4)* commissioned an update to plans set out in RMP3. RMP4 offers an opportunity to reflect on the impact of the pandemic on the delivery of services, specifically where this might have changed since the RMP3 was submitted including opportunity to revise activity templates.

SG have acknowledged that planning is an ongoing activity throughout the year, therefore a Delivery Planning Template is now required to be completed. This will form the basis of annual plans going forward and will include information on risks (and mitigation) and outcomes. This will include key deliverables identified within RMP3, as well as any additional key actions that have been identified since RMP3 was submitted, such as national projects/programmes that have launched or substantially developments in the last 6 months. Template will also include any actions relating to winter, as SG are not requesting a separate Winter Plan.

2.3 Assessment

RMP3 Action Tracker

An Action Tracker was created following approval from SG of RMP3 with regular 2-monthly updates being provided by services. The Fife Remobilisation Plan Forum was re-established to review and ensure the document is updated regularly. Reports to EDG, Committees and Board was by exception only.

New Templates

The RMP4 documentation included Delivery Planning Templates to be used in the submission of RMP4. Information already collated in the RMP3 Action Tracker has been transferred to Delivery Planning Template with service through the RMP Forum being asked to review, amend and provide additional content in accordance with the RMP4 guidance.

Progress

From previous updates, diagnostic pathway for Children and Young People within Primary/Community Care has been reinstated and activity in Adult Mental Health Day Hospitals has resumed. All other actions from RMP3 are currently in progress, on track or complete so there are no actions to be reported by exception.

Winter Actions

In relation to winter planning, during 2020/21 due to the COVD-19 emergency planning measures being in place, one meeting took place to review winter 2019/20 and plan for winter 2020/21. In 2021, a Winter Review event was held in April 2021. Learning from this event was considered in terms of performance, what went well, what went less well and the key planning priorities for the Winter of 2021/22.

These will be formalised into Winter Actions following the Winter Planning Event on 25th August and will be included in the Winter Planning/Whole System Actions within the RMP4 Delivery Planning Template.

2.3.1 Quality/ Patient Care

Quality of patient care and safety are at the heart of the Remobilisation Plan.

2.3.2 Workforce

Oversight to workforce implications during remobilisation have been considered and form part of the Strategic Planning and Resource Allocation process.

2.3.3 Financial

Oversight to financial implications during remobilisation have been considered and form part of the Strategic Planning and Resource Allocation process.

2.3.4 Risk Assessment/Management

Risk Assessment is contained within the Remobilisation Plan.

2.3.5 Equality and Diversity, including health inequalities

Remobilisation Plan included the appropriate equality and diversity impact assessment process as part of the restart process.

2.3.6 Other impact

N/A.

2.3.7 Communication, involvement, engagement and consultation

Appropriate communication, involvement, engagement and consultation within the organisation and with key external stakeholders is integral to the implementation of the Remobilisation Plan.

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.

- Remobilisation Plan Forum on 11th August.
- Integrated Capacity and Flow meeting on 11th August.
- EDG Strategy meeting, 19 August 2021
- All Board Committee meetings during September 2021

2.4 Recommendation

- **Assurance –** The Joint Remobilisation Plan 2021/22 RMP3 and process in place for production of the RMP4

3 List of appendices

The following appendices are included with this report:

Report Contact

Susan Fraser
Associate Director of Planning and Performance
Email: susan.fraser3@nhs.scot

AUDIT & RISK COMMITTEE

DATES FOR FUTURE MEETINGS

Date
18 May 2022
16 June 2022
15 September 2022
8 December 2022
16 March 2023

Please note that all meetings take place via **MS Teams** / in the **Staff Club** (TBC) and start at **2pm**

A pre-meeting of Non-Executive Members is routinely held, beginning at **1.30pm**

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