NHS Fife Audit & Risk Committee

Mon 05 December 2022, 14:00 - 16:15

MS Teams

Agenda

14:00 - 14:00
0 min

1. Apologies for Absence

Alastair Grant

14:00 - 14:00
0 min

2. Declaration of Members' Interests

Alastair Grant

14:00 - 14:00
0 min

3. Minutes of Previous Meeting held on Monday 12 September 2022

Enclosed *Alastair Grant*

Item 03 - Audit & Risk Committee Minutes (unconfirmed) 20220912.pdf (7 pages)

14:00 - 14:10
10 min

4. Matters Arising / Action List

Enclosed *Alastair Grant*

Item 04 - Audit & Risk Committee Action List 20221205.pdf (1 pages)

14:10 - 14:25
15 min

5. GOVERNANCE MATTERS

5.1. Losses & Special Payments

Enclosed *Kevin Booth*

Item 05.1 - SBAR Losses & Special Payments.pdf (3 pages)
Item 05.1 - Appendix 1 Summary of Losses and Special Payments.pdf (1 pages)

5.2. Proposal to Increase Procurement Tender Thresholds

Enclosed *Kevin Booth*

Item 05.2 - SBAR Proposal to Increase Procurement Tender Thresholds.pdf (4 pages)
Item 05.2 - Appendix 1 Code of Corporate Governance Extract Pages 61-62.pdf (2 pages)

14:25 - 15:15
50 min

6. RISK

6.1. Corporate Risk Register

Enclosed *Margo McGurk*

Item 06.1 - SBAR & Appendix 1 - Corporate Risk Register.pdf (7 pages)
Item 06.1 - Appendix 2 NHS Fife Corporate Risk Register.pdf (7 pages)
Item 06.1 - Appendix 3 Risk 13 - Deep Dive Delivery of a balanced in-year financial position.pdf (2 pages)

Item 06.1 - Appendix 4 Assurance Principles.pdf (1 pages)

6.2. Risk & Opportunities Group Terms of Reference and Progress Report

Enclosed *Pauline Anne Cumming*

Item 06.2 - SBAR Risks and Opportunities Group ToR and Progress Report final.pdf (5 pages)
Item 06.2 - Appendix 1 Risks and Opportunities Group ToR.pdf (3 pages)

6.3. Risk Management Key Performance Indicators Update

Verbal *Pauline Anne Cumming*

15:15 - 15:40
25 min

7. GOVERNANCE – INTERNAL AUDIT

7.1. Internal Audit Progress Report

Enclosed *Barry Hudson*

Item 07.1 - SBAR Internal Audit Progress Report.pdf (3 pages)
Item 07.1 - Appendix A Internal Audit Progress Report.pdf (4 pages)

7.2. Internal Audit – Follow Up Report on Audit Recommendations 2022/23

Enclosed *Barry Hudson*

Item 07.2 - SBAR & Appendices Internal Audit – Follow Up Report on Audit Recommendations 2022-23.pdf (18 pages)

7.3. Draft Internal Control Evaluation Report 2022/23

Enclosed *Barry Hudson*

Item 07.3 - SBAR Draft Internal Control Evaluation Report 2022-23.pdf (3 pages)
Item 07.3 - Appendix 1 Draft Internal Control Evaluation Report 2022-23.pdf (39 pages)

15:40 - 16:05
25 min

8. GOVERNANCE – EXTERNAL AUDIT

8.1. External Audit – Follow Up Report on Audit Recommendations

Enclosed *Kevin Booth*

Item 08.1 - SBAR External Audit – Follow Up Report on Audit Recommendations.pdf (6 pages)

8.2. External Audit Plan 2022/23 – AZETs

Enclosed / Presentation *Chris Brown*

Item 08.2 - NHS Fife External Audit Strategy 2022-23.pdf (19 pages)

16:05 - 16:10
5 min

9. FOR ASSURANCE

9.1. Audit Scotland Technical Bulletin 2022/3

Enclosed *Kevin Booth*

Item 09.1 - SBAR Audit Scotland Technical Bulletin 2022-3.pdf (3 pages)
Item 09.1 - Appendix 1 Audit Scotland Technical Bulletin 2022-3.pdf (32 pages)

9.2. Delivery of Annual Workplan 2022/23

Enclosed *Margo McGurk*

Item 09.2 - Delivery of Annual Workplan 2022-23.pdf (5 pages)

9.3. Proposed Annual Workplan 2023/24

Enclosed *Margo McGurk*

Item 09.3 - Proposed A&R Annual Workplan 2023-24.pdf (4 pages)

16:10 - 16:10
0 min

10. ESCALATION OF ISSUES TO NHS FIFE BOARD

10.1. Chair's comments on the Minutes / Any other matters for escalation to NHS Fife Board

Alastair Grant

16:10 - 16:15
5 min

11. ANY OTHER BUSINESS

16:15 - 16:15
0 min

12. DATE OF NEXT MEETING - WEDNESDAY 15 MARCH 2023 AT 2PM

MINUTE OF THE AUDIT & RISK COMMITTEE MEETING HELD ON MONDAY 12 SEPTEMBER 2022 AT 2PM VIA MS TEAMS

Present:
M Black, Non-Executive Member (Chair)
D Graham, Non-Executive Member
A Grant, Non-Executive Member
A Lawrie, Non-Executive Member
K MacDonald, Non-Executive Member

In Attendance:
K Booth, Head of Financial Services & Procurement
A Brown, Principal Auditor *(deputising for B Hudson)*
C Brown, External Auditor (Azets)
G Couser, Associate Director of Quality & Clinical Governance
P Cumming, Risk Manager
T Gaskin, Chief Internal Auditor
G MacIntosh, Head of Corporate Governance & Board Secretary
M McGurk, Director of Finance & Strategy
H Thomson, Board Committee Support Officer (Minutes)

Chair's Opening Remarks

The Chair welcomed everyone to the meeting.

A welcome was extended to C Brown, the Board's new External Auditor from Azets, who is attending his first meeting of the Audit & Risk Committee.

A welcome was also extended to Cllr David Graham, who has been re-appointed to the Audit & Risk Committee, and he was welcomed to his first meeting of his new term.

The Chair congratulated A Grant, who has been appointed as Chair of the Audit & Risk Committee with effect from 1 October 2022.

1. Apologies for Absence

Apologies were received from attendees B Hudson (Regional Audit Manager) and C Potter (Chief Executive).

2. Declaration of Members' Interests

There were no declarations of interest made by members.

3. Minute of the last Meeting held on 29 July 2022

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

4. Action List / Matters Arising

The Audit & Risk Committee **noted** the updates provided and the closed items on the Action List.

Action 1: National Risk Management System

The Risk Manager reported that an update was received from National Procurement via the Health Improvement Scotland Adverse Events Network, advising that a tendering process is underway with a view to procuring a Once for Scotland digital system. The system will include risk management and adverse events modules. The timeframe for the outcome of the tendering process is October 2022, with evaluation in November 2022 and the preferred supplier to be agreed in December 2022. All NHSS Boards will have the option to procure the preferred system or go forward on an individual basis.

The Chief Internal Auditor questioned why it was decided to link both the adverse events SAR system and the Datix Cloud IQ system. It was also questioned who defines the criteria and decides on the specification. The Risk Manager confirmed that the system will not be exclusive for adverse events, and that the notification received was via that route. It was advised the specification that was presented to the companies was not shared with the NHS Boards.

The Associate Director of Quality & Clinical Governance added that our preference is to procure a system that supports our ability to implement a quality management system, in which risk management, adverse events and other areas would be contained. The Associate Director of Quality & Clinical Governance, recommended waiting on the outcome of the tender process and, at that point, the Board can make an assessment and confirm whether the selected system meets our requirements.

The Chair questioned if the national risk management system will link in with systems used in Fife Council and the Health & Social Care Partnership, given that risks can sit across partners. The Associate Director of Quality & Clinical Governance advised that this can be raised during national discussions.

5. Introduction from Azets External Auditors

C Brown, External Auditor, delivered a short presentation as an introduction to Azets, who are now providing external audit services to the Board.

The Director of Finance & Strategy highlighted that Azets' values are closely aligned to the values within NHS Fife.

The presentation will be shared with the Committee.

Action: Board Committee Support Officer

6. GOVERNANCE MATTERS

6.1 Proposed Audit & Risk Committee Meeting Dates 2023/24

It was agreed to change the proposed June 2023 to a slightly later date that month, due to the likely timing of the Annual Accounts process. The Committee **approved** the proposed Committee meeting dates for 2023/24, subject to the amendment of the June 2023 date.

D Graham, Non-Executive Member, thanked the team for rescheduling the remaining 2022/23 meetings to accommodate his diary.

7. RISK

7.1 Board Assurance Framework (BAF)

The Risk Manager reported on the current position of the BAF, and advised that the BAF, in its current format, is coming to the Committee for the last time and this will be replaced by the new Corporate Risk Register going forward. The paper that will be presented to the next Committee meeting will outline the transition process and strategic risks proposed for inclusion in the Corporate Risk Register.

The Risk Manager highlighted that the risk in relation to the Integrated Joint Board has now been closed.

The Committee took **assurance** from the update on the BAF and from the approach to transitioning from the BAF to the new Corporate Risk Register.

7.2 Draft Corporate Risk Register & Dashboard

The Director of Finance & Strategy provided background information and advised that the new draft Corporate Risk Register, has been considered by all Governance Committees during September.

The Director of Finance & Strategy advised that the paper presents a new Strategic Risk Profile (annex 1), which will allow Governance Committees and the Board to be sighted on the overall risk profile of the organisation. It was reported the strategic level risks have been mapped across to our four key strategic priorities, and the risk appetite levels for each of the four key strategic priorities is also highlighted. It was noted the revised risk appetite was agreed by the Board recently. It was advised that detailed scrutiny and deep dive areas will be identified as the new process embeds.

The Director of Finance & Strategy advised that 18 strategic risks have been identified within the Corporate Risk Register, detailed at annex 2. It was noted that the 18 risks have been given an indicative risk level. It was advised that the risk mitigations are described at a high level.

It was reported that the Draft Corporate Risk Register had been presented to the Public Health & Wellbeing Committee, Staff Governance Committee and Clinical Governance Committee, with positive feedback received and further enhancements suggested. The Draft Corporate Risk Register will also be con the Finance, Performance & Resources Committee at the September meeting.

Feedback was requested from the Audit & Risk Committee on whether the 18 strategic risks identified are the key challenges and risks that the organisation is facing.

The External Auditor noted that articulating strategic risks and mitigating actions is a difficult task for all NHSS Health Boards, due to the various inherent risks associated with delivering healthcare. He also noted it can be difficult to distinguish between objectives within the organisation and the risks, and what are currently issues and the risks those issues present to the delivery of the objectives.

The External Auditor highlighted there are strengths in the current BAF, which distinguishes between current mitigation actions and action plans. He questioned if this would be carried forward to the new dashboard, and if future plans with actions would also be included. The Director of Finance & Strategy explained a presentation is being created of corporate risks that allows meaningful discussion, supported by more detailed information. It was advised there will be operational risk registers linked to the corporate risk register that will have significant levels of detail in terms of current and future plans. It was noted operational level risks can be escalated to strategic level, and vice versa, if required. In terms of mitigation planning, the Director of Finance & Strategy agreed to explore how this can be captured.

K MacDonald, Non-Executive Member, questioned where changes, improvements, outcomes and mitigations will be reflected. The Director of Finance & Strategy advised that currently there is risk level trend which will indicate how the risk profile has moved between the reporting period and previous period.

K MacDonald, Non-Executive Member, also questioned if there will be changes to some of the narrative within the Integrated Performance & Resources Committee. The Director of Finance & Strategy reported it is intended to clearly identify the connection and link between strategic level risks and performance, and that the presentation of this information requires further work.

The Associate Director of Quality & Clinical Governance advised that a Risk & Opportunities Group has been formed, with the first meeting scheduled for 14 September 2022. They will carry out detailed scrutiny and challenge the Corporate Risk Register before consideration at EDG and Committee level. The Group will also try and identify any new potential risks. The Committee will be provided with an update from the first meeting of the Group, along with a draft Terms of Reference for consideration and review.

K MacDonald, Non-Executive Member, questioned if staff identify risks which prevent them reaching objectives and goals, how will these risks be escalated through the governance process and through to the Corporate Risk Register, if appropriate. The Director of Finance & Strategy advised that through existing operational teams and senior leadership teams, these risks would be considered for the operational risk register, and depending on the severity, the Risk & Opportunities Group may request these risks are escalated to the Corporate Risk Register.

The Chair queried if there would be a Committee Development Session arranged for Committee members to receive training on the Corporate Risk Register. The Director of Finance & Strategy advised a Development Session would benefit members who could

have an overview of the Corporate Risk Register in practice and an oversight into the detail that will be retained, for assurance.

Action: Board Committee Support Officer

The Chair asked who would identify the deep dives into deteriorating risks. The Director of Finance & Strategy advised that the Executive Team carry out active risk management on a daily basis and would propose deep dives. It was noted that the Board has primary responsibility to review the information presented to them and instruct, as appropriate, deep dives into specific risks. The External Auditor highlighted that Governance Committees have responsibility for risks within their own areas. The Chief Internal Auditor agreed to share the Committee Assurance Principles with the External Auditor.

Action: Chief Internal Auditor

A Grant, Non-Executive Member, commended the improvements made in the revised format of the new Corporate Risk Register, welcoming its clarity.

The Committee took **assurance** from the work to date on developing the Corporate Risk Register and Dashboard reporting.

7.3 Risk Management Improvement Programme – Progress Report

The Risk Manager spoke to the report.

The Committee took **assurance** from this update on the Risk Management Improvement Programme.

8. GOVERNANCE – INTERNAL AUDIT

8.1 Internal Audit Progress Report 2021/22

The Principal Auditor advised that the progress report details activity on the internal audit plan, and it was noted Appendix A provides the status of all remaining reviews since June 2022. The Principal Auditor also advised that fieldwork is progressing on the 2022/23 plan.

The Committee took **assurance** from the progress on the delivery of the Internal Audit Plans.

8.2 Internal Audit – Follow Up Report on Audit Recommendations 2021/22

The Principal Auditor spoke to the paper.

The Committee took **assurance** of the current status of Internal Audit recommendations recorded within the Audit Follow-Up system.

8.3 Internal Audit Review of Property Transactions Report 2021/22

The Principal Auditor provided an overview on the audit opinion for the property transactions concluded in 2021/22, as detailed in the report. It was noted checklists

were provided to the Property Department and it is expected these checklists will be used to improve certain areas which have been raised previously regarding the timing of transaction sign-offs, and other minor areas.

The Committee took **assurance** from the report.

8.4 Internal Audit Service - External Quality Assessment (5 yearly)

The Chief Internal Auditor spoke to the paper and advised that NHS Fife scored well in the external quality assessment and that there were no major findings of concern. It was noted that internal assessments continue to be carried out.

The Committee noted the **assurance** provided within the FTF Self-Assessment.

8.5 Fife IJB Draft Internal Audit Joint Working and Reporting Protocol

The Chief Internal Auditor spoke to the paper and welcomed comments on the standard report format to be used for all IJB Internal Audit Reports.

The Board Secretary highlighted the difference in timelines between Fife Council and NHS Fife in terms of the Annual Accounts process, which can sometimes cause issues around the availability of information. The Chief Internal Auditor advised that steps have been taken to ensure information is received timeously for the following year.

The Committee **approved** the draft Internal Audit Joint Working and Reporting Protocol.

9 FOR ASSURANCE

9.1 Losses & Special Payments Quarter 1

The Head of Financial Services & Procurement advised that the number of losses and special payments were of a similar level in comparison to the previous 12 months. An increase in costs was reported and it was noted that this is in comparison to quarter 4 of the previous year, which was an outlier in terms of being historically low.

The Head of Financial Services & Procurement provided assurance and confirmed that a serious of local reviews are carried out for adverse events and follow both local and national guidance to ensure that learning is taken and this reduces the risk of the Board being exposed to similar future claims.

The Committee took **assurance** from the report.

9.2 Audit Scotland Technical Bulletin 2022/2

The Head of Financial Services & Procurement advised that the bulletins provides support to Auditors in the public sector, cover any ongoing technical accounting developments and provides information on any ongoing professional matters. It was advised that the current iteration of the Bulletin primarily focuses on annual account matters. The bulletin will be presented to this Committee on a quarterly basis.

The Committee took **assurance** from the Audit Scotland Technical Bulletin 2022/2.

9.3 Delivery of Annual Workplan

The Board Secretary presented the annual workplan, noting that the Risk Management Key Performance Indicators (KPIs) 2021/22 has been deferred until work on the risk management framework has concluded. The Risk Manager provided an update on this item and advised that it is proposed the Risk Management KPIs will be discussed through the Risk & Opportunities Group, with an update on the position to the next Audit & Risk Committee meeting in December 2022.

Action: Risk Manager

The Committee **approved** the tracked workplan.

10. ESCALATION OF ISSUES TO NHS FIFE BOARD

There were no issues to highlight to the Board.

11. ANY OTHER BUSINESS

11.1 Audit & Risk Committee Chair

The Director of Finance & Strategy, on behalf of the Chief Executive, the finance team and Committee members, warmly thanked M Black for all his support during his term as Chair of the Audit & Risk Committee, and he was wished well for the future.

Date of Next Meeting: Monday 5 December 2022 at 2pm via MS Teams

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

AUDIT & RISK COMMITTEE – ACTION LIST

Meeting Date: Monday 5 December 2022

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	TIMESCALE	COMMENTS / PROGRESS	RAG
1.	16/09/2021	**National Risk Management System**	Exploratory discussions are ongoing at a national level around procurement of risk management systems. Currently, the local preference is for Datix Cloud IQ. The outcome of national discussions is awaited.	**PC**	An update will be brought back to the Committee on developments as the business case is finalised.	17/03/22 - A business case is being developed in April 2022 for NHS Fife, and the preferred upgrade package is Datix Cloud IQ. A verbal update was provided at the September meeting.	In progress
2.	12/09/22	**Committee Assurance Principles**	To share the Committee Assurance Principles	**TG**	05/12/22	Closed. Circulated.	Closed
3.	12/09/22	**Risk Management KPIs**	To provide an update to the Committee at the December meeting.	**PC**	05/12/22	On agenda.	Closed
4.	12/09/22	**Committee Development Session**	To arrange a Committee Development Session.	**HT**	Date to be arranged	Session arranged for 13 February 2023.	Closed
5.	17/03/2022	**Committee Development Session Topics**	Members and attendees to suggest topics to be covered at a development session, twice a year, to delve deeper into topics relevant to the Committee's remit.	**All**	Dates of Development Sessions to be confirmed	Agreed topics: • Committee Assurance Principals • Corporate Risk Register Added to workplan.	Closed
6.	12/09/22	**Azets Presentation**	To share the presentation with the Committee.	**HT**	September 2022	Closed. Sent on 20/09/22.	Closed

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**5 December 2022**
Title:	**Losses and Special Payments**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Report Author:	**Kevin Booth, Head of Financial Services & Procurement**

1 Purpose

This is presented to the Committee for:

- Assurance

This report relates to a:

- National policy

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

- Effective

2 Report summary

2.1 Situation

This paper presents a summary of the Board's Losses and Special Payments covering quarter two (01/07/22 – 30/09/22).

2.2 Background

The Boards Losses and Special Payments are controlled by the Financial Services Department and are reported to the Scottish Government as part of the Annual Accounts process. As per section 16 of the Financial Operating Procedures, any potential losses or special payments are approved by the relevant Directorate/Department Head. The Loss, theft or damage paperwork is then provided to the Deputy Director of Finance for final approval.

The Losses and Special payments for the quarter are compiled into a report with a format and categories defined by the requirements of the Scottish Government. These categories include losses relating to fraud, damage to buildings/equipment, Debtors balances written off, damage/loss of equipment and stock, Vehicle accident and insurance excess payments and compensation payments covering financial losses suffered by patients amongst others. The report also quantifies both the clinical and non-clinical ex-gratia compensation

payments for any legal claims that are negotiated and settled on the Board's behalf by the Central Legal Office following consultation with the Director of Finance & Strategy.

2.3 Assessment

The attached appendix summarises the Boards losses and Special Payments for the period 01/07/22 – 30/09/22. The reports categorise the types of losses and special payments made in the period whilst also quantifying the number of cases of each and the total monetary value.

There were 178 Losses and Special Payments in the quarter which is a reduction in comparison to the previous 12-month figure of 816. The cost in the quarter was an increase in comparison to the first quarter of 2022/23 (£773,361 compared to £644,321). This increase was predominantly as a result of the increase in value of the clinical ex-gratia compensation payments (£714,448 up from £529,045) whilst the Non-Clinical ex-gratia compensation payments did reduce (£50,682 down from £99,008).

The Losses and Special Payments out-with the Clinical and Non-Clinical Legal settlements were significantly down in comparison to quarter 1 (£8,231 down from £16,268). This reduction is predominantly related to a reduction in the value of payments for financial loss suffered by patients, The quarter one position had been identified previously for being higher than anticipated and will remain under review in the following months .

The current position covering the first half of 2022/23 (399 payments for a total of £1,417,682) compares positively to the full year position reported to the Scottish Government during the 2021/22 Annual Accounts process.

2.3.1 Quality/ Patient Care

N/A

2.3.2 Workforce

The procedural guidance for staff to ensure appropriate treatment is stated in the Financial Operating Procedures.

2.3.3 Financial

The Losses and Special Payments require to be tightly controlled as they can have a material impact on the Boards financial position.

2.3.4 Risk Assessment/Management

The level of the Board's Losses and Special Payments are monitored to minimise any potential reoccurrence and future exposure to the Board.

2.3.5 Equality and Diversity, including health inequalities

The Board's treatment of its losses and special Payments is consistently applied and follows the Financial Operating Procedures where relevant to ensure equity of treatment.

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

The Boards quarterly Losses and Special Payments are compiled by the Treasury Team and are presented to the Head of Financial Services and Procurement ahead of the annual submission to the Scottish Government. The losses and Special Payments included in the report have been approved by the appropriate Directorate/Department Head or in the case of legal settlements have come through following agreement/notification by the Central Legal Office.

2.3.8 Route to the Meeting

This paper is brought to the members attention to give visibility of the Board's losses and special payments in the quarter to 30 September 2022.

2.4 Recommendation

- **Assurance**

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Summary of Losses and Special Payments 01/07/22 – 30/09/22

Report Contact
Kevin Booth
Head of Financial Services & Procurement
Email kevin.booth@nhs.scot

FIFE HEALTH BOARD

SUMMARY OF LOSSES AND SPECIAL PAYMENTS

ITEM NO.	CATEGORY	JUL-SEP'22		OCT'21 - SEP'22	
	Miscellaneous / Theft / Arson / Wilful Damage				
1	Cash			2	170
2	Stores/procurement				
3	Equipment	1	1050	2	1300
4	Contracts				
5	Payroll *Salary Overpayment Debtors Invoices*			15	11626
6	Buildings & Fixtures *Vandalism*	20	2688	96	9869
7	Other			3	36
	Fraud, Embezzlement & other irregularities (incl. attempted fraud)				
8	Cash				
9	Stores/procurement				
10	Equipment				
11	Contracts				
12	Payroll				
13	Other				
14	**Nugatory & Fruitless Payments**				
	Claims Abandoned:				
15	(a) Private Accommodation				
	(b) Other *Hardship Accounts / Insurance Excess / Debtors WO's*	129	1450	581	37751
	Stores Losses:				
16	Incidents of the Service :				
	- Fire				
	- Flood				
	- Accident				
17	Deterioration in Store				
18	Stocktaking Discrepancies				
19	Other Causes				
	Losses of Furniture & Equipment				
	and Bedding & Linen in circulation:				
20	Incidents of the Service :				
	- Fire				
	- Flood				
	- Accident *Loss / Damaged Equipment*	6	2017	26	9142
21	Disclosed at physical check				
22	Other Causes				
	Compensation Payments - legal obligation				
23	Clinical				
24	Non-clinical				
	Ex-gratia payments:				
25	Extra-contractual Payments				
26	Compensation Payments - ex-gratia - Clinical	9	714448	30	4172977
27	Compensation Payments - ex-gratia - Non Clinical	6	50682	26	321575
28	Compensation Payments - ex-gratia - Financial Loss	7	1026	31	14545
29	Other Payments				
	Damage to Buildings and Fixtures:				
30	Incidents of the Service :				
	- Fire				
	- Flood				
	- Accident *Vehicle Expenditure*			4	877
	- Other Causes				
31	**Extra-Statutory & Extra-regulationary Payments**				
32	**Gifts in cash or kind**				
33	**Other Losses**				
		178	773361	816	4579868

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**5 December 2022**
Title:	**Proposal to Increase Procurement Tender Thresholds**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Kevin Booth, Head of Financial Services & Procurement**

1 Purpose

This is presented to the Committee for:

- Decision

This report relates to a:

- Local policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The current tendering and quotation thresholds contained within the NHS Fife Financial Operating Procedures and Standing Financial Instructions are out of step with the other Scottish Health Boards and the Scottish Public Procurement Regulations as set out by the Procurement Reform (Scotland) Act 2014.

In addition, there is also a distinction of limits between capital equipment and other goods and services which is not reflective of the Scottish Public Procurement Regulations.

2.2 Background

When the Scottish Government Procurement Directorate developed the Procurement Journeys for the whole of the Public Sector in Scotland some years ago the Tendering Threshold was set at £50,000 to be compliant with Public Scotland Procurement Regulations.

The whole of the Public Sector in Scotland now uses this threshold therefore ensuring consistency across the sector and the supplier marketplace. The current threshold for Route 2 tendering in NHS Fife is £25,000, which is out of step and results in a required increased level of procurement activity, compared to other Boards and public sector organisations, before any contracts can be awarded in the £25,000 - £50,000 range.

2.3 Assessment

The NHS Fife Route 2 Tendering Threshold in the Financial Operating Procedures and the Standing Financial Instructions should be increased to £50,000 as per the Procurement Reform (Scotland) Act 2014, for both the procurement of equipment and other goods and services, removing the current distinction in commodity type. This will amend the limit currently used by Procurement staff and ensure consistency to the external marketplace for future procurement of all goods and services.

<u>The levels are proposed to be updated in the FOPs and SFIs as follows:</u>

£5,000 - £15,000

Quotes should be obtained from at least one supplier using the Quick Quote function on the Public Contracts Scotland Portal.

£15,001 - £49,999

Quotes should be obtained from at least three suitable suppliers using the Quick Quote Function on the Public Contracts Scotland Portal.

£50,000 – £138,759 (below GPA threshold)

Complete a full route two tendering process using Public Contracts Scotland Tender Portal.

£138,760 > (GPA threshold)

Complete a full route three tendering process using Public Contracts Scotland Tender Portal.

2.3.1 Quality/ Patient Care

None anticipated

2.3.2 Workforce

Revising the Route 2 Tendering Threshold should ensure that any future contracts between £25,000 and £50,000 are processed in a reduced timeframe, allowing Procurement staff to award contracts consistent to other boards.

2.3.3 Financial

The reduced timeframe to process any future contracts between £25,000 and £50,000 will ensure that any associated financial efficiencies can be more promptly realised without the need to commit to the additional time to follow the full route 2 tendering process.

2.3.4 Risk Assessment/Management

Any future contracts between £25,000 and £50,000 will be subject to the Route 1 requirement for a minimum of three suitable quick quotes to ensure a competitive process is undertaken.

2.3.5 Equality and Diversity, including health inequalities

N/A

2.3.6 Climate Emergency & Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

The associated benefits and risks of standardising the NHS Fife Tendering Thresholds was discussed between the Interim Head of Procurement and the Head of Financial Services & Procurement and was subsequently supported by the Deputy Director of Finance.

2.3.8 Route to the Meeting

This recommendation was endorsed by the Procurement Governance Board on 29/10/12 and thereafter by EDG members on 20/10/22 and the FP&R Committee on 15/11/22.

2.4 Recommendation

The Audit & Risk committee is asked to endorse the amendment to the current Tender Threshold limit and to recommend approval to the Board of the update to the Standing Financial Instructions as per the attached extract. The Code of Corporate Governance will be updated following Board approval.

3 List of appendices

The following appendices are included with this report:

- Code of Corporate Governance Extract Pages 61-62 (Standing Financial Instructions), showing tracked changes.

Report Contact
Kevin Booth
Head of Financial Services & Procurement
Email kevin.booth@nhs.scot

9.11 For all orders raised between ~~£2,500~~£5,000 and ~~£10,000~~£15,000 there is a requirement for the ordering officer to obtain ~~two~~at least one written quotation~~s~~. Orders over ~~£10,000~~£15,000 and up to ~~£25,000~~£49,999 should ensure 3 ~~tendered~~written quotes are received. Any orders above £50,000 are subject to the Board's tendering procedures.

In the following exceptional circumstances, except in cases where Public Sector Procurement Regulations must be adhered to, the Director of Finance and Chief Executive, as specified in the Scheme of Delegation, can approve the waiving of the above requirements. Where goods and services are supplied on this basis and the value exceeds ~~£2,500~~£50,000, a "Waiver of Competitive Tender~~/Quotation~~" may be granted by completing a ~~Single Source Justification~~Waiver of Competitive Tender F~~f~~orm for approval by the appropriate director and the Head of Procurement. ~~Where the purchase of equipment is valued in excess of £5,000 and where the purchase of other goods and services on this basis exceeds £10,000, the completed Single Source Justification~~ This F~~f~~orm shall be endorsed by the Director of Finance and Chief Executive and submitted to the Audit and Risk Committee.

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

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

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

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

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

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

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

The use of supplies within the Office of Government (OGC) framework agreements may negate the need for three competitive tenders. The use of this route must always be recorded. In all instances, Public Sector Procurement Regulations must be followed.

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

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

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

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

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

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

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

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

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**5 December 2022**
Title:	**Corporate Risk Register**
Responsible Executive:	**Margo McGurk - Director of Finance and Strategy**
Report Author:	**Pauline Cumming - Risk Manager**

1 Purpose

This is presented for:

- Assurance

This report relates to:

- Annual Operational Plan
- Government policy/directive
- Local policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This report is presented to the Committee to provide assurance on the management of corporate risks. The content reflects the new approach to presenting the Corporate Risk Register following the first cycle of reporting to the governance committees and Fife NHS in November 2022. Due to the timing of Committee meetings and reporting requirements, an earlier version of this paper was reported to the Board on 29 November 2022.

2.2 Background

A key component of the Board's commitment to refresh the NHS Fife Risk Management Framework was to replace the Board Assurance Framework (BAF) with a renewed Corporate Risk Register which aligns to our 4 strategic priorities, allows us to present the corporate risks in a way that facilitates effective and focused scrutiny, and reflects and is sensitive to the internal and external environment. To achieve this aim, each risk will be subject to regular review and scrutiny, including at the committees, to ensure:

• All relevant risks are identified
• Risks are clearly described in terms of risk description, cause and consequence
• Risks are scored appropriately
• Mitigating actions are clearly framed as to how they will address the risks

The Assurance Principles at Appendix 4 are intended to support the process; these replace the questions formerly included in the BAF SBAR.

The Corporate Risk Register content will be reviewed between each committee cycle, noting members' feedback. The Risks and Opportunities Group (ROG) will play a key role in supporting the development of the Corporate Risk Register. This will include monitoring and reviewing the risks, considering links to the Board's risk appetite, the strategic priorities, the operational risk profile, and providing critique, recommendations and assurance to EDG, committees and other stakeholders.

The ROG has met on two occasions, with the focus to date on developing its Terms of Reference (ToR), clarifying its role and building consensus on its remit.

The ROG will also develop and implement an approach to horizon scanning in the identification of emerging risks or opportunities, using frameworks to support this activity such as PESTLE (**P**olitical **Ec**onomic **S**ocial **T**echnological **L**egal and **E**nvironmental).

2.3 Assessment

Following Board approval of the Corporate Risk Register and the Strategic Risk Profile arrangements in September 2022, the EDG reviewed the risks on 20 October 2022. The Committee is asked to note the resultant updates as detailed below:

Alignment of Corporate Risks to Governance Committees

Risks should be aligned to the Committee where the subject matter is reported. This resulted in the following changes:

- Risk 6 - Whole System Capacity – moved from the Clinical Governance Committee (CGC) to the Finance, Performance & Resources (F,P&R) Committee
- Risk 7 - Access to Outpatient, Diagnostic and Treatment Services – moved from the CGC to the FPR Committee
- Risk 8 - Cancer Waiting Times – moved from the CGC to the FPR Committee
- Risk 10 - Primary Care Services – moved from the CGC to the Public Health & Wellbeing Committee (PHWB) Committee.

Risk Ownership

Risks which previously had two owners should be re-allocated to a single owner:

- Risk 5 - Optimal Clinical Outcomes - Risk owner confirmed as the Medical Director
- Risk 10 - Primary Care Services - Risk owner confirmed as the Director of Health & Social Care.

Alterations to Risk Levels and Ratings

There have been changes to several risk ratings to more accurately reflect the extent of delivery challenge, and in terms of risk targets, what might be realistically achieved in respect of risk reduction in the current financial year.

- Risk 7 - Access to outpatient, diagnostic and treatment services: Following EDG discussion and subsequently with the Director of Acute Services, target level increased from 4 to 12 respectively.
- Risk 13 - Delivery of a balanced in-year financial position: Current and target risk ratings increased from 15 and 8, to 16 and 12 respectively.
- Risk 14 - Delivery of recurring financial balance over the medium-term: Current and target risk ratings increased from 15 and 8, to 16 and 12 respectively.
- Risk 15 - Prioritisation & Management of Capital funding: Target risk rating increased from 6 to 8.
- Risk 17 - Cyber Resilience: Target risk rating increased from 6 to 12.

The Strategic Risk Profile and Risk Improvement Trajectory are provided at Appendix 1.
The Corporate Risk Register with Committee Alignment is provided at Appendix 2.

Assurance Reports to Governance Committees

During November 2002, each Governance Committee considered a report setting out the Strategic Risk Profile and the Corporate Risks aligned appropriate to that Committee.

An objective of the new approach to reporting, is to enhance members' understanding of the corporate risks in order to support scrutiny and assurance. One method of doing this, is to select and present risks for a "deep dive" review. A template to facilitate this process has been tested in the November committee reports. Members' feedback will be considered and acted upon as appropriate.

The following "deep dives" have been conducted to date:

- Risk 8 - Cancer Waiting Times to FPR and CGC, and for illustrative purposes to Staff Governance Committee
- Risk 13 - Delivery of a balanced in-year financial position to FPR
- Risk 4 - Policy Obligations in relation to environmental management and climate change to PHWC.

Risk 13 "deep dive" is provided for illustrative purposes at Appendix 3.

2.3.1 Quality/ Patient Care

Effective management of risks to quality and patient care will support delivery of our strategic priorities, to improve health and wellbeing and improve the quality of health and care services.

2.3.2 Workforce

Effective management of workforce risks will support delivery of our strategic priority to improve staff health and wellbeing, and the quality of health and care services.

2.3.3 Financial

Effective management of financial risks will support delivery of our strategic priority to deliver value and sustainability.

2.3.4 Risk Assessment/Management

As outlined in this report.

2.3.5 Equality and Diversity, including health inequalities and Anchor Institution ambitions

An Equality Impact Assessment (Stage 1) was carried out to identify if any items of significance need to be highlighted to the Board. The outcome of that assessment concluded on Option 1: No further action required.

2.3.6 Climate Emergency & Sustainability Impact

This paper does not raise, directly, issues relating to climate emergency and sustainability. These items do form elements of risk for NHS Fife to manage.

2.3.7 Communication, involvement, engagement and consultation

Communication and engagement on this report has taken place with a range of stakeholders across the organisation.

2.3.8 Route to the Meeting

2.3.9 Executive Directors' Group on 20/10/22
2.3.10 Clinical Governance Committee on 04/11/22
2.3.11 Public Health & Wellbeing Committee on 07/11/22
2.3.12 Staff Governance Committee on 10/11/22
2.3.13 Finance, Performance & Resources Committee on 15/11/22
2.3.14 Risks & Opportunities Group on 14/09/22 and 27/10/22
2.3.15 Fife NHS Board on 29/11/22

2.4 Recommendation

This paper is provided to the Committee for **Assurance**.

3 List of appendices

Appendix No. 1, Strategic Risk Profile and Risk Improvement Trajectory
Appendix No. 2, NHS Fife Corporate Risk Register at 25/11/22
Appendix No. 3, Deep Dive - Risk 13 Delivery of a balanced in-year financial position
Appendix No. 4, Assurance Principles

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Appendix 1

NHS Fife Strategic Risk Profile

Strategic Priority	Total Risks	Current Strategic Risk Profile				Risk Movement	Risk Appetite
To improve health and wellbeing	5	3	2	-	-	◀ ▶	High
To improve the quality of health and care services	5	5	-	-	-	◀ ▶	Moderate
To improve staff experience and wellbeing	2	2	-	-	-	◀ ▶	Moderate
To deliver value and sustainability	6	4	2	-	-	◀ ▶	Moderate
Total	**18**	**14**	**4**	**0**	**0**		

Summary Statement on Risk Profile
Current assessment indicates delivery against 3 of the 4 strategic priorities facing a risk profile in excess of risk appetite.

Mitigations in place to support management of risk over time with some risks requiring daily assessment.

Risk Improvement Trajectory for high risks and Corporate Risk Register assessment in place.

Risk Key

High Risk	15 - 25
Moderate Risk	8 - 12
Low Risk	4 - 6
Very Low Risk	1 - 3

Movement Key

▲ Improved - Risk Decreased
◀ ▶ No Change
▼ Deteriorated - Risk Increased

NHS Risk Improvement Trajectory

To improve health and wellbeing	Risk Improvement Trajectory			
Risk Level	**High**	**Mod**	**Low**	**Very Low**
Risks which have improved	-	-	-	-
Risks which have deteriorated	-	-	-	-
Risks which have not moved	3	2	-	-
Risks which have reached acceptable level of tolerance	-	-	-	-
Total	**3**	**2**	**0**	**0**

To improve the quality of health and care services	Risk Improvement Trajectory			
Risk Level	**High**	**Mod**	**Low**	**Very Low**
Risks which have improved	-	-	-	-
Risks which have deteriorated	-	-	-	-
Risks which have not moved	5	-	-	-
Risks which have reached acceptable level of tolerance	-	-	-	-
Total	**5**	**0**	**0**	**0**

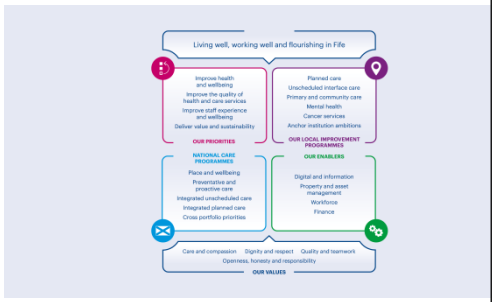
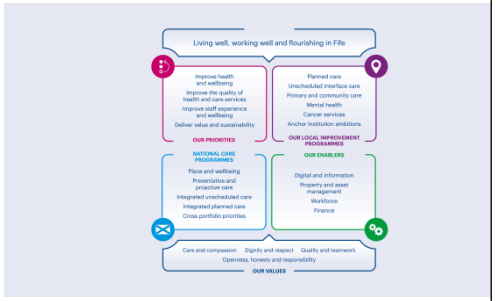
To improve staff health and wellbeing	Risk Improvement Trajectory			
Risk Level	**High**	**Mod**	**Low**	**Very Low**
Risks which have improved	-	-	-	-
Risks which have deteriorated	-	-	-	-
Risks which have not moved	2	-	-	-
Risks which have reached acceptable level of tolerance	-	-	-	-
Total	**2**	**0**	**0**	**0**

To deliver value and sustainability	Risk Improvement Trajectory			
Risk Level	**High**	**Mod**	**Low**	**Very Low**
Risks which have improved	-	-	-	-
Risks which have deteriorated	2	-	-	-
Risks which have not moved	2	2	-	-
Risks which have reached acceptable level of tolerance	-	-	-	-
Total	**4**	**2**	**0**	**0**

NHS Fife Corporate Risk Register as at 25/11/22

No	Strategic Priority	Risk	Mitigation	Risk Level/ Rating	Target Risk / Date 31/03/23	Risk Level Trend	Risk Owner	Primary Committee
1		**Population Health and Wellbeing Strategy** There is a risk that the ambitions and delivery of the new organisational Strategy do not deliver the most effective health and wellbeing and clinical services for the population of Fife.	EDG has established a Portfolio Board, reporting to the Public Health and Wellbeing Committee to deliver the required system leadership and executive support to enable effective strategy development. The Portfolio Board commissions and monitors the delivery of key milestone activity associated with the delivery of an effective new strategy.	Mod 12	Mod 8	◄►	Chief Executive	Public Health & Wellbeing
2		**Health Inequalities** There is a risk that if NHS Fife does not develop and implement an effective strategic approach to contribute to reducing health inequalities and their causes, health and wellbeing outcomes will continue to be poorer, and lives cut short in the most deprived areas of Fife compared to the least deprived areas, representing huge disparities in health and wellbeing between Fife communities.	Public Health and Wellbeing Committee established, with the aim of providing assurance that NHS Fife is fully engaged in supporting wider population health and wellbeing for the local population. Public health department and wider partners ongoing programme of work on reducing health inequalities relating to Public Health Priorities, Health Promotion, Vaccination, Screening, and Dental Public Health (ongoing). Leadership and partnership working to influence policies to 'undo' the causes of health inequalities in Fife.	High 20	Mod 10	◄►	Director of Public Health	Public Health & Wellbeing
3		**COVID 19 Pandemic** There is an ongoing risk to the health of the population, particularly the clinically vulnerable, the elderly and those living in care homes, that if we are unable to protect people through vaccination and other public health control measures to break the chain of transmission or to respond to a new variant, this will result in mild-to-moderate illness in the majority of	Delivery plans are being developed for the autumn/winter vaccination campaign. The proposed start date is early September 2022; some planning is pending JCVI decisions. Implementation of new treatments for individuals at higher risk of adverse outcomes.	High 16	Mod 12	◄►	Director of Public Health	Clinical Governance

		the population, but complications requiring hospital care and severe disease ,including death in a minority of the population.	Public communications programme to raise awareness of infection prevention and control measures across the region population cross the population.					
4		**Policy obligations in relation to environmental management and climate change** There is a risk that if we do not put in place robust management arrangements and the necessary resources, we will not meet the requirements of the 'Policy for NHS Scotland on the Global Climate Emergency and Sustainable Development, Nov 2021.'	Robust governance arrangements have been put in place including an Executive Lead and Board Champion appointed. Regional working group and representation on the National Board Active participation in Plan 4 Fife.	Mod 12	Mod 10	◄►	Director of Property & Asset Management	Public Health & Wellbeing
5		**Optimal Clinical Outcomes** There is a risk that recovering from the legacy impact of the ongoing pandemic, combined with the impact of the cost-of-living crisis on citizens, will increase the level of challenge in meeting the health and care needs of the population both in the immediate and medium-term.	The Board has agreed a suite of local improvement programmes, as detailed in the diagram below to frame and plan our approach to meeting the challenges associated with this risk. The governance arrangements supporting this work will inform the level of risk associated with delivering against these key programmes and reduce the level of risk over time. 	High 15	Mod 10	◄►	Medical Director	Clinical Governance

6		**Whole System Capacity** There is a risk that significant and sustained admission activity to acute services, combined with challenges in achieving timely discharge to downstream wards and/or provision of social care packages, that the management of Acute hospital capacity and flow will be severely compromised.	The combination of application of our OPEL process on a daily basis and the improvement work through our Integrated Unscheduled Integrated Care and Planned Care programmes provides the operational and strategic response to the challenges posed through this risk. 	High 20	Mod 9	◀▶	Director of Acute Services	Finance, Performance & Resources
7		**Access to outpatient, diagnostic and treatment services** There is a risk that due to demand exceeding capacity, compounded by COVID -19 related disruption and stepping down of some non-urgent services, NHS Fife will see a deterioration in achieving waiting time standards. This time delay could impact clinical outcomes for the population of Fife.	Recovery Plans developed outlining additional activity and resources required to reduce backlog and meet ongoing demand. Speciality level plans in place outlining local actions to mitigate the most significant areas of risk. The governance arrangements supporting this work will inform the level of risk associated with delivering against these key programmes and reduce the level of risk over time. 	High 16	Mod 12 ▼	◀▶	Director of Acute Services	Finance, Performance & Resources

8		**Cancer Waiting Times** There is a risk that due to increasing patient referrals and complex cancer pathways, NHS Fife will see further deterioration of Cancer Waiting Times (CWT) 62-day performance.	Effective Cancer Management Framework Action plan agreed both locally and by Scottish Government and actions identified. A national Short Life Working Group (SLWG) is being set up to develop a 'Once for Scotland' approach to management of breaches standard operating procedure. This will be led by the NHS Fife Cancer Transformation Manager (Chair of National Cancer Managers' Forum). The Cancer Framework and delivery plan is almost complete. Optimal Pathways and integrated care are included in the framework along with viewing CWT targets as a minimum standard. The governance arrangements supporting this work will inform the level of risk associated with delivering against these key programmes and reduce the level of risk over time.	High 15	Mod 12	◄►	Director of Acute Services	Finance, Performance & Resources
9		**Quality & Safety** There is a risk that if our governance, arrangements are ineffective, we may be unable to recognise a risk to the quality of services provided thereby being unable to provide adequate assurance and possible impact to the quality of care delivered to the population of Fife.	Effective governance is in place and operating through the clinical Governance Oversight Group (CGOG) providing the mechanism for assurance and escalation of clinical governance (CG) issues to Clinical Governance Committee(CGC). This is further supported by the Organisational Learning Group to ensure that learning is used to optimise patient safety, outcomes and experience, and to enhance staff wellbeing and job satisfaction. There are also effective systems & processes to ensure oversight and monitoring of national & local strategy / framework / policy /audit implementation	High 15	Mod 10	◄►	Medical Director	Clinical Governance

			and impact.					
10		**Primary Care Services** There is a risk that due to a combination of the demand on services, workforce availability and current funding and resourcing of Primary Care, it may not be possible to deliver sustainable quality services to the population of Fife into the medium-term.	A Primary Care Governance and Strategy Oversight Group has been established. The group brings together both the transformation and sustainability initiatives for all four of the independent primary care contractors, whilst also overseeing any critical aspects of governance. It is co-chaired by the Medical Director and the Director of Health and Social Care. The group will provide assurance to NHS Fife Board and the Integration Joint Board through the appropriate sub committees. The establishment of this group will allow governance and scrutiny of all aspects of primary care delivery and to provide a focus for improving patient care for the population of Fife.	High 16	Mod 8	◄►	Director of Health & Social Care	Public Health & Wellbeing
11		**Workforce Planning and Delivery** There is a risk that if we do not implement effective strategic and operational workforce planning, we will not deliver the capacity and capability required to effectively deliver services.	Development and implementation of the Workforce Strategy to support the Clinical Strategy, workforce elements of the Annual Delivery Plan, Population Health & Wellbeing Strategy and Strategic Framework; alongside the Workforce Plan for 2022 to 2025. Implementation of the Health & Social Care Workforce Strategy to support the Health & Social Care Strategic Plan for 2019 to 2022, the integration agenda and the development of the H&SCP Workforce Strategy and Workforce Plan for 2022 to 2025. Implementation of the NHS Fife Board Strategic and Corporate Objectives, particularly the “exemplar employer / employer of choice” and the associated values and behaviours and aligned to the ambitions of an anchor institution.	High 16	Mod 8	◄►	Director of Workforce	Staff Governance

12		**Staff Health and Wellbeing** There is a risk that if due to a limited workforce supply and system pressure, we are unable to maintain the health and wellbeing of our existing staff we will fail to retain and develop a skilled and sustainable workforce to deliver services now and in the future.	Working in partnership with staff side and professional organisations across all sectors of NHS Fife to ensure staff engagement opportunities are maximised. Scoping a Staff Experience and Engagement Framework that sets out our key ambitions and commitments for improving staff experience, which will help to develop a culture that values and supports our workforce.	High 16	Mod 8	◄►	Director of Workforce	Staff Governance
13		**Delivery of a balanced in-year financial position.** There is a risk that the Board may not achieve its statutory financial targets in 2022/23 due to the ongoing impact of the pandemic combined with the very challenging financial context both locally and nationally.	Financial Improvement and Sustainability Programme (FIS) board established to provide oversight to the delivery of Cost Improvements Plans and approve pipeline schemes to be taken to implementation.	High 16 ▼	Mod 12 ▼	◄►	Director of Finance & Strategy	Finance, Performance & Resources
14		**Delivery of recurring financial balance over the medium-term** There is a risk that NHS Fife will not deliver the financial improvement and sustainability programme actions required to ensure sustainable financial balance over the medium-term.	Strategic Planning and Resource Allocation process will continue to operate and support financial planning. The FIS Programme will focus on medium-term productive opportunities and cash releasing savings. The Board will maintain its focus on reaching the full National Resource Allocation (NRAC) allocation over the medium- term.	High 16 ▼	Mod 12 ▼	◄►	Director of Finance & Strategy	Finance, Performance & Resources
15		**Prioritisation & Management of Capital funding** There is a risk that lack of prioritisation and control around the utilisation of limited capital and staffing resources will affect our ability to deliver the PAMS and to support the developing Population Health and Wellbeing Strategy.	Infrastructure developments prioritised and funded through the NHS Board capital plan. Regular Property and Asset Management Strategy (PAMS) report submitted to FP&R, NHS Board and Government.	High 12	Mod 8 ▼	◄►	Director of Property & Asset Management	Finance, Performance & Resources

16		**Off-Site Area Sterilisation and Disinfection Unit Service** There is a risk that by continuing to use a single off-site service Area Sterilisation Disinfection Unit (ASDU), our ability to control the supply and standard of equipment required to deliver a safe and effective service will deteriorate.	Monitoring and review through Decontamination Group. Establishment of local SSD for robotic being planned.	Mod 12	Low 6	◄►	Director of Property & Asset Management	Clinical Governance
17		**Cyber Resilience** There is a risk that NHS Fife will be overcome by a targeted and sustained cyber attack that may impact the availability and / or integrity of digital and information required to operate a full health service.	Considerable focus continues in 2022 with heightened threat level to improve our resilience to attack and ability to recover quickly.	High 16	Mod 12 ▼	◄►	Medical Director	Clinical Governance
18		**Digital & 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 current operational lifecycle commitment to enable transformation across Health and Social Care.	Consistent alignment of the D&I Strategy with the NHS Fife Corporate Objectives and developing Health & Wellbeing Strategy. Digital & Information Board Governance established and supporting prioritisation with ongoing review.	High 15	Mod 10	◄►	Medical Director	Clinical Governance

Risk Movement Key

▲ Improved - Risk Decreased
◄► No Change
▼ Deteriorated - Risk Increased

Appendix 3

Risk 13- Deep Dive Delivery of a balanced in-year financial position

Corporate Risk Title	**Delivery of a balanced in-year financial position.**		
Strategic Priority	**To deliver value and sustainability**		
Risk Description	There is a risk that the Board may not achieve its statutory financial targets in 2022/23 due to the ongoing impact of the pandemic combined with the very challenging financial context both locally and nationally.		
Root Cause	Uncertainty of both expenditure levels and funding allocations to support Covid related expenditure. Ongoing legacy impact of Covid driving high activity levels across all services. Flow within the acute hospital and out to HSCP impacted by high levels of staff absence, ward and care home closures and service provision levels in care at home. Impact of UK budget on Scottish Government funding levels leading to reductions in a range of in-year funding allocations. Impact of cost-of-living crisis, rising inflation and energy costs on all areas of spend. Potential further impact likely in relation to the ongoing national pay negotiations. Challenges with staff absence driving high locum, bank and agency costs is impacting on the deliverability of a number of FIS schemes.		
Current Risk Level	**16**	**Likelihood 4**	**Consequence 4**
Target Risk Level (in year delivery)	**12**	**Likelihood 3**	**Consequence 4**

Management Actions (current)	
Action	**Status**
Consideration of potential revenue to capital cost reclassification.	**Significant level of delivery challenge**
Review of SLA costs with a view to reduce and/or redirect costs in year.	**Significant level of delivery challenge**
Reviewing opportunities to reduce direct and indirect Covid spend.	**At Risk**
Report on and agree recommendations arising from the Mid-year financial review.	**Significant level of delivery challenge**
Deliver on all aspects of the FIS programme.	**Significant level of delivery challenge**
Management Actions (future)	
Action	**Status**
Create pipeline for additional and or replacement FIS schemes.	**Significant level of delivery challenge**
Escalate system wide solution to acute hospital surge activity costs.	**Significant level of delivery challenge**

Action Status Key
Completed
On track
Significant level of delivery challenge
At risk of non delivery
Not started

Assurance Principles

Risk Assurance Principles:

Board

- Ensuring efficient, effective and accountable governance

Standing Committees of the Board

- Detailed scrutiny
- Providing assurance to Board
- Escalating key issues to the Board

Committee Agenda

- Agenda items should relate to risk (where relevant)

Seek Assurance on Effectiveness of Risk Mitigation

- Relevance
- Proportionality
- Reliable
- Sufficient

Chairs Assurance Report

- Consider issues for disclosure
- Emergent risks or – Escalation / Recording
- Scrutiny of risk delegated to Committee

Year End Report

- Highlight change in movement of risks aligned to the committee, including areas where there is no change
- Conclude on assurance of mitigation of risks
- Consider relevant reports for the workplan in the year ahead related to risks and concerns

GENERAL QUESTIONS:

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

SPECIFIC QUESTIONS WHEN ANALYSING A RISK DELEGATED TO THE COMMITTEE IN DETAIL:

- History of the risk (when was risk opened); has it moved towards target at any point?
- Is there a valid reason given for the current score?
- Is the target score:
  - In line with the organisation's defined risk appetite?
  - Realistic/achievable or does the risk require to be tolerated at a higher level?
  - Sensible/worthwhile?
- Is there an appropriate split between:
  - Controls – processes already in place which take the score down from its initial/inherent position to where it is now?
  - Actions – planned initiatives which should take it from its current to target?
  - Assurances - which monitor the application of controls/actions?
- Assessing Controls
  - Are they 'Key' i.e. are they what actually reduces the risk to its current level (not an extensive list of processes which happen but don't actually have any substantive impact)?
  - Overall, do the controls look as if they are applying the level of risk mitigation stated?
  - Is their adequacy assessed by the risk owner? If so, is it reasonable based on the evidence provided?
- Assessing Actions – as controls but accepting that there is necessarily more uncertainty :
  - Are they are on track to be delivered?
  - Are the actions achievable or does the necessary investment outweigh the benefit of reducing the risk?
  - Are they likely to be sufficient to bring the risk down to the target score?
- Assess Assurances:
  - Do they actually relate to the listed controls and actions (surprisingly often they don't)?
  - Do they provide relevant, reliable and sufficient evidence either individually or in composite?
  - Do the assurance sources listed actually provide a conclusion on whether:
    - the control is working
    - action is being implemented
    - the risk is being mitigated effectively overall (e.g. performance reports look at the overall objective which is separate from assurances over individual controls) and is on course to achieve the target level
  - What level of assurance can be given or can be concluded and how does this compare to the required level of defence (commensurate with the nature or scale of the risk):
    - 1st line – management / performance / data trends?
    - 2nd line – oversight / compliance / audits?
    - 3rd line – internal audit and/or external audit reports / external assessments?

LEVEL OF ASSURANCE

Substantial Assurance	Adequate Assurance	Limited Assurance
Controls are applied continuously with minor lapse	Controls are applied with some lapses	Significant breakdown in the application of controls

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**5 December 2022**
Title:	**Risks and Opportunities Group: Terms of Reference and Progress Report**
Responsible Executive:	**Margo McGurk - Director of Finance and Strategy**
Report Author:	**Pauline Cumming - Risk Manager** **Alistair Graham - Associate Director of Digital & Information**

1 Purpose

This is presented to the Committee for:

- Assurance

This report relates to:

- Local Policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

Following the commitment by NHS Fife's Board, in March 2022, to a risk management improvement programme, several initiatives have been progressed and completed to provide the mechanics for an effective and refreshed risk management framework within NHS Fife.

One of these initiatives was the establishment and operation of a Risks and Opportunities Group (ROG).

The Executive Directors' Group (EDG) considered an earlier version of this paper on 17 November 2022.

2.2 Background

NHS Fife is committed to a period of refreshing its Risk Management Framework, with a comprehensive plan to develop and implement the following items. (These items have either been developed or are in development).

- Update of the Annual Risk Appetite Statement
- A Board Strategic Risk Profile
- A Corporate Risk Register to replace the current Board Assurance Framework
- Risk dashboard to complement the new Integrated Performance and Quality Report and to support performance management
- An updated process to support the escalation, oversight, and governance of risks
- A Risks and Opportunities Group

The ROG has been established and met on two occasions in September and October 2022, developing their role and building consensus on their remit. The Group has considered its Terms of Reference (ToR), at both meetings, and the final version, following EDG review, is included at Appendix 1.

Consideration has been given to the ROG membership and its support to the revised Corporate Risk Register process. The Group remain aware of the need to balance supportive action with critique and assurance reporting.

The following section outlines the work of the Group so far.

2.3 Assessment

Terms of Reference

A facilitated discussion was held to consider the Group ToR. The questions considered allowed members to outline, their definition of:-

- Effectiveness
- Good Practice
- Enablers and
- Responsibilities and Reporting

The ToR were updated to provide opportunity for the Group to make recommendations to EDG and Governance Committees, contribute to and develop organisational support for effective risk management practice, reduce duplication of risk management effort, embed the application of assurance principles and enhance our collective knowledge and understanding to capitalise on opportunities.

EDG reviewed the ToR on 17 November 2022 and advised on a number of required changes which have been incorporated in the revised version.

Corporate Risk Register and Dashboard

The Corporate Risk Register (Appendix 2) and associated reports were presented to the ROG for consideration and comment. The presentation of the Corporate Risk Register included the Risk Appetite Statement and provided a focus for discussion at the October meeting. Members noted the alignment to the Governance Committees, the confirmation of Risk Owners and in some cases, alteration to more realistic in-year Target Risk ratings.

Given the alignment of the Corporate Risk Register to the developing Population Health and Wellbeing Strategy, the Group made arrangements for a presentation of the strategy work at their next meeting.

Supporting Good Practice

The ROG have shared elements of good or developing practice with regards to managing risk. Presentations on the Digital and Information Team's approach to risk management were provided and other examples of strong practice will be considered for awareness and learning. The element of "deep dive" into core components of risk identification and management was noted in the review of Assurance Committee Reports.

Assurance Reports to Governance Committees

At their second meeting, the ROG reviewed the presentation of Corporate Risk reporting templates and specifically the report to the Finance, Performance and Resources Committee. The Group noted that "deep dives" had been conducted for:-

- Cancer Waiting Times (Risk 8)
- Delivery of a balanced in-year financial position (Risk 13)

The Group also noted that a "deep dive" had been conducted for the Public Health and Wellbeing Committee on:-

- Policy Obligations in relation to environmental management and climate change (Risk 4)

While the Group look forward to hearing feedback from the governance committees, they also discussed possible improvements to the reports. These included the need for intended actions to be clear on the impact to the risk rating when complete, and assurance that the action is clearly described to support confidence that the mitigation will support the reduction, or as a minimum, the maintenance of the risk profile.

The Group recognised how the Corporate Risks would, by their nature, be more sensitive to external factors and these could be included in the risk descriptions section.

Horizon Scanning

The ROG will develop and implement an approach to horizon scanning activity in the identification of emerging risks or factors. The Group will consider frameworks to support this activity such as **PESTLE** (**P**olitical **Ec**onomic **S**ocial **T**echnological **L**egal and **E**nvironmental), which is currently being used within work being undertaken by the Operational Workforce Planning Group.

Future Developments

While the early work of the ROG has focussed on establishment of the ToR and the review of the Corporate Risk Register, members have also discussed their role in supporting the management of operational risks and the alignment to Key Performance Indicators (KPI) in providing a mechanism for services to promptly review and update their current risks. The ROG will consider the current suite of KPIs at its next meeting and identify areas for development in support of the refreshed framework.

The ROG will also develop a work plan to align with its commitments to risk reporting to the governance committees.

2.3.1 Quality/ Patient Care

Effective management of risks to quality and patient care will support delivery of our strategic priorities, to improve health and wellbeing and the quality of health and care services.

2.3.2 Workforce

Effective management of workforce risks will support delivery of our strategic priorities, to improve staff health and wellbeing, and the quality of health and care services.

2.3.3 Financial

Effective management of financial risks will support delivery of our strategic priorities including delivering value and sustainability.

2.3.4 Risk Assessment/Management

As outlined in this report.

2.3.5 Equality and Diversity, including health inequalities and Anchor Institution ambitions

An Equality Impact Assessment (Stage 1) has been completed to identify if any items of significance that need to be highlighted to the Committee. The outcome of that assessment concluded on Option 1: No further action required.

2.3.6 Climate Emergency & Sustainability Impact

This paper does not raise, directly, issues relating to climate emergency and sustainability. These items do form elements of risk for NHS Fife to manage.

2.3.7 Communication, involvement, engagement and consultation

Communication and engagement on this issue has included: -

- The ROG meetings
- Review of existing work on items relating to the revised risk management framework

2.3.8 Route to the Meeting

EDG on 17 November 2022

2.4 Recommendation

The Committee is asked to **take assurance from** the activities outlined within the paper.

3 List of appendices

Appendix No. 1, Risks and Opportunities Group Terms of Reference (Final)

Appendix No. 2, Corporate Risk Register as at 25 November 2022: **please see 'Item 6.1, Appendix 2 Corporate Risk Register' within the Boardbook/AdminControl.**

Report Contacts
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Risk Manager
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Alistair Graham
Associate Director of Digital and Information
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Appendix 1

NHS FIFE
RISKS AND OPPORTUNITIES GROUP
TERMS OF REFERENCE
2022/ 2023

1. Purpose

The Group has been delegated responsibility by the Executive Directors' Group (EDG) to progress the activities described in this document and to prepare regular formal reports on progress and seek approval for proposals from the Group.

The purpose of the Risks and Opportunities Group (ROG) is to support and embed an effective risk management framework and culture through:

- Promoting leadership to ensure the organisation gives risk management the appropriate priority;
- Contributing to the development and implementation of the risk management framework to ensure processes are in place and operating effectively to identify, manage, and monitor risks across the organisation;
- Identifying risks and opportunities to the strategic objectives of the organisation and escalating to the EDG as appropriate;
- Assessing risks, opportunities, issues and events that arise and responding accordingly;
- Horizon scanning for future opportunities, threats and risks linked to the delivery of NHS Fife's strategic priorities;
- Considering the external environment for review of risks and opportunities in the context of national directives;
- Ensuring continuous improvement of the organisation's control environment;
- Creating a collective and enabling approach to risk controls and actions

2. Composition

2.1 Core membership who attend all meetings and provide consistent direction for the agenda and work plan is as follows:

Assistant Director Research, Innovation and Knowledge
Associate Director of Allied Health Professionals (AHPs)
Associate Director of Communications
Associate Director Digital and Information (co-chair)
Associate Director for Planning and Performance
Associate Director of Quality and Clinical Governance (co-chair)
Associate Nurse Director, Corporate Services
Deputy Director of Finance

Deputy Director of Pharmacy and Medicine
Deputy Director of Workforce
Deputy Medical Director
Estates Manager, Compliance
General Manager, Acute Services Division
Head of Corporate Governance and Board Secretary
Healthcare Public Health Consultant
HSCP Representative
Partnership Representative
Risk Manager

2.2 A member of the Internal Audit team will be **in attendance** at meetings.
2.3 Other colleagues may be invited to attend meetings to contribute to particular topics as required.
2.4 In the event of a member being unable to attend, he/she should identify a deputy to attend on their behalf.
2.5 Members of the group commit to role modelling positive attitudes and behaviours which align to NHS Fife's organisational values.

3. Role and Remit

3.1 The role and remit of the ROG is to:

a) Maintain an overview of the corporate risk register.
b) Assess the corporate risk register using knowledge and understanding from members' respective areas of responsibility and assist the Executive Directors' Group (EDG) and the governance committees with recommendations (by way of a regular exception report) in relation to:

- The risk levels including target, and corresponding risk appetite level
- Adequacy of controls (stabilising risk) and actions (current and future to reduce risk)
- Specific timescales for impact of risks and ensuring that actions and corresponding timescales for delivery are appropriate
- Identifying risks which require a more detailed assessment to ensure improvement is delivered
- Horizon scanning of risks and opportunities which may impact the risk profile
- Providing assurance that the corporate risk register reflects and aligns to the strategic priorities and in year corporate objectives.
- Assessment of immediate, mid and long term risks in terms of proximity

c) Ensure a prioritised programme of work which responds to the corporate risk register and connects to the Integrated Performance & Quality Report

(IPQR) deliverables, the Strategic Planning Resource Allocation (SPRA), and the Annual Delivery Plan (ADP) with a view to reducing the risk exposure.

d) Maintain oversight of the operational risk profile
e) Monitor risk performance through the implementation of key performance indicators
f) Identify operational risks for escalation
g) Develop a work plan which effectively embeds the NHS Fife Risk Management Framework. This will be submitted to EDG and to the Audit and Risk Committee (ARC).
h) Provide leadership across respective areas of responsibility to promote, support and embed an effective risk management culture.

i) Contribute to and monitor the development of organisational support to ensure effective risk management practice through:
   - delivery of targeted education and training; and
   - regular communications on developments in policy and process

4. Meetings and Reporting Arrangements

4.1 Meetings will be held bi-monthly.
4.2 The group will be quorate when at least one of the co-chairs plus at least 8 other members are present.
4.3 The ROG will report to EDG bi- monthly.
4.4 The ROG will provide an exception report bi - monthly to the governance committees including the ARC.
4.5 Individual members will report into respective local governance groups to ensure a focus on effective risk management arrangements. These groups include: e.g. Clinical Governance Oversight Group (CGOG), Senior Leadership Teams (SLTs), Public Health Assurance Committee (PHAC)

5. Review

5.1 These terms of reference will be reviewed on an annual basis.

29 November 2022

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**5 December 2022**
Title:	**Internal Audit Progress Report**
Responsible Executive/Non-Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Barry Hudson – Regional Audit Manager**

1 Purpose

This is presented to the Committee for:

- Assurance
- Discussion

This report relates to a:

- Local policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this report is to:

- Provide the Audit and Risk Committee with assurance on the one remaining review from the 2021/22 Internal Audit Plan and the progress of the 2022/23 plan.

2.2 Background

The Internal Audit year runs from May to April. The Internal Audit team is progressing the 2022/23 Annual Internal Audit Plan under the supervision of the Chief Internal Auditor. Audit work completed allows the Chief Internal Auditor to provide the necessary assurances prior to the signing of the annual accounts.

The work of Internal Audit and the assurances provided by the Chief Internal Auditor in relation to internal control are key assurance sources taken into account when the Chief Executive undertakes the annual review of internal controls, and forms part of the consideration of the Audit and Risk Committee and the Board prior to finalising the Governance Statement which is included and published in the Board's Annual Accounts.

2.3 Assessment

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

Appendix A shows:

- Finalised Internal Audit Reports
- Internal Audit Reports issued in draft at the time of submission of papers for the Audit and Risk Committee
- Internal Audit Work in Progress and Planned
- Summary of Internal Audit Findings in Final Internal Audit Reports issued since the last Audit and Risk Committee
- Internal Audit Performance against Service Specification Key Performance Indicators.

2.3.1 Quality/ Patient Care

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

2.3.2 Workforce

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

2.3.3 Financial

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

2.3.4 Risk Assessment/Management

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

2.3.5 Equality and Diversity, including health inequalities

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

2.3.6 Other impacts

N/A

2.3.7 Communication, involvement, engagement and consultation

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

2.3.8 Route to the Meeting

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

2.4 Recommendation

The Audit and Risk Committee is asked to:

- **Discuss** and **note** the progress on the delivery of the Internal Audit Plans

3 List of appendices

The following appendices are included with this report:

- Appendix A – Internal Audit Progress Report

Internal Audit Progress Report

Introduction

This report presents the progress of internal audit activity up to 24 November 2022.

Internal Audit Activity

NHS Fife Completed Audit Work

The following audit products, with the audit opinion shown, have been issued since the last Audit and Risk Committee meeting on 12 September 2022. Each review completed has been categorised within one of the five strands of corporate governance. A summary of each report is included for information within the 'Summary of Audit findings' section.

Audit 2022/23	Opinion on Assurance	Recommendations	Draft issued	Finalised
Corporate Governance				
B08/23 – Internal Control Evaluation (ICE)	N/A	11 Recommendations	24 November 2022	To be considered at 5 December meeting with final version to March 2023 meeting.
B09/23 – Audit Follow Up	N/A	N/A	N/A	Report provided to each Audit and Risk Committee and a year-end summary will be presented to May 2023 Audit and Risk Committee.

NHS Fife Draft Reports Issued

	Draft issued
B13/22 Strategic Planning	2 December 2022
B18/23 Workforce Planning	2 December 2022

Fife IJB Draft Reports Issued

	Draft issued
F05-22 Strategic Plan	2 December 2022
F06-22 Clinical and Care Governance	2 December 2022

NHS Fife Work in Progress and Planned:

Audit 2022/23		Status	Target Audit and Risk Committee
B10/23	Attendance at meetings/ Ad-hoc Advice provided by Chief Internal Auditor, Audit Manager and Principal Auditors	WIP	A year-end summary will be presented to May 2023 Audit and Risk Committee.
B11/23	Assurance Framework	Planned	May 2023
B12/23	Risk Management[1]	Planned	TBC
B13/23	Resilience and Business Continuity	Planned	May 2023
B15/23	Operational Service Planning – Delayed Discharges	Planned	May 2023
B16/23	Health and Social Care Integration	WIP	Contribution to deliver Fife IJB audit plans. IJB reports will be shared with the NHSF Audit and Risk Committee.
B17/23	Medicines Management	Planned	March 2023
B19/23	Whistleblowing	WIP	March 2023 (Previously 8 December 2022)[2]
B21/23	Financial Process Compliance	WIP	March 2023

B22/23	Patients Funds	WIP	March 2023

[1] Internal Audit attend the Risk Opportunities Group and are providing advice and feedback as the Risk Management Framework evolves.

[2] Target Audit and Risk Committee date extended – staff member has been off work for approximately a 6 week period and has recently returned to work.

Summary of Audit Findings

This section provides a summary of the findings of internal audit reviews concluded since the previous Audit and Risk Committee meeting of March 2022 where a progress report was considered.

1. B08-23 – Internal Control Evaluation (ICE)

See separate agenda item 7.3

2. B09-23 Audit Follow Up

See separate agenda item 7.2

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**5 December 2022**
Title:	**Internal Audit – Follow Up Report on Audit Recommendations 2022/23**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Report Author:	**Barry Hudson, Regional Audit Manager/ Andy Brown, Principal Auditor**

1 Purpose

This is presented to the Committee for:

- Assurance
- Discussion

This report relates to the:

- Audit Follow up Protocol

This aligns to the following NHSScotland quality ambition:

- Effective

2 Report summary

2.1 Situation

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

2.2 Background

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

External Audit recommendations will continue to be followed up through NHS Fife Finance Directorate and Internal Audit will continue to review progress against External Audit recommendations where relevant to internal audit fieldwork.

Internal Audit will validate the evidence supplied by responding officers for actions they are declaring as completed to confirm that those actions address the recommendations made.

This report now includes progress regarding recommendations from our Internal Control Evaluation (ICE) and Annual reports.

2.3 Assessment

We include reports which have actions with a status of Extended, Outstanding or Not Yet Due. Reports with all actions either completed and validated or superseded are not included. This is to promote focus on addressing the remaining recommendations.

The table below shows the status of all remaining internal audit recommendations, other than ICE and Annual Report recommendations, as at 22 November 2022, with comparable figures from the last Audit Follow-Up (AFU) report as at 31 August 2022.

	November 2022	**August 2022**
Remaining Recommendations	**38**	**48**
Extended with revised dates (agreed by Responding Officer) *(Appendix C)*	8	30
Outstanding – Date passed *(Appendix D)*	23[1]	0
Not yet due	2	18

[1] **These actions are categorised as outstanding due to the date of producing this report, with most of these recommendations being due for completion by 31 October 2022. Engagement with officers for updates has been undertaken, but for the majority there has not sufficient time for Internal Audit to obtain evidence and validate or agree an appropriate extension. We would expect that for the next update report to the Audit and Risk Committee that these outstanding recommendations will either be extended or completed. The role of the EDG around scrutinising these outstanding recommendations will help to ensure the level of remaining recommendations continues to reduce.**

The table below shows the status of all remaining ICE and Annual Report recommendations, as at 22 November 2022. This is the first time we have reported on these recommendations so comparable figures from the previous Audit Follow-Up (AFU) will be included in our next report.

	November 2022	**-**
Remaining Recommendations	**5**	**-**
Extended with revised dates (agreed by Responding Officer) *(Appendix C)*	5	-
Outstanding – Date passed *(Appendix D)*	0	-
Not yet due	0	-

Progress summary

The following reports, featured in our September 2022 report, but have either been completed and validated or superseded by recommendations in more recent reports:

Report	Remaining Actions Status
B18/22 Procurement Governance Board	All actions completed and validated.
B17/20 Organisational Performance Management	All actions either completed and validated or superseded.

The role of Internal Audit in the follow-up process is to maintain a record of responses received by management and to assess and validate responses. Appendix F records where we have concluded evidence provided was insufficient to allow us to validate that action as complete, and where further information has been requested.

We have assessed progress to date for responses in relation to those remaining recommendations with extended target implementation dates and a RAG status is included to aid prioritisation.

Where no appropriate or sufficient response is received from the responsible officer we liaise with the Director of Finance and Strategy and the Board Secretary to escalate.

2.3.1 Quality/ Patient Care

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

2.3.2 Workforce

There are no workforce implications arising from this report.

2.3.2 Financial

There are no direct financial implications arising from this report.

2.3.3 Risk Assessment/Management

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

2.3.4 Equality and Diversity, including health inequalities

Not applicable

2.3.5 Other impacts

Not applicable

2.3.6 Communication, involvement, engagement and consultation

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

2.3.7 Route to the Meeting

Not applicable

2.4 Recommendation

The Audit and Risk Committee is asked to:-

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

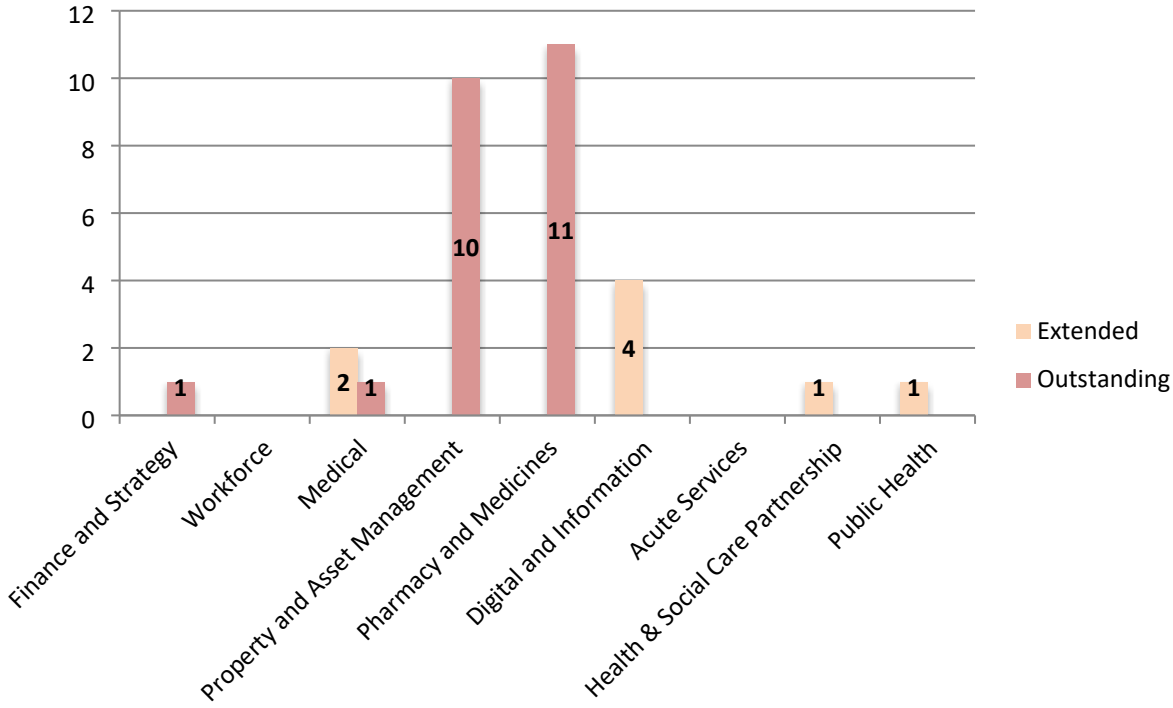
3. List of appendices

The following appendices are included with this report:

Report Contact

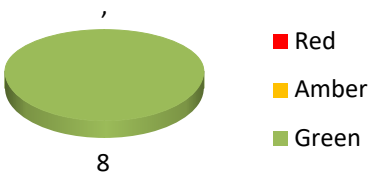
Barry Hudson, Regional Audit Manager, Email: barry.hudson@nhs.scot

Outstanding and Extended by Directorate

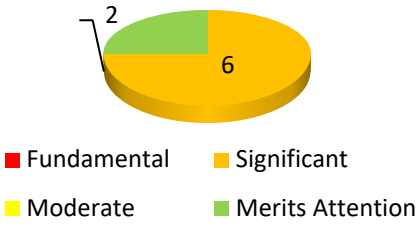


Extended Recommendations RAG Status and Priority

RAG Status

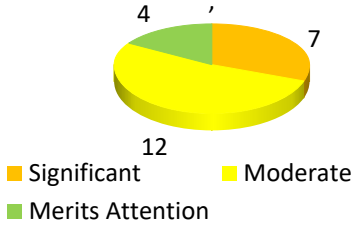


Priority



Outstanding Recommendations Priority

Priority



Internal Audit Reports with Remaining Actions	Date of Issue	Total Recs.	Complete	Superseded	Remaining		Extended	Outstanding	Not Yet Due		Not Validated
Appendix							*C*	*D*			*E*
2020/21											
B13/21 Risk Management Strategy	Sep 21	5	4	0	1		1	0	0		-
B14/21 Sharps Management	Dec-21	14	10	0	4		1	3	0		-
B19/21 Clinical Governance Strategy and Assurance	Sep-21	2	1	0	1		0	1	0		-
B20/21 Adverse Events Management	Mar-21	1	0	0	1		1	0	0		-
B21/21 Medical Equipment and Devices	Nov-21	4	0	0	4		0	4	0		-
B22/21 Manual Handling Training	Jun-21	7	4	0	3		0	3	0		-
B23/21 ITIL Processes	Jul-21	6	2	0	4		4	0	0		-
2020/21 Totals		**39**	**21**	**0**	**18**		**7**	**11**	**0**		**0**
2021/22											
B16/22 Prescription Stationery Security	May-22	11	0	0	11		0	11	0		-
B20/22 Financial Process Compliance	May-22	1	0	0	1		0	1	0		-
B23/22 Resilience	Apr-22	5	2	0	3		1	0	2		-
2021/22 Totals		**17**	**2**	**0**	**15**		**1**	**12**	**2**		**0**
Overall Totals (Actions from reports where recommendations remain unaddressed)		**56**	**23**	**0**	**33**		**8**	**23**	**2**		**0**

Previous ICE and Annual Reports with Remaining Actions	Date of Issue	Total Recs.	Complete	Superseded	Remaining		Extended	Outstanding	Not Yet Due		Not Validated
Appendix							*C*	*D*			*E*
2020/21											
B08/21 ICE	Mar-21	6	5	0	1		1	0	0		-
2020/21 Totals		**6**	**5**	**0**	**1**		**1**	**0**	**0**		**-**
2021/22											
B08/22 ICE	Feb-22	12	9	0	3		3	0	0		-
B06/23 Internal Audit Annual Report	Jun-22	4	3	0	1		1	0	0		-
2021/22 Totals		**16**	**12**	**0**	**4**		**4**	**0**	**0**		**-**
Overall Totals (Actions from reports where recommendations remain unaddressed)		**22**	**17**	**0**	**5**		**5**	**0**	**0**		**-**

	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
2020/21							
B13/21 Risk Management Strategy	3	S	Now that there is clarity around responsibility for operations, an IJB Risk Management Strategy should be produced and formally agreed with the parties as soon as possible and incorporated into the NHS Fife Framework. More detailed aspects of the risk management arrangements between NHS Fife and Fife IJB should be included in GP/R7 - Risk Register and Risk Assessment policy.	**Director of Health & Social Care**	~~31 Mar 22~~ ~~30 Sep 22~~ 31 Dec 22		Following sign off on the revised Integration Scheme in March 2022 a meeting of the IJB was held on 22 April to consider the new governance structure and proposed terms of reference for the refreshed Committees with a view to these being implemented once the new IJB was formed following the Local Government elections in May 2022. Since then, work has been ongoing to consider the amendments required in the IJB Risk Management Policy and Strategy to reflect the changes and discussions are ongoing with the Senior Leadership Team. We are aiming to present these in the next Committee cycle (November) and therefore would appreciate an extension to 31 December 2022.
B14/21 Sharps Management	2f	M A	Update the Adverse Events Policy to: • clearly outline processes for review and analysis of Health and Safety Incidents related to staff • refer to lessons learned needing to be applied across the organisations to all departments and wards that they are applicable to.	Associate Director of Quality and Clinical Governance **Medical Director**	~~26 Mar 21~~ ~~30 Apr 22~~ ~~31 Oct 22~~ 31 Aug 23		The Adverse Events Procedure will be developed and endorsed by June 2023 and will be published on Stafflink.

	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
B20/21 Adverse Events Management	1	M A	Address concerns of DATIX Action Module users expressed by the comments made in this review regarding unfamiliarity with the DATIX Action Module and the lack of a full understanding of users' individual responsibilities Based on the findings of the initial review in B19/20 – Adverse Event Management, plus the additional comments made by users in this review, consideration should be given to a review of the framework and processes currently in place, to determine if any system changes could result in benefits and improvements, which would reduce the number of actions actually outstanding and those incorrectly recorded as outstanding.	Associate Director of Quality and Clinical Governance **Medical Director**	~~31-May-21~~ ~~30-Apr-22~~ ~~31 Oct 22~~ 30 Apr 23		Adverse Event Policy to be finalised by December with a view to taking to CGOG December 2022 and then CGC in January 2023. Extension to April 2023 requested to allow leeway given anticipated challenges over the winter period and to allow for publication on Stafflink.
B23/21 ITIL Processes	3	S	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.	Head of Digital Operations **Associate Director - Digital and Information**	~~31-Aug-21~~ ~~31-Mar-22~~ ~~30-Jun-22~~ 31-Mar-23		Cost / Benefit paper presented to D&I Board 19/10/21. Time to allow for engagement with other services regarding introducing ITIL practices Recruitment now completed and lead resource starting on 5th September 2022. Further resource is at preferred candidate stage. Then initial engagement can begin. Extension required due to delays in recruitment.
	4	S	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. 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	Service Delivery Manager **Associate Director - Digital and Information** 4	~~30-Sep-21~~ ~~31-Dec-21~~ ~~31-Mar-22~~ ~~30-Jun-22~~ 31-Mar-23		Extension required to allow migration of change management process from Cherwell to ServiceNow which is now possible following technical difficulties.

	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
	5	S	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.	Service Delivery Manager **Associate Director - Digital and Information**	~~31-Aug-21~~ ~~31-Mar-22~~ ~~30-Jun-22~~ 31-Mar-23		As per 4 above.
	6	S	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. 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 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.	Service Delivery Manager **Associate Director - Digital and Information**	~~31-Aug-21~~ ~~31-Mar-22~~ ~~30-Jun-22~~ 31-Mar-23		As per 4 above.
20/21 Sub Total	**7**			5			

	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
2021/22							
B23/22 Resilience	1c	S	Presenting finalised Major Incident Operational Plan to CGC and providing an update on Action Cards stakeholder testing to the Resilience Forum.	Head of Resilience **Director of Public Health**	~~30 Sep 22~~ 30 Nov 22		The Major Incident Operational Plan was ratified at the Resilience Forum on 25 August 2022 and will be presented to CGC on 4 November 2022. Action Cards were presented to the Resilience Forum on 25 August 2022 and feedback on stakeholder testing of these will be reported to their next meeting on 24 November 2022. Extension required to allow relevant papers to be presented to CGC on 4 November 2022 and the Resilience Forum on 24 November 2022.
21/22 Sub Total	**1**						
Total	**8**						

ANNUAL and ICE REPORTS	Rec Number	Priority	Brief Description	Responsible Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
2020/21							
B08/21 – ICE Report – 2020/21	1	S	Production of the Population Health & Wellbeing Strategy and Delivery Plan and the Governance arrangements.	**Chief Executive**	~~31 Mar 22~~ 31 Mar 23		Development activities were paused as a consequence of the pandemic. However this has now progressed with the Population Health and Wellbeing Strategy to be presented to Fife NHS Board in January 2023.
20/21 Sub Total	**1**						

	Rec Number	Priority	Brief Description	Responsible Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
2021/22							
B08/22 – ICE Report – 2021/22	2	M A	Performance Reporting linked to Risks	**Director of Finance and Strategy**	~~31 Mar 22~~ 31 Mar 23		To allow for evidence of presentation and discussion at at least 1, and possibly 2, rounds of standing committee meetings. Discussion at the meetings is crucial to evidencing these actions as completed so the relevant section of the minutes from the standing committee meetings will be key evidence for these actions.
	3	M A	CGC Annual Assurance Report and Statement including assurance on Duty of Candour, including assurance on 2022/23 activity understood at this time.	**Medical Director**	~~31 Mar 22~~ 31 Mar 23		To allow 2022/23 DoC information to be included in the SBAR supporting the 2021/22 DoC Annual Report when it is presented to CGC.

	Rec Number	Priority	Brief Description	Responsible Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
	7	M A	Linking the Financial Sustainability Corporate Risks to Strategy, PMO Savings Programme & relevant External audit recommendations	**Director of Finance and Strategy**	~~31 Mar 22~~ 31 Mar 23		To allow for evidence of presentation and discussion at at least 1, and possibly 2, rounds of standing committee meetings. Discussion at the meetings is crucial to evidencing these actions as completed so the relevant section of the minutes from the standing committee meetings will be key evidence for these actions.
B06/23 – Internal Audit Annual Report – 2021/22	1	M	Paper presented to Fife NHS Board or one of its standing committees including updates on: • work being undertaken to foster closer working relationships with colleagues in local authorities and IJBs • progress towards the indicators from the MSG report.	**Director of Health and Social Care**	~~30 Sep 22~~ 31 Jan 23		To allow paper to be presented to FP&RC in January 2023.
21/22 Sub Total	**4**						
Total	**5**						

Report	Issue Date	Rec Ref.	Audit Finding & Recommendation	Responsible Officer & Executive Director	Further Information	Priority	Original and Extended Due Dates
2020/21							
B14/21 Sharps Management	22 Dec 20	3a 3b 3c	Action plan to address issues raised in report (section 3 - Control 2) and appendix 1 to be developed and implementation progress to be reported to the Sharps Strategy Group and the Health and Safety Sub-Committee.	H&S Manager **Director of Property and Asset Management**	The impact of the pandemic on workload and senior staff being seconded to other roles has delayed progress in addressing these actions. A new Health and Safety Manager recently commenced working for NHS Fife Internal Audit are working with them to agree a way forward. This is likely to be in the form of a paper to H&S Sub-Committee explaining the roles and responsibilities of the now defunct Sharps Strategy Group and how these responsibilities are to be discharged by other groups.	S	~~Feb-21~~ ~~Jun-21~~ ~~Feb-22~~ ~~Jul-22~~
B19/21 Clinical Governance Strategy and Assurance	14 Sep 21	1	Revision of Clinical and Care Governance Strategy addressing recommendations made in Internal Audit report B15/17 & B18/18 – Clinical Governance Strategy & Assurance.	Associate Director of Quality and Clinical Governance **Medical Director**	The recommendation from this report has many component parts and although the finalisation of the draft Clinical Governance Strategic Framework will go a long way to addressing the recommendations there are others that also need to be addressed. These have been discussed with the relevant manager and revised timescales for these are in the process of being agreed.	S	~~Jan-22~~ ~~May-22~~ ~~Oct-22~~
B21/21 Medical Equipment and Devices	08 Nov 21	1	Updates required to both the GP/E4 – Medical Equipment Management Policy (including related appendices) and E14.1 - Equipment Procurement Operational Policy and these require to be authorised by the Capital Equipment Management Group.	Head of Estates **Director of Property and Asset Management**	There has been engagement with the relevant manager and Internal Audit but we have not yet agreed upon appropriate extended dates for the following evidence to be provided: • An updated General Policy GP/E4 – Medical Equipment Management Policy approved by CEMG and published on Stafflink? [Point 1] • Publication of E14.1 – Equipment Procurement Operational Policy on Stafflink [Point 1] • The ERF form being further updated to include provision for the level of training required and the training to be provided to be recorded [Point 2] • Provision of a sample of completed ERFs to evidence the completion of the fuller information required on the new form [Points 2 & 3] • Updated Terms of Reference of the including a member from IT/Data Support in the membership?	MA	~~Jan-22~~ ~~Jul-22~~
		2	Equipment Request Form (ERF) requires updating to include prompts for sufficient detail to be recorded regarding consultation, training requirements, maintenance costs and needs assessment.			MA	~~Jan-22~~ ~~Jul-22~~
		3	As per 2 above.			MA	~~Jan-22~~ ~~Jul-22~~
		4	The CEMG should review the KPIs within Annex 2 of CEL 35 (2010) and consider whether receipt of these would benefit its decision making process and arrange for the receipt of such information in future. In addition it			MA	~~Jan-22~~ ~~Jul-22~~

Report	Issue Date	Rec Ref.	Audit Finding & Recommendation	Responsible Officer & Executive Director	Further Information	Priority	Original and Extended Due Dates
			terms of reference (currently being reviewed) should be updated to note the monitoring of such KPIs.		[Point 3] • Discussion of CEL 35 (2010) KPIs have been discussed at CEMG [Point 4]		
B22/21 Manual Handling Training	29 Jun 21	1	An annual manual handling training plan should be put in place to ensure that NHS Fife can effectively deliver manual handling training to all the necessary staff in line with government requirements.	H&S Manager **Director of Property and Asset Management**	As per B14/21 above - A new Health and Safety Manager recently commenced working for NHS Fife and Internal Audit are working with them to agree a way forward. The following evidence is being sought: • An annual plan for manual handling training being presented to H&S Sub-Committee [Point 1] • The results of Training Needs Analysis (ie Completed training needs analysis forms and analysis of these extrapolated to NHS Fife requirements) [Point 2] • Manual Handling Training reporting to H&S Sub Committee (in same manner as reported to ASD & CD LPF) – the reason this is required is that the H&S Sub Committee reports directly to a standing committee of the Board (the Clinical Governance Committee) whereas the ASD & CD LPF does not. Evidence required is the minute of the H&S Sub-Committee the reports were presented to and copies of the papers presented [Point 3]	S	~~Aug 21~~ ~~Mar 22~~
		2	A training needs exercise should be undertaken to determine manual handling training requirement.			S	~~Aug 21~~ ~~Mar 22~~
		3	Routine manual handling training management reports should be prepared detailing the number of courses held in comparison with the planned number, with explanations being provided for significant variations. High level reporting on this should be reported to the Clinical Governance Committee.			S	~~Sep 21~~ ~~Mar 22~~
20/21 Sub Total		**11**					
2021/22							
B16/22 Manual Handling Training	09 May 22	1	Checking of staff ordering prescription stationery to confirm that they are authorised to order the stationery.	Lead Pharmacist Medicine Governance and Medicines Supply Chain Manager **Director of Pharmacy & Medicines**	The following evidence is required to allow these actions to be recorded as complete and validated: • Updated SOP recording the check to be undertaken (ie registered nurse or clinician working in the department the stationery is being ordered for) [Point 1] • Risk assessments of areas used in Pharmacy departments at VHK and QMH for the storage of Prescription Stationery based on legislative and NSS guidance and evidence of any issues identified being	M	~~Oct 22~~
		2a	Risk assessments of areas used in Pharmacy departments at VHK and QMH for the storage of Prescription Stationery.			M	~~Oct 22~~
		2b	Implementing a protocol for changing any combination locks remaining in use whenever anyone who knew the code leaves the service.			M	~~Oct 22~~
		2c	SOP CDP021 and the SSUMPP to be updated to include the process for dealing with prescription stationery that			M	~~Oct 22~~

Report	Issue Date	Rec Ref.	Audit Finding & Recommendation	Responsible Officer & Executive Director	Further Information	Priority	Original and Extended Due Dates
			is no longer suitable for use including the need for a separate member of staff being required to witness destruction of prescription stationery.		addressed [Point 2a] • Evidence of a protocol being put in place or evidence of combination locks having been replaced for changing any combination locks remaining in use whenever anyone who knew the code leaves the service [Point 2b] • Updated SOP CDP021 including: ○ Destruction of prescription stationery processes[Points 2c] ○ Timing of the weekly checks of prescription stationery undertaken in Pharmacy Dept [Point 2d] ○ Details of the process introduced to check prescription stationery orders received to confirm that these are consistent with wards/departments only holding the stock they require [Point 3e] • Publication of updated SSUMPP on Stafflink and communication of this to wards/departments including: ○ Destruction of prescription stationery processes [Point 2c] ○ Changes as a result of review against NSS guidance [Point 3a] ○ Communication of revised SSUMPP and associated record keeping templates to ward/deparments [Point 3b] ○ Risk assessment advice, related to areas used to store prescription stationery, for wards/departments [Point 3c] ○ Ward/department guidance on record keeping and retention of stationery [Point 3d&f].		
		2d	SOP CDP021 updated to include the times that the check of the 'Controlled Stationary – Record of Issues and Receipts log' for each pad is required to be undertaken.			M	~~Oct-22~~
		3a	Review of SSUMMP against NSS guidance for prescription stationery security and resultant updates made to the SSUMMP (eg the requirement to hold records prescription stationery stock levels for 3 years and to hold the minimum stock required based on usage).			M	~~Oct-22~~
		3b	Ward/Department advice from Pharmacy (eg emails or memos) and distribution of standard templates for: i. conducting risk assessments of storage areas used for prescription stationery incorporating NSS requirements ii. stock control record keeping iii. issue and return record keeping			M	~~Oct-22~~
		3c	As per 3b re advising wards/departments to undertake risk assessments of the areas they use to store prescription stationery and to take any remedial action required to address any unmitigated risks identified. Also evidence of advising wards/departments that the risk assessment should be revisited whenever there are any changes made to the storage area or changes to legislation.			M	~~Oct-22~~
		3d	As per 3b re advising wards/departments to undertake record keeping in a consistent manner in compliance with the SSUMPP/SOP and NSS guidance and specifically of the requirement to retain stock records for 3 years.			M	~~Oct-22~~
		3e	Details of the process introduced to check prescription stationery orders received to confirm that these are consistent with wards/departments only holding the stock they require (and documentation of this in the			M	~~Oct-22~~

Report	Issue Date	Rec Ref.	Audit Finding & Recommendation	Responsible Officer & Executive Director	Further Information	Priority	Original and Extended Due Dates
			SOP or SSUMMP).				
		3f	Evidence (emails/memos) of wards & departments being asked to keep their prescription stationery stock and use records separately from where the prescription stationery is stored and to hold the minimum stock of prescription stationery required.			M	~~Oct-22~~
B20/22 Financial Process Compliance	09 May 22	1	Providing EDG with regular Invoice Register reports including commentary on progress to reduce the number of disputed invoices.	Head of Financial Services and Procurement **Director of Finance and Strategy**	A paper on the Invoice Register was drafted for EDG and was intended presented to EDG in September but we don't yet have evidence of it having been presented.	M	~~Aug-22~~ ~~Oct-22~~
21/22 Sub Total		12					
Total		**23**					

Audit Year/Report	Rec. Ref.	Finding & Recommendation	Priority	Responsible Officer, Executive Director & Action by Date	Follow-up Response	Internal Audit Opinion on Further Evidence Required to Allow Action to be Recorded as Complete [*This further evidence will be requested from the Responsible Officers through the Follow-up Process*]
N/A	N/A	N/A	N/A	N/A	N/A	N/A
Total						

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

Recommendation Priority	
Term	**Definition**
Fundamental (F)	Non-Compliance with key controls or evidence of material loss or error. Action is imperative to ensure that the objectives for the area under review are met.
Significant (S)	Weaknesses in control or design in some areas of established controls. Requires action to avoid exposure to significant risks in achieving the objectives for area under review.
Moderate (M)	Weaknesses in design or implementation of controls which contribute to risk mitigation. Requires action to avoid exposure to moderate risks to achieving the objectives for area under review.
Merits Attention (MA)	There are generally areas of good practice. Action may be advised to enhance control or improve operational efficiency.

RAG Status Definitions for Importance of Extended and Outstanding Recommendations		
RAG Status		**Definition**
Red		**Action is imperative to ensure that the objectives for the area under review are met and risks are mitigated.**
Amber		**Stated actions have not been progressed sufficiently to mitigate the identified risk. Completion of updated actions should ensure objectives are achieved.**
Green		**Good progress is being made and completion of updated actions will achieve objectives and mitigate identified risks.**

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**5 December 2022**
Title:	**Draft Internal Control Evaluation (ICE)**
Responsible Executive/Non-Executive:	**M McGurk, Director of Finance & Strategy**
Report Author:	**T Gaskin – CIA / B Hudson – Regional Audit Manager**

1 Purpose

This is presented to the Committee for:

- Assurance
- Discussion

This report relates to a:

- Local policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation and Background

As Accountable Officers, Chief Executives are responsible for maintaining a sound system of internal control and to manage and control all the available resources used in his/her organisation. The work of Internal Audit and the assurances provided by the Chief Internal Auditor in relation to internal control are key assurance sources taken into account when the Chief Executive undertakes the annual review of internal controls, and forms part of the consideration of the Audit and Risk Committee and the Board prior to finalising the Governance Statement which is included and published in the Board's Annual Accounts.

This review aims to provide early warning of any significant issues that may affect the Governance Statement.

The ICE was issued to the Director of Finance on the 25th November 2022 and will require input from the Executive Directors Group (EDG) to finalise. Once the EDG have reviewed the report and updated the recommendations, the Final Report will issued to members as soon as it is finalised and will be presented for consideration to the March 2023 Audit and Risk Committee.

2.2 Assessment

Key Themes

Our 2021/22 Annual Report noted that a number of the issues highlighted within that year's ICE were being addressed as part of a wide range of governance and strategic initiatives. This continues and we were pleased to see good progress in:

- Development of an overall Health and Wellbeing Strategy and associated governance arrangements
- Continuing development of Risk Management arrangements
- The development of the Clinical Governance Strategic Framework
- The approval of the Staff and Wellbeing Framework
- The approval of the NHS Fife Workforce Plan 2022-2025
- An interim update Property & Asset Management Strategy (PAMS) was approved by the NHS Fife Board
- Ongoing development of the SPRA process to link with and support the overall and financial strategies
- Establishment of the Financial and Sustainability Programme Board early in 2022 to oversee Cost Improvement plans

Many of these areas are subject to ongoing Internal Audit review or are planned for review, and will be completed by year-end, when we will be able to provide a final opinion. We are, however, pleased to note the significant progress made to date and the robust processes and principles adopted, as well as the very positive engagement with Internal Audit where we have provided input and advice on a wide range of issues at the outset. It is particularly encouraging that these developments have continued despite the enormous ongoing pressures created by Covid.

The report also highlights the worsening external environment and, as previously, the importance of an achievable strategy accompanied by realistic objectives and robust prioritisation. This report contains a number of recommendations, intended to enhance the processes referred to above, to embed good governance principles and to ensure coherence between Governance Structures, Performance Management, Risk Management and Assurance. We would stress the importance of ensuring that current and target risk scores fully reflect the external environment accompanied by an informed understanding of the extent to which controls and actions will be able to mitigate them.

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.

This report contains narrative on the overall system of Risk Management as well as detailed commentary on a number of individual risks. It will be supplemented by a detailed review of Risk Management later in this financial year.

2.3.5 Equality and Diversity, including health inequalities

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

2.3.6 Other impacts

N/A

2.3.7 Communication, involvement, engagement and consultation

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

2.3.8 Route to the Meeting

This paper has been produced by the Regional Audit Manager and reviewed by the Chief Internal Auditor, then presented to the Audit and Risk Committee for initial discussion. The EDG will then review the report and update the recommendations, with the Final Report issued to members as soon as it is finalised and presented for consideration to the March 2023 Audit and Risk Committee.

2.4 Recommendation

The Audit and Risk Committee is asked to:

- **Consider** and **discuss** the **draft** Internal Control Evaluation (ICE)

3 List of appendices

The following appendices are included with this report:

- Internal Control Evaluation (ICE)

FTF Internal Audit Service

Internal Control Evaluation 2022/23

Report No. B08/23

Issued To: **[C Potter, Chief Executive]**
[M McGurk, Director of Finance and Strategy]

[G MacIntosh, Head of Corporate Governance/Board Secretary]
[Executive Directors Group]
[H Thomson, Board Committee Support Officer]

[Audit Follow-Up Co-ordinator]

[Audit and Risk Committee]
[External Audit]

Contents

Draft Report Issued	25 November 2022
Management Responses Received	xx
Target Audit & Risk Committee Date	8 December 2022
Final Report Issued	**xx**

EXECUTIVE SUMMARY

1. As Accountable Officers, Chief Executives are responsible for maintaining a sound system of internal control and to manage and control all the available resources used in the organisation. This review aims to provide early warning of any significant issues that may affect the Governance Statement.

OBJECTIVE

2. The NHS in Scotland remained on an emergency footing until 30 April 2022. NHS Fife is now at an advanced stage of developing its Population and Health Wellbeing Strategy, which should demonstrate how NHS Fife will deliver services in a post Covid environment whilst reflecting on the financial and staffing challenges facing the NHS.
3. The NHS Recovery Plan 2021-26, issued in August 2021, sets out key headline ambitions and actions to be developed and delivered now and over the next 5 years. The aim of the plan is to drive the recovery of the NHS in Scotland, not just to pre pandemic levels but beyond.
4. The NHS Fife 2022/23 Annual Delivery Plan was submitted on 29 July 2022. The Scottish Government (SG) 2022/23 Annual Delivery Planning Guidance, issued in May 2022, set out a timeline which indicated medium term plans would be required by the end of January 2023. Guidance for the 2023-24 Planning was issued by the SG on 14 November 2022.
5. The internal audit plan provides cyclical coverage of all key elements of Corporate, Clinical, Staff, Financial and Information Governance. The strategic risk profile of the organisation has altered significantly and NHS Fife is making progress in revising and developing its risk management framework. We have prioritised our audit work to provide assurance on the areas of likely highest risk.
6. Together, the Internal Control Evaluation (ICE) and annual report provide an opinion on the overall systems of internal control, incorporating the findings of any full reviews undertaken during the year. The ICE and Annual Report do not, and cannot, provide the same level of assurance as a full review but do allow an insight into the systems which have not been audited in full, and provide early warning of issues and allow a holistic overview of governance within NHS Fife.
7. This ICE also provides a detailed assessment of action taken to address internal audit recommendations from previous ICE and Annual Reports, and assesses the adequacy and effectiveness of internal controls, which should allow remedial actions to be taken before year-end, allowing the annual accounts process to be focused on year-end assurances and confirmation that the required actions have been implemented.
8. Whilst there was no overarching corporate/strategic risk relevant to this review, our audit assessed the design and operation of the controls in place and specifically considered whether:
    - Governance arrangements are sufficient, either in design or in execution, to control and direct the organisation to ensure delivery of sound strategic objectives.

AUDIT OPINION

9. Ongoing and required developments and recommended actions are included at Section 2.
10. The Annual Internal Audit Report was issued on 13 June 2022 and was informed by detailed review of formal evidence sources including Board, Standing Committee, Executive Directors Group (EDG), and other papers.
11. As well as identifying key themes, the Annual Internal Audit Report made four specific recommendations as follows:

- Provision of a clearer view of how the remaining two years of the Digital and Information Strategy will be delivered within the financial budget, with clarity around elements of the strategy that will not be delivered by the end date of 31 March 2024.
- An Implementation Plan for delivering the Property and Asset Management Strategy (PAMS) should be properly documented, approved and monitored to ensure the delivery of actions and outcomes and provide assurance to the Board that the PAMS is being delivered.
- Enhanced written reports to the Staff Governance Committee (SGC) indicating how ongoing workstream and other activity meets the appropriate Staff Governance Standards (SGSs), to be presented in accordance with its Workplan. Any related reports, such as the Health and Wellbeing Update, should also state which strands they provide assurance on and where possible report on the impact as well as the implementation of any actions taken.
- NHS Fife should be provided with an update/precis on work being undertaken in response to Ministerial Steering Group (MSG) recommendations, to foster closer working relationships with colleagues in local authorities and IJBs.

12. Outstanding actions from previous ICE and Annual Report recommendations are shown in table 1. 11 actions have been completed since the issue of our annual report.
13. In this report we have provided an update on progress to date and, where appropriate, built on and consolidated previous recommendations to allow refreshed action and completion dates to be agreed. This has culminated in 11 recommendations for which management have agreed action to be progressed by year end. Whilst this appears to be a large number given the overall positive conclusions within the report, these recommendations are primarily suggestions to enhance governance improvement activities already underway within NHS Fife.
14. We recommend that this report is presented to each Standing Committee so that key themes can be discussed and progress against the recommendations can be monitored.

KEY THEMES

15. Detailed findings are shown later in the report. Key themes emerging from this review and other audit work during the year are detailed in the following paragraphs.
16. Audit Scotland previously stated that "*the NHS was not financially sustainable before the pandemic and responding to Covid-19 has increased those pressures*." Since then, the overall financial position has worsened considerably across the whole of NHSScotland. Previous Internal Audit reports have recorded similar concerns and highlighted the strategic changes required in order to address them. The ongoing impact of UK government budget changes, the pandemic, rising inflation and associated pressure on public pay, substantial rises in waiting lists, difficulties in recruitment, extremely ambitious SG targets across a range of areas and many other challenges have all increased financial risk for NHS Fife, NHSScotland and the public sector in general including our Local Authority partners.
17. We previously highlighted the risks associated with the National Workforce Strategy for Health and Social Care and the need for realistic plans within NHS Fife. Since then, the NHS Fife Workforce Plan 2022-2025, a high-level overview of the workforce and further work is underway to inter-relate and align financial planning to the workforce plan via the Strategic Planning Resource Allocation (SPRA) process using a template to collect both the workforce projections and the SPRA information. Workforce risks remain high across NHSScotland and indeed health sectors all over the world and the current risk and target risk scores for Workforce within NHSF

will require careful consideration to ensure they reflect local, national and international pressures and the extent to which these are and can be mitigated locally.

18. In the face of the challenges posed by Covid maintaining operational performance against mandated targets has been almost impossible to achieve. It is likely that these challenges will continue and that operational improvements, whilst necessary will only serve to buy time, until genuinely strategic solutions can be found, including closer working in partnership with the IJB to address underlying capacity and flow issues.

19. As reported in the Internal Audit Annual Report for 2021/22, the challenge now is balancing short term risks against longer term risks which can only be mitigated through strategic change. The shape of future strategy will be dependent on a number of complex factors, with some subject to change. However the Board has continued to react and risk assess to ensure the most urgent work is prioritised.

20. Whilst the SGHSCD has set a number of very challenging national objectives, many of which appear to be high risk, NHS Fife must set achievable strategic objectives which can be delivered within its own risk tolerances.

21. NHS Fife continues to progress its Risk Management Framework Improvement Programme. A Corporate Risk Register has been developed and a Risk Opportunities Group established which aims to embed an effective risk management framework and culture within NHS Fife, including assurance mapping principles. Consideration of current risks scores and achievement of target scores by target dates will require constant monitoring to ensure they fully reflect current risk and controls and in particular, target scores must be realistic.

22. Governance and assurance processes for clinical activity undertaken in services provided by the IJB continue to evolve but are not yet fully agreed and in place to ensure that NHS Fife Clinical Governance Committee is assured appropriately and timeously. Assurance should be provided to the NHS Fife Clinical Governance Committee on inspection reports and on Child and Adult Protection risks.

23. We have made recommendations on provision of adequate and effective assurance to the Clinical Governance Committee, the Clinical Governance Oversight Group (CGOG) and the Organisational Learning Group (OLG) on effectiveness of internal control systems in identifying issues raised in external inspection reports, and on the management of clinical risks due to delayed treatment, and on the management of adverse events.

24. 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 further enhance governance through the application of assurance mapping principles. Our recommendations are aimed at ensuring coherence between Governance Structures, Performance Management, Risk Management and Assurance.

KEY DEVELOPMENTS SINCE THE ISSUE OF THE ANNUAL REPORT INCLUDED:

- The reporting of the OPEL (Operational Pressures Escalation Levels) on the NHS Fife intranet, and the high escalation levels reported, reinforces the heightened risk environment both locally and across NHSScotland;
- Establishment of the Financial and Sustainability Programme Board early in 2022 to oversee Cost Improvement plans which will be required to achieve financial balance in the short and medium term;
- An interim update PAMS endorsed by the Finance, Performance & Resources Committee (FPRC) and approved by the NHS Fife Board in September 2022;

- Three year Financial Plan developed and approved by the NHS Fife Board in September 2022;
- Scottish Government (SG) approval, on 21 September 2022, of the Annual Delivery Plan (ADP) for 2022/23 and the development of a progress reporting tool to monitor delivery against the ADP;
- Ongoing enhancements to the Integrated Performance and Quality Report (IPQR) through the IPQR Review Group;
- Development of Risk Management arrangements including a Corporate Risk Register;
- Development of the Clinical Governance Strategic Framework with the draft approved by the Clinical Governance Committee in November 2022;
- The Staff Health and Wellbeing Framework, setting out the NHS Fife ambitions in respect of staff health and wellbeing, presented to the November 2022 Staff Governance Committee (SGC) for approval;
- The NHS Fife Workforce Plan 2022-2025 endorsed by the SGC and approved by the Board prior to submission to the Scottish Government for 31 July 2022;
- Whistleblowing directives issued by the Independent National Whistleblowing Officer are being implemented with NHS Fife.

25. Overall, there has been good progress on recommendations from the ICE from last year and the Annual Report for 2021/22. Where action is still to be concluded, the Board has been informed of the planned approach and timescales, as well as associated improvement plans.

ACTION

26. The action plan [has been agreed with management] to address the identified weaknesses. A follow-up of implementation of the agreed actions will be undertaken in accordance with the audit reporting protocol.

ACKNOWLEDGEMENT

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

A Gaskin, Bsc. ACA
Chief Internal Auditor

TABLE 1 - Update of Progress Against Outstanding Actions from previous ICE and Annual Reports		
Agreed Management Actions with Dates	**Management Actions Updates with Dates**	**Assurance Against Progress**
Annual Report 2021/22 – B06/23		
1 - MSG • A report on the MSG indicators will be presented to the Finance and Performance Committee. ***Original date of expected completion 30 September 2022.***	A report on the MSG indicators was not reported to FPRC in July, September, and November 2022, nor Fife NHS Board in July, August, September and November 2022. An update will be provided to the next FPRC meeting.	 **Significant Slippage**
ICE Report 2021/22 – B08/22		
1. Performance Reporting • As part of the Active Governance action plan, consideration should be given to how Performance Reports can provide overt assurance on the accuracy of the narrative and scores for related strategic (BAF) risks as well as the adequacy and effectiveness of key controls. • The risk section of Board and Committee papers should be given higher priority than at present and should contain basic information to facilitate a focused discussion on the risk implications, be overtly linked to any operational or BAF risks and contain enough information for members to be able to form a conclusion on whether the score narrative and other elements of the related risk are adequately described. ***Original date 31 March 2022.*** **Revised Date 30 June 2022** **Further Revised Date March 2023**	The Corporate Risk Register and Dashboard paper was approved by Fife NHS Board in September 2022. This included proposals for: • A risk profile dashboard • deep dive reports • IPQR including the risk profile dashboard. The manner in which the revised risk reporting drives discussion at standing committee meetings is key to the actions being considered completed. Therefore the target implementation date has been extended to 31 March 2023 to allow this to be discerned from the standing committee minutes and papers in the remainder of 2022/23.	 **Minor slippage on agreed timelines**
2.Organisational Duty of Candour (DoC) • An update on the number of instances Organisational Duty of Candour has been applied in NHS Fife in 2021/22 should be scheduled for presentation to CGC prior to conclusion in the Annual Assurance Report and Statement, which should highlight any issues experienced and be	The DoC annual report for 2020/21 included comparative information regarding the previous 2 years and this approach will continue in future. In addition, the SBAR supporting the 2021/22 DoC annual report (now scheduled for presentation to CGC in March 2023) will include commentary on 2022/23 activity to	 **Significant Slippage**

TABLE 1 - Update of Progress Against Outstanding Actions from previous ICE and Annual Reports		
Agreed Management Actions with Dates	**Management Actions Updates with Dates**	**Assurance Against Progress**
sufficient allow the CGC to conclude whether there were adequate and effective Duty of Candour arrangements throughout 2021/22. • The Committee should be told when it can expect the final report on the year's activity and how arrangements will be developed in future to allow more timely reporting. ***Original date 31 March 2022.*** ***Revised Date 31 March 2023***	date and whether there are any issues with compliance that the CGC needs to be aware of. The timing of adverse event reviews means that this information will not be definitive, but it will provide CGC with the assurance available at that time ahead of it concluding on its own annual assurance statement. Proposal to extend to 31 March 2023 agreed by Medical Director.	
3.IPQR and Financial Sustainability BAF • Links between the Financial Sustainability BAF and IPQR should be clear and overtly linked so the controls/mitigations of the BAF provide assurance that challenges within the IPQR is being managed. • The financial sustainability BAF should be updated to include links to Strategy, PMO Savings Programme and relevant External audit recommendations. ***Action Owner:* Director of Finance and Strategy** ***Original date 31 March 2022.*** ***Revised Date 31 March 2023***	The Corporate Risk Register and Dashboard paper was approved by Fife NHS Board in September 2022. This included proposals for: • A risk profile dashboard • deep dive reports • IPQR including the risk profile dashboard. The dashboard in the IPQR is to be further developed over the next 4 months and feedback from committee members used to decide whether it is an effective addition. Reporting on corporate risks in the risk profile dashboards, deep dive reports and the IPQR to FP&RC during the remainder of 2022/23, and the manner in which the revised reporting drives discussion at these meetings is key to the actions being considered completed. Therefore the target implementation date has been extended to 31 March 2023.	 **Minor slippage on agreed timelines**
ICE Report 2020/21 – B08/21		
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 development of the NHS Fife Population Health and Wellbeing Strategy is ongoing. Fife NHS Board was updated in September 2022 on progress against the milestones previously presented to the Board in March 2022. This includes a target of December 2022 for a draft strategy to be ready for presentation to Fife NHS Board at their January 2022 meeting. The original target implementation date for this action was extended to 31 March 2023 and the update provided to Fife NHS Board in September 2022 indicates that this will be achieved.	 **Significant Slippage**

TABLE 1 - Update of Progress Against Outstanding Actions from previous ICE and Annual Reports		
Agreed Management Actions with Dates	**Management Actions Updates with Dates**	**Assurance Against Progress**
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. ***Original date 31 March 2022.*** ***Revised Date 31 March 2023***		

CORPORATE GOVERNANCE

Corporate Risks:

Risk 1 – Population Health and Wellbeing Strategy – High Risk (12); Target (8) Moderate

There is a risk that the ambitions and delivery of the new organisational Strategy do not deliver the most effective health and wellbeing and clinical services for the population of Fife.

Risk 2 – Health Inequalities – High Risk (20); Target (10) Moderate

There is a risk that if NHS Fife does not develop and implement an effective strategic approach to contribute to reducing health inequalities and their causes, health and wellbeing outcomes will continue to be poorer, and lives cut short in the most deprived areas of Fife compared to the least deprived areas, representing huge disparities in health and wellbeing between Fife communities.

Governance Arrangements

The Governance Structure update provided to the May 2022 Board meeting advised that the NHS in Scotland has formally stepped down from its emergency footing and is moving from remobilisation to recovery on a transitional approach. NHS Fife has set up an Executive Directors Group (EDG) huddle which will be kept under review with the possibility of re-establishing the Gold Command, or stepping down the EDG huddle depending on activity levels.

Board Development Sessions (BDS) were held for a diverse selection of topics during 2022/23, including Clinical Strategy, Equality and Diversity, Cyber Security, role of the Assistant Practitioner, Integrated Planned Care Elective Recovery and Culture, Values and the Role of the Board as well as Risk Management. Given the importance of these sessions and to ensure their value is maximised, consideration should be given to formal outputs from BDS and action plans to ensure any agreed decisions/actions are taken forward.

Whilst progress is being made locally, it is unfortunate that delays in proposed national governance initiatives have inhibited the Board's ability to undertake local improvement and assessment work on Board governance.

Committee Assurance

The Terms of References were reviewed by the respective standing committees and a revised Code of Corporate Governance formally approved at the July 2022 Board meeting.

Each Standing Committees has an Action List to ensure any actions from previous meetings are followed up. However, the Board Action List is administered by Corporate Services and should be presented as a standing item to each Board meeting.

The previous action plan for the Blueprint evaluation was reported to the Board in January 2022, with all actions reported as completed. Further national iterations of the Blueprint are awaited.

Policies

A General Policies and Procedures update was provided to the November 2022 meeting of the FPRC. 46% (26 /57) of polices are up to date, with 5 currently going through formal approval. The risk section of the SBAR - General Policies and Procedures, did not articulate the risks to NHS Fife of these policies not being up to date. We are also aware of superseded policies remaining on Stafflink which could lead to confusion.

Culture and Values

A BDS in April 2022 focussed on the culture and values of NHS Fife. The NHS Fife Code of Corporate Governance includes references to culture and values and we have seen examples of the Board and its officers promulgating these values. However, there is further scope to ensure Committee and Board papers reflect and promote these values and assess whether the desired culture is in place.

Strategy

As highlighted within B06-23 Internal Audit Annual Report 2021/22, the process for developing the Population Health and Wellbeing Strategy was approved at the 29 March 2022 Board meeting. The Board has been regularly informed on the development of the Strategy with assurance papers presented to the May, July, September and November 2022 Board meetings and to a BDS in April 2022. The SBAR to the September Board meeting provided an update (to 22 August) on the Milestone Plan and provided assurance that the Population Health and Wellbeing Strategy is aligned with the National Care and Wellbeing Portfolio. The draft Strategy and associated Delivery plan is to be presented to the NHS Fife Board by January 2023.

We note an update on the existing Clinical Strategy 2016-2021 is to be presented to the 29 November 2022 Board meeting.

The Public Health and Wellbeing Committee (PHWC) has oversight of the development of the Strategic Plan with the Portfolio Board established to commission and monitor the delivery of key milestone activity related to the delivery of the new strategy. The Portfolio Board reports to the PHWC. The Corporate Risks aligned to the PHWC along with the Assurance Principles were considered at the November 2022 meeting.

On 14 November 2022, the Scottish Government outlined its planning approach for 2023-24 which stated an intention to have a more co-ordinated and coherent approach to delivery planning across the whole system. This new planning approach will include:

- clear, high level, population based priorities for the NHS as a whole
- goal setting at national level
- continuation of short, medium and longer term planning by Boards
- a new commissioning approach which will engender greater collaboration to reflect Scotland's population needs as a whole in local, regional and national plans.

Further guidance will be issued in February 2023, including articulation of national priorities which will form the basis for the strategic 'commission' for Boards' own plans. The extent to which these national priorities will be achievable within the constraints under which NHS Fife operates and also the extent to which they match identified local population needs, will not become clear until then.

Internal audit B14-23 Strategic Planning, will further evaluate the development of the Strategic Plan, including an assessment of whether it is likely to deliver services which are sustainable within key constraints, most notably workforce and finance. We will also be issuing a similar assessment of the Fife IJB Strategic Plan, which will inform NHS Fife's Strategic priorities and direction.

Operational Planning

The draft ADP 2022-23 is in line with Scottish Government guidance and was presented to the Board in July 2022 before submission to the Scottish Government by the end of July 2022 and subsequent approval by the Board in September 2022.

We commend the Operational Pressures Escalation Levels (OPEL) tool, developed within NHS Fife and introduced to help provide consistency in reporting and the defined levels of action points linked to the OPEL score and escalation in response to key triggers with the process, roles and

responsibilities defined. The OPEL tool is published on a daily basis on Stafflink for organisational awareness and has shown the extreme pressures within the system and the high risk environment the Board is currently operating within.

Assurance Mapping

The Committee Assurance Principles were endorsed by the NHSF Audit & Risk Committee (ARC) in May 2021. A development session is planned for the ARC in February 2023, which will discuss how to roll out these principles further within NHS Fife. The Board Secretary is currently working with Standing Committee Chairs to ensure they continue to be embedded within the Board's formal assurance processes

Internal Audit will continue to promote the use of the assurance principles through continued leadership of the Assurance mapping Group, attendance at the Risk Opportunities group and though individual Internal Audits.

Integration

The Integration Scheme was reviewed and approved by the NHS Fife Board in September 2021. An MSG self-assessment update was provided to the April 2022 meeting of the Fife IJBA&RC. Two areas were identified for further investigation with all other actions having planned completion dates. An update on MSG recommendations has still to be presented to the FPRC, as agreed in the Internal Audit Annual Report for 2021/22.

The SBAR supporting the Board Assurance Framework presented to the September 2022 A&RC stated that the IJB component of the BAF was discussed at the EDG meeting on the 16 June 2022 and, in light of the review of the Integration Scheme and strengthened governance arrangements, a decision was made to close this risk, with any residual elements included within the new Corporate Risk Register.

Performance

Enhancements to the IPQR continue to be progressed through the IPQR Review Group. An update was provided to Fife NHS Board on 29 March 2022 on the format of the IPQR and consideration of which metrics are to be included within IPQR in 2022/23 was undertaken by the FPRC on 12 July 2022. We commend the ongoing commitment to improving the presentation of the IPQR including enhancement of the performance risk section, further information on adverse events and information on the Establishment Gap.

Covid-19 vaccinations and uptake of flu vaccination will be included in the IPQR. The enhanced IPQR should negate the requirement for separate reports on these topics in the future.

The Board, the FPRC, the SGC, the CGC and the PHWC have received regular performance reports against a range of key measures (Scottish Government and local targets). Projected & Actual Activity for Patient TTG, New Outpatients and Diagnostics are also reported.

The latest IPQR presented at the September 2022 Board meeting highlighted:

- There were no breaches against the 31-Day Cancer Diagnostic Decision to first Treatment measure and performance has been above the Standard for the last 26 months. Performance against the 62-day Cancer Standard fell slightly in comparison to May to 84.5% with a target of 95%.
- Antenatal are meeting target, with three indicators not achieving target but performing within the upper quartile within benchmarking: Delayed discharge % Bed Days Lost (Standard); Patient TTG %<=12 weeks and C Diff HAI/HCAI.
- Twelve indicators are not achieving target but are performing within the Mid Range quartile for benchmarking: 4- Hour Emergency Access; Cancer 62 Day RTT; 18 Weeks RTT; New

Outpatients; Diagnostics; Detect Cancer Early; ECB – HAI/HCAI; Complaints Closed Stage 2; Sickness Absence; Smoking Cessation; CAMHS Waiting Times and Psychological Therapy Waiting Times. The waiting lists for New Outpatients had an increase of 16% when compared to the previous year, and TTG waiting lists increased by 53%.

- The Projected Activity compared against Actual Activity within New Outpatients and Diagnostics was higher than the forecast and TGG activity was approximately 6% lower than forecast.

Clearly performance against a range of targets is proving problematic for NHS Fife, in common with the entirety of NHSScotland and it is imperative that NHS Fife is able to set and deliver realistic targets, within the context of its new Strategic Framework, as soon as possible.

Risk Management

The Risk Management Improvement Programme has continued with an SBAR update of the programme presented to the September 2022 meeting of the ARC.

The Board considered its risk appetite pre-pandemic in 2019 and a revised risk appetite statement was considered at a Board Development Session in June 2022, with approval by the Board on 26 July 2022.

Following engagement with the EDG, Senior Leadership Teams and the Board, a draft Corporate Risk Register (CRR) has now been developed, with the initial presentation of the CRR to each of the standing committees in November 2022, and formal approval due at the 29 November 2022 NHS Fife Board meeting.

The Director of Finance and Strategy informed the September Board that *'the CRR is a dynamic document which requires further refinement'.* Corporate Risk Register papers to standing committees in November 2022 were significantly improved and included the Assurance Principles. This should, in future, allow much greater scrutiny of and focus on the risk and target scores within the revised CRR and greater overt consideration of the effectiveness and impact of mitigating actions and controls. We did note some a number of risks where achievement of the target score in the stated timescale would be exceedingly challenging.

Key Performance Indicators still require further development, to allow the ARC to oversee performance management of the risk management framework. As the framework evolves we would expect risk appetite to be overtly reflected, particularly within target scores, when risks are updated and reviewed.

A risk escalation process was considered by the EDG on 18 August 2022 and the newly established Risk and Opportunities Group (ROG) will take this forward as part of its remit. The ROG's purpose is to provide leadership and promote and embed an effective risk management culture. The group held its initial meeting on 14 September 2022, and is co-chaired by the Associate Director of Quality and Clinical Governance and the Associate Director of Digital & Information. A Terms of Reference has been developed and the group will report to the EDG.

Internal Audit attend the ROG and will input accordingly, with a focus on embedding the assurance principles within the risk processes. A full Internal Audit review of the risk management arrangements, with further exploration of some of the issues identified within this section, will be completed before year-end.

Action Point Reference 1 – Committee Assurances

Finding:

We have noted some areas where there is further scope to enhance governance arrangements:

a) The Board has an Action List which is administered by Corporate Services and is not presented at Board meetings;

b) The risk section of the SBAR papers presented to the Standing Committees still do not always articulate risks and possible consequences associated with the paper

c) The General Policies and Procedures update provided to the November meeting of the FPRC, reported a significant number of policies which are out of date and, in particular, a number of Staff Governance policies that had surpassed their review date, but did not articulate the associated risks. Superseded policies remain on Stafflink.

Audit Recommendation:

We recommend that:

a) The Action List is presented to the Board as a Standing Agenda Item, in line with good practice;

b) The risk section within the SBAR papers presented to the Standing Committees and the Board should fully articulate the risks associated with the report, the linkage to the relevant Corporate or Operational risk and any related consequences;

c) Future SBARs on Policy updates should include a risk assessment on each policy which has passed its renew date, which highlights the risks and possible consequences of the policy not being reviewed within the timescale. Superseded policies should be removed from Stafflink.

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:

Action by:	Date of expected completion:

Action Point Reference 2 – Risk Management	
Finding:	
Corporate Risk Register papers to standing committees in November 2022 were significantly improved and included the Assurance Principles. This should, in future, allow much greater scrutiny of and focus on the risk and target scores within the revised CRR and greater overt consideration of the effectiveness and impact of mitigating actions and controls. We did note some a number of risks where achievement of the target score in the stated timescale would be exceedingly challenging.	
Audit Recommendation:	
Key Performance Indicators still require further development, to allow the ARC to oversee performance management of the risk management framework. As the framework evolves we would expect risk appetite to be overtly reflected, particularly within target scores, when risks are updated and reviewed.	
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:	
Action by:	**Date of expected completion:**

CLINICAL GOVERNANCE

Corporate Risks:

Risk 3 - COVID 19 Pandemic – High Risk (16); Target (12) Moderate

There is an ongoing risk to the health of the population, particularly the clinically vulnerable, the elderly and those living in care homes, that if we are unable to protect people through vaccination and other public health control measures to break the chain of transmission or to respond to a new variant, this will result in mild-to-moderate illness in the majority of the population, but complications requiring hospital care and severe disease, including death in a minority of the population.

Risk 5 - Optimal Clinical Outcomes – High Risk (15);Target (10) Moderate

There is a risk that recovering from the legacy impact of the ongoing pandemic, combined with the impact of the cost-of living crisis on citizens, will increase the level of challenge in meeting the health and care needs of the population both in the immediate and medium term.

Risk 9 - Quality & Safety – High Risk (15);Target (10) Moderate

There is a risk that if our governance, arrangements are ineffective, we may be unable to recognise a risk to the quality of services provided thereby being unable to provide adequate assurance and possible impact to the quality of care delivered to the population of Fife.

Risk 16 - Off-Site Area Sterilisation and Disinfection Unit Service – Moderate Risk (12);Target (6) Low

There is a risk that by continuing to use a single offsite service Area Sterilisation Disinfection Unit (ASDU), our ability to control the supply and standard of equipment required to deliver a safe and effective service will deteriorate.

Clinical Governance Framework

The draft Clinical Governance Strategic Framework (CGSF) and associated annual delivery plan for 2022/23 were approved by the NHS Fife Clinical Governance Committee on 4 November 2022 and we are advised that finalised versions are to be presented to CGC in January 2023. The draft CGSF has been developed with contribution from key stakeholders across NHS Fife. The draft strategy includes elements that address recommendations made in our report on Clinical Governance Strategy and Assurance (B19/21), although we did note that some of our recommendations were not completely addressed either in the framework or through other agreed actions such as adjusting workplans and ToR. Management have been informed of the detailed omissions via the internal audit follow-up system.

The annual delivery plan references 18 separate workstreams at different stages of completion. Work on establishing an Organisational Learning Group, reviewing the Clinical Governance Oversight Group, Development of an Acute Services Division Quality report and on embedding processes for the reviews of deaths of children and young people are reported as complete. Implementation of the delivery plan is to be monitored by the Clinical Governance Oversight Group.

The papers presented to CGC with the draft CGSF included a paper on Health and Social Care Partnership (HSCP) Clinical and Care Governance and Assurance Arrangements. These are not currently reflected in the draft CGSF but we have been advised that arrangements for providing Fife NHS Board with assurance on clinical governance in services delegated to the Integration Joint Board (IJB) will be included in the finalised version. These proposals are considered within our draft report

to the IJB on their Clinical and Care Governance arrangements (F06/22) a summary of which will be presented to the NHS Fife ARC as part of the information sharing protocol.

We would highlight that the Framework states that '*Any direction issued by the IJB must meet all clinical and care governance requirements and standards to ensure patient safety and public protection as well as ensure staff and financial governance. Every IJB has senior professional, clinical and financial advisors as part of their core membership to provide scrutiny of these aspects and to provide assurance. This does not require to be remitted for additional checking through Local Authority of Health Board systems: Local Authorities and Health Boards should ensure that the professional and clinical advisors tasked to provide advice to IJBs are appropriately experienced and supported in their role'.* It is therefore imperative that the Health Board is assured that staff working in the IJBs are aware of this key responsibility and of the need to consult with relevant Health Board staff where there are issues of significant clinical concern.

Section 6.2d of the standing orders of Fife NHS Board states that the strategies for all the functions it has planning responsibility for are a matter reserved for the Board therefore the CGSF, once finalised and endorsed by the CGC, should be presented to Fife NHS Board for approval.

We noted that the CGSF doesn't specifically reference the impact of deferred treatment due to Covid 19 will impact upon the clinical care provided and how it will be mitigated, nor does it refer to Adult and Child Protection and the latest guidance thereon (Scottish Government's NHS Public Protection Accountability and Assurance Framework).

The Framework does not state how it will relate to the Population Health and Wellbeing Strategy currently being developed, however, it is aligned to the same strategic framework document and therefore should not require substantial revision once the PHWS is approved.

Clinical Governance Committee

The CGC Terms of Reference (ToR) included in issue 19 of the CoCG approved by Fife NHS Board on 26 July 2022 included additions related to clinical governance aspects of the developing Population Health & Wellbeing Strategy and alignment and oversight with the emerging Programmes reporting through the Portfolio Board.

The CGC annual workplan for 2022/23 is presented to each CGC meeting and is updated to show items considered as planned and any deferred to later dates. The latest presentation of the workplan indicates that CGC should receive all items in 2022/23 with the exception of Annual Assurance Report and Statements for the following committees and groups, which were missing from the workplan:

- IJB Quality and Communities Committee
- Health and Safety Sub-Committee
- Information Governance & Security Steering Group.

As noted above, not all agreed actions from B19/21 have been implemented.

Clinical Risk Management

The four corporate risks detailed at the start of this section have been aligned to the CGC, as have 2 Information Governance risks .

We will consider the papers presented to CGC during the remainder of 2022/23 to determine whether the new deep dive reports and enhanced scrutiny at CGC meetings allows the CGC to provide reasonable assurance on these risks at year-end, including accuracy of scores, adequacy and effectiveness of key controls and key actions.

The CGC has not received any assurance in 2022/23 to date regarding the Adult and Child Protection risk recorded in the NHS Fife Covid 19 Risk Register and the IJB strategic risk register.

We also noted that the description of the risk titled 'Optimal Clinical Outcomes' (Risk 5) does not fully describe the risk associated with deferred treatment due to the pandemic, does not reflect on any additional risks posed by the requirement by the SG to treat the least clinically urgent cases and the scoring of this risk does not appear to be realistic in the current circumstances.

Clinical Performance Reporting

The latest IPQR and supporting presented to CGC on 4 November 2022 highlighted the following areas which are not reaching target:

- Pressure Ulcers
- ECB (HAI/HCAI)
- CDiff (HAI/HCAI)
- Complaints (S1 & S2)

The IPQR SBAR notes:

- *'As part of ongoing improvement work, revised targets for Falls and Pressure Ulcers have been set for FY 2022/23. These are a 10% reduction on the FY 2021/22 target for Falls, and a 25% reduction on the actual achievement in FY 2020/21 for Pressure Ulcers.*
- *Ongoing challenges relating to COVID and staffing levels within the Patient Relations Department has meant that closure performance of Stage 2 Complaints fell 2/4 significantly during FY 2021/22. An improvement target of 50% by March 2023, rising to 65% by March 2024 has been agreed by the Director of Nursing'*.

The IPQR now includes the relevant corporate risk within each performance section.

External Review

While External Inspection Reports are included on an Activity Tracker document routinely considered by the Clinical Governance Oversight Group (CGOG), the CGOG Terms of Reference do not include responsibility for consideration of external review outcomes and whether appropriate action has been undertaken to address any recommendations made.

The Activity tracker documents presented to CGOG in 2022/23 did not include reports from the Mental Welfare Commission regarding inspections in wards at Lynebank, Queen Margaret, Whyteman's Brae and Stratheden Hospitals, which were however reported to the IJB's Quality Matters Assurance Group. Whilst these reports did not contain any significant matters of concern, this highlights a potential gap in assurance provision to the NHS Fife CGC on recommendations made in external inspection reports related to services delegated to the IJB, which will need to be addressed, avoiding unnecessary duplication.

The recently established Organisational Learning Group (OLG) has met on 4 occasions to date in 2022/23. The remit of the group is focussed on identifying lessons and good practice that can be shared across the organisation and on identifying the best communication methods for this. However, whilst they are fulfilling many aspects of their remit, the group has not yet used issues identified in external reports to assess the adequacy of internal assurances, although this was an agreed Internal Audit recommendation. In addition, the process for triangulating data to assess whether the internal control framework is functioning effectively is not referred to in the CGSF or the SAER process.

Significant Adverse Events

A full review of the Adverse Events Policy and Procedures is being undertaken with a target timescale for publication of January 2023 for a revised Adverse Events Policy and June 2023 for the related Procedural document.

The Key Performance Indicator (KPI) information provided to CGOG on 18 October 2022 highlighted

that over half of open SAERs Significant Adverse Event Reviews (SAERs) with had exceed the 90 day target for completion.

Implementation of actions identified from SAERs is to be added to the IPQR from December 2022 as a metric to provide overview and assurance. The average number of actions closed within the target timeframe over the last 12 months is 51%. An improvement target will be set out in the IPQR to achieve 70% closure rate and this target will be reviewed annually.

The poor performance in processing SAERs was not escalated by CGOG to CGC.

Duty of Candour (DoC)

The DoC Annual Report for 2021/22 is now scheduled for presentation to CGC in March 2023. We have recommended in internal audit B08/22 that the SBAR supporting this report should include all known information on DoC activity in 2022/23.

Action Point Reference 3 – Clinical Governance and Assurance re Services Delegated to the Integration Joint Board	
Finding:	
We identified the following examples of assurance processes associated with services delegated to the IJB are not operating in a manner that would provide CGC with timely assurance on clinical issues and risk management in these services: • The Activity tracker documents presented to CGOG in 2022/23 to date have not included reports from the Mental Welfare Commission regarding inspections in wards at Lynebank, Queen Margaret, Whyteman's Brae and Stratheden Hospitals which were, however, reported to the IJB's Quality Matters Assurance Group (QMAG) • The Clinical Governance Committee has not received any assurance in 2022/23 to date regarding the Adult and Child Protection risk recorded in the NHS Fife Covid 19 and the IJB strategic risk registers.	
Audit Recommendation:	
A process should be established, avoiding unnecessary duplication, to ensure that CGOG is provided with assurance that appropriate action is being undertaken to address recommendations made by external bodies in relation to their inspections of services delegated to the IJB. The NHS Fife Clinical Governance Committee should be provided with assurance regarding the management of risks associated with Adult and Child Protection and should be updated on how the latest Scottish Government's NHS Public Protection Accountability and Assurance Framework is to be used in mitigation of the risks.	
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:	
Action by:	**Date of expected completion:**

Action Point Reference 4 – Clinical Governance Strategic Framework & Clinical Governance Risk Management

Finding:

Clinical Governance Strategic Framework

The CGSF has not yet been scheduled for presentation to Fife NHS Board for approval and does not cover:

- how deferred treatment due to Covid 19 will impact upon the clinical care provided.
- Adult and Child Protection or the latest guidance (Scottish Government's NHS Public Protection Accountability and Assurance Framework)
- the process for triangulating data to assess whether the internal control framework is functioning effectively (also not referred to in the SAER process).

Clinical Governance Oversight Group (CGOG)

The Terms of Reference for CGOG do not include a specific responsibility regarding consideration of external reviews and whether appropriate action has been undertaken to address any recommendations made.

Organisational Learning Group (OLG)

The OLG has not yet fulfilled its responsibility to consider issues identified in external reports and determining whether the issues were identified by internal control systems, before they were discovered by an external auditor/regulator, and what needs to change as a result (this responsibility was included in the OLG remit in response to a previous internal audit recommendation). We also noted that the minutes of OLG meetings are not being presented to CGOG as per the OLG ToR.

Management of Clinical Risk

The description of the risk titled Optimal Clinical Outcomes (Risk 5) does not fully reflect the risks associated with deferred treatment and the scoring of this risk and the associated target risk require further consideration to ensure they are realistic.

Adverse Events Management Assurance

The poor performance in processing SAERs has not been specifically escalated by CGOG to CGC. Examples of issues with performance, reported to CGOG on 18 October 2022, are:

- 28 of 47 SAERs over the 90 day target for investigating and reporting
- Only 1 of 5 scheduled oversight meetings re SAERs went ahead as scheduled
- August 22 – 41% of Major/Extreme incidents closed within 90 days
- Only 50% of LAER and SAER actions closed within target date.

Audit Recommendation:

Clinical Governance Strategic Framework

Section 6.2d of the standing orders of Fife NHS Board states that the strategies for all the functions it has planning responsibility for are a matter reserved for the Board therefore the CGSF once finalised should be presented to Fife NHS Board for approval.

The CGSF should be updated to specifically refer to:

- the process in place to address deferred treatment due to Covid 19 and how this will be monitored

- Adult and Child Protection and the latest guidance (Scottish Government's NHS Public Protection Accountability and Assurance Framework).
- the process for triangulating data to assess whether the internal control framework is functioning effectively (this should also be referred to in the SAER process) ie:
    - If so why were the issues not addressed prior to the inspection
    - If not – what improvements are required to internal control processes to make sure such issues are reported and addressed in future.

Clinical Governance Oversight Group (CGOG)

The CGOG ToR should be amended to include a specific responsibility regarding consideration of external reviews and whether appropriate action has been undertaken to address any recommendations made.

Organisational Learning Group (OLG)

In the remainder of 2022/23 an OLG meeting should be focussed on this topic (ie how to build in the consideration of issues identified in external reports into future OLG agendas and the analysis that would need to be undertaken to provide the OLG with the information to discharge their responsibility as per its ToR item 2.4 – '*Analysis of internal control systems to identify why these did not identify the issues highlighted by the external reports to allow changes to be made so that these issues are highlighted internally earlier in the future*'). The group should consider whether Internal Audit input at this meeting would be beneficial.

Minutes of OLG meetings should be presented to CGOG routinely.

Management of Clinical Risk

The description of risk 5 - Optimal Clinical Outcomes should be updated to describe the risk associated with deferred treatment due to late presentation due to the pandemic and the scoring of this risk should be revised to take account of the related performance information.

Adverse Events Management Assurance

The difficulties in meeting SAER targets should be reported to CGC.

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:

Action by:	Date of expected completion:

STAFF GOVERNANCE

Corporate Risks:

Risk 11 - Workforce Planning and Delivery – High Risk (16); Target (8) Moderate

There is a risk that if we do not implement effective strategic and operational workforce planning, we will not deliver the capacity and capability required to effectively deliver services.

Risk 12 - Staff Health and Wellbeing – High Risk (16);Target (8) Moderate

There is a risk that if due to a limited workforce supply and system pressures, we are unable to maintain the health and wellbeing of our existing staff, we will fail to retain and develop a skilled and sustainable workforce to deliver services now and in the future.

Governance Arrangements

The SGC approved revised Terms of Reference in March 2022 and the revised CoCG was approved by the Board at its July 2022 meeting. Updates on the stage of completion of the 2022/23 SGC workplan are now being reported to each SGC.

While SGC assurance reports to Board do not highlight key risks on Personal Development Plan Reviews (PDPR) completion and completion of training, this risk is reported within the IPQR. To enhance the process and demonstrate triangulation, the SGC Assurance report should highlight any issues, irrespective if they are included within other reporting mechanisms to the Board.

Workforce Strategy/Planning

In compliance with the SG requirements to re-introduce a 3 yearly planning cycle across NHS Scotland, a NHS Fife Workforce Plan 2022-2025 has been produced. The deadlines were met for SGC endorsement and Board approval of the plan before submission to the Scottish Government by 31 July 2022. Internal Audit has completed a review of the plan and will comment on it in detail within the B17/23 – Workforce Planning report, which will be presented to the SGC once finalised.

Risk Management

The SGC will now review corporate risks for Workforce Delivery & Planning and Staff Health & Wellbeing, both of which have a current high rating. Our assessment is that the initial corporate risks report provided to the SGC in November 2022 did not provide sufficient detail on the mitigating actions to enable members to conclude on the current risk scores and the likelihood of the target scores being achieved. The current target reduction from high to moderate for both risks by the end of March 2023 is highly ambitious in the current circumstances.

Staff Governance Standards

Guidance is still awaited from the SG review on staff governance standard monitoring arrangements and accordingly there was no requirement to prepare a staff governance action plan (SGAP) for 2022/23. A number of positive measures are being introduced during 2022/23 to provide the SGC with more detail on the initiatives to meet the SGSs. This includes reports on work undertaken to meet each strand of the SGS within the SGC workplan for 2022/23. At the BDS on 24 October 2022, a presentation gave an overview of the mechanism by which NHS Fife implements and monitors compliance with the SGS. The mechanism is considered by NHS Fife to provide a sound framework for monitoring compliance with the standard, but it does not provide details of the planned initiatives or a measure of how successfully and effectively they are being implemented.

Completion of the 2022/23 SGC Workplan (to date) was reviewed and it was noted that individual reporting to the SGC on each strand of the SGS is planned for 2022/23. However, with the next SGC meeting not until January 2023 this may not be achieved as reporting on the Improved and Safe

Working Environment strand has already been deferred until the January 2023 SGC meeting, and the dates for reports on two other strands (Well Informed and Involved in Decisions) has still to be confirmed.

An update was given to the November 2022 SGC meeting on developing and maintaining local HR policies and also those that fall within the scope of the Once for Scotland Workforce Policies programme (restarting in June 2022). Although details of forthcoming reviews were provided, an overall summary on the maintenance of up to date policies within NHS Fife was not provided, which would have enabled the SGC to assess the adequacy of these.

Staff Experience

The ongoing impact of the Covid 19 pandemic has continued to be reported to the SGC in reports covering staff health and wellbeing, providing assurance on the action being taken to support staff. The Annal Delivery Plan 2022/23 which has workforce implications, was approved at the September 2022 SGC meeting. An update on its completion, including a summary of the completion of high level deliverables was presented to the November 2022 SGC meeting and 65% were reported as on track or complete. An improvement in the uptake of iMatters survey by staff for 2021 - 59% NHS Fife and 61% H&SCP – was reported to the November 2022 SGC meeting.

Whistleblowing

A review of NHS Fife's whistleblowing arrangements is being completed as part of the 2022/23 Annual Internal Audit Plan. At present the work completed indicates that NHS Fife is taking steps to fully implement the directives of the Independent National Whistleblowing Officer. Quarterly and annual reporting on the number of whistleblowing instances and subsequent investigation and implementation of lessons learned forms part of the SGC annual Workplan. Internal Audit B17/23 will be presented to the SGC for consideration.

The SGCs Annual Statement of Assurance for 2021/22 gives a detailed summary of the implementation of whistleblowing arrangements since they were introduced in April 2021. However, although the details of further developments still to be made to current whistleblowing arrangements are noted, an overt opinion on the adequacy of existing whistleblowing arrangements was not included. Providing the annual whistleblowing report to coincide with the issue of the SGCs Annual Statement of Assurance, as supported by a concluding statement from the Whistleblowing Champion, would enable the SGC to provide an overt opinion on the adequacy of whistleblowing arrangements for each year end.

Remuneration Committee

The Remuneration Committee (RC) reviewed its terms of reference at its April 2022 meeting and completed a self assessment of its performance, with only a small number of minor changes arising. Formal guidance and a standardised template on the format of standing committee terms of reference is still awaited from the Once for Scotland team.

Appraisals

The RC reviewed the completion of the 2021/22 performance appraisal process for the Executive and Senior Manager Cohort at its May 2022 meeting. It approved the 2022/23 objective setting process for the Executive and Senior Management Cohort at its July 2022 meeting.

The completion of annual AfC appraisals as reported to the SGC in November 2022 is still being impacted by the Covid19 pandemic, with 33% of appraisals being completed at 31 October 2022. This is a marginal improvement on the 30% completed as at 31 March 2022. The SGC was advised that appraisal performance is being monitored and actions to support staff engagement continue in order to increase the focus on this process and sustain improvement. However, this issue was not escalated to the Board in the Committee Assurance Report. This was also highlighted in the latest SGS update where Appropriate Training and Development was identified as an area of required

improvement.

The Annual Report on Medical Consultant and GP appraisals for 2021/22 was presented to the November 2022 SGC meeting. It shows that 80% of Medical Consultants and 92% of General Practitioners had completed appraisals. The appraisal process was reported as recovering well from the impact of the Covid19 pandemic, with the main challenges being getting sufficient appraisers and also evidential feedback from patients.

Core Skills Training

Obtaining reliable data on core skills training, which NHS Fife is required to deliver to its workforce in order to meet either legal training requirements or to comply with key quality standards in accordance with organisational policy and regulatory requirements, has previously been problematic. No overall reports on core training are currently available. Implementation of Phase 2 of TURAS Learn (replacing Learnpro) is expected to go live towards the end of 2022. It will record the staff training completed and thereby enable the completion rate to be reported in future.

Sickness Reporting

Sickness absence is now reported to the SGC on a regular basis through the Promoting Attendance update reports, which detail the work currently being undertaken by the Attendance Management Taskforce and Operational Group towards improving attendance and wellbeing. This is supplemented by summary data being included in the IPQR presented to each SGC meeting. The absence rate at 31 August 2022 was 6.50%. This is expected to rise further in future months with the removal of the temporary Covid19 absence policy at 1 September 2022. As at August 2022 Covid19 contributed an additional 0.98% to absence levels.

Action Point Reference 5 – Staff Governance Standard	
Finding:	
The mechanism for implementing the SGS as presented to the October 2022 BDS is considered by NHSF to provide a sound framework for monitoring compliance with the standard. However, it does not provide robust assurance of the planned initiatives or a measure of how successfully and effectively they are being implemented. We note in particular the very low rates of Turas completion and the associated risk that staff are not appropriately managed and trained.	
Audit Recommendation:	
As part of the March 2023 year end SGSs overview included in the 2022/23 SGC Workplan, a listing detailing the work still outstanding from 2022/23 to meet the different strands, for completion in 2023/24 should be presented to the SGC. The listing should also include the additional work planned for 2023/24. This will enable the SGC to assess the work completed during 2022/23 and approve the work schedule for 2023/24.	
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:	
Action by:	**Date of expected completion:**

Action Point Reference 6– Staff Governance Standard	
Finding:	
As the final quarter of 2022/23 approaches, planned reporting on all strands of the SGS to the SGC may not be achieved. The Improved and Safe Working Environment strand has already been deferred until the January 2023 SGC meeting and dates for reports on the Well Informed and Involved in Decisions strands are still to be confirmed.	
Audit Recommendation:	
Dates should be set as soon as possible for those strands of the SGS which are not yet confirmed to ensure that the SGC will be able to reach an informed conclusion on compliance with the SGS in its annual report and assurance statement.	
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:	
Action by:	**Date of expected completion:**

Action Point Reference 7 – Whistleblowing	
Finding:	
The SGCs Annual Statement of Assurance gives a detailed summary over whistleblowing arrangements since implementation started in April 2021 but did not provide an overt opinion on the adequacy of current whistleblowing arrangements within NHS Fife.	
Audit Recommendation:	
To enable the SGC to provide an overt opinion on the adequacy of NHS Fife's whistleblowing process as part of its Annual Statement of Assurance, the arrangements for providing the annual whistleblowing report should be reviewed to enable the required information to be provided as part of the year end process. A concluding statement from the Whistleblowing Champion should also form part of the year end assurance process.	
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:	
Action by:	**Date of expected completion:**

FINANCIAL GOVERNANCE

Corporate Risk:

13 Delivery of a balanced in-year financial position

Score 16 High; Target 12 Moderate

There is a risk that the Board may not achieve its statutory financial targets in 2022/23 due to the ongoing impact of the pandemic combined with the very challenging financial context both locally and nationally.

14 Delivery of recurring financial balance over the medium-term

Score 16 High; Target 12 Moderate

There is a risk that NHS Fife will not deliver the financial improvement and sustainability programme actions required to ensure sustainable financial balance over the medium-term.

Financial Environment

The ADP for 2022/23 was approved by NHS Fife Board on 27 September 2022. SG Quarter 1 feedback was that '*all boards are facing a challenging financial position and we note that, at the time the plans were developed, there was considerable uncertainty around expected allocations. We would therefore ask that ADPs are regularly reviewed to ensure they are deliverable within the current financial envelope and from within expected staffing levels'.*

The Director of Finance and Strategy provided a mid-year report on the Financial Position to the EDG on 22 October 2022, and then the FPRC in November 2022. In summary, the forecast outturn for Health retained services at the end of March 2023, in the absence of any actions to mitigate costs, is an overspend of £21.9m. This includes the planned financial deficit of £10.4m and further cost pressures of £11.5m.

The report references a Scottish Government (SG) letter of 12 September 2022 which reemphasised '*the requirement to deliver the £10.4m position, including the cost impact of Covid, as a minimum'.*

Papers presented to the Board have highlighted many risks to the achievement of the target deficit budget position of £10.4m and its achievement is by no means certain.

Financial Planning

The Strategic Financial Plan 2022/23 was approved by the NHS Fife Board on 28 March 2022. This identified a projected budget gap for 2022/23 of £24.1m with plans for this to be mitigated in part through a range of cost improvement plans and a significant capital to revenue transfer. The forecast financial position after the application of these proposed actions is a deficit of £10.4m.

The 3 year financial plan was approved by NHS Fife Board at its meeting on 27 September 2022. This plan has been updated since March to reflect revised planning assumptions issued by SG and extended to cover the three-year period as advised by SG. This plan includes the changes around additional Covid funding.

The financial gap highlighted in the original financial plan to the NHS Fife Board in March 2022 remains the same at £10.4m. However the following assumptions have been made which will be very challenging:

- *The approved cost improvement programme of £11.7m will be delivered during 2022-23*
- *The board will maintain the financial gap confirmed in March 2022 and will pursue potential new opportunities to reduce the gap, in conjunction with ongoing discussion with SG.*

Other assumptions within the financial plan have now changed due to SG decisions. Earmarked reserves of £7.5m, originally intended to offset additional health delegated and set aside costs due to Covid, are not now available and the costs will have to be covered by the NHS Fife core allocation. These are fundamental changes to original financial planning assumptions, which are being managed and reported within the IPQR, and are making the achievement of financial targets extremely challenging.

Financial Reporting

Finance reporting to Board and FPRC has been transparent and open and the Director of Finance and Strategy has consistently and clearly articulated financial challenges through EDG, Standing Committees and the Board. However, there would be benefit, given the importance of these issues, in ensuring that all members are able to understand the technical language used in finance reports and that this does not obscure key messages.

Finance Risk Reporting

The Financial Sustainability BAF, last reported as a High risk to the FPRC in September 2022, recognised the ongoing impact of COVID funding implications and the reduced availability of COVID funding due to inflationary pressure and service demand. High levels of unscheduled care along with workforce fatigue impacting on cost improvement programmes were also highlighted as current challenges. The Financial Improvement/Sustainability (FIS) Programme was highlighted as the key enabling programme to support the delivery of NHS Fife's corporate objectives and longer-term strategy development.

Two corporate financial risks have been created, one for in year delivery of the financial plan and the second related to the longer term financial plan. These risks were first reported to the FPRC at the 15 November 2022 meeting. We welcome this approach for managing finance related risks with a clear split between short and long term financial planning/reporting which should allow for greater clarity around the reporting on adequacy and effectiveness of key controls and key actions. We also welcome the 'deep dive' report provided 'on the aim of achievement of in year financial balance'.

The risk reporting process will continue to evolve over the coming months and we would recommend detailed consideration of both target and actual risks, which need to reflect the extreme pressures the Board is facing, which have been well reported. In particular, the target risk scores due to be achieved by 31 March 2023 appear to be optimistic in the circumstances.

The 3-year financial plan also highlights a number of risks which continue to have an impact on the delivery of the financial plan, which are not all clearly incorporated within either of the two corporate finance risks. The Financial Plan identifies that '*significant but as yet unknown employment issues with financial implications have not been included in the medium term financial plan'*. Workforce risks, together with finance and unrealistic expectations are fundamental risks facing the NHS and will need to be managed and reflected within overall strategy, workforce plans, the updates to Financial Plans and the Corporate Risks.

Cost Improvement Plans (Savings)

Over the last year NHS Fife has progressed work through its Strategic Planning and Resource Allocation (SPRA) process with the aim of helping to deliver financial balance. NHS Fife has established a Financial Improvement and Sustainability (FIS) Programme with the aim to deliver financial improvement and sustainability, with a FIS Programme Board in place. Membership of the FIS Programme Board is appropriate, with the FIS Board having a clear remit and objectives, governance processes and a benefits delivery tracker.

In addition to having oversight of delivery of approved cost improvement plans, the FIS Programme Board also consider a "pipeline" of future plans and developments.

A Cost Improvement Plans (CIP) progress report was presented to the November 2022 FPRC. At the

end of August £2.628m of anticipated CIP of £4.312m was achieved, resulting in a current year to date shortfall of £1.684m. Recurring savings achieved were £1.075m, equivalent to 9% of the full year target. At this stage in the financial year a significant risk remains around the delivery of the overall £11.7m CIP target but overall financial plan for 2022/23 assumes that all CIPs will be delivered by financial year end and also that there will be no impact on the quality of patient care and safety.

Savings identified within the FIS Programme are mainly operational rather than strategic in nature and there is, as yet, no clear links to the process for developing overall strategy. To achieve financial stability in the medium to long term, the PHWS will need to identify priority areas and disinvestment opportunities, with clear linkages to savings and transformation programmes.

Standards of Business Conduct

The Board Secretary is currently updating the Standards of Business Conduct to ensure they reflect best practice and guidance. In addition, a guidance document on how the Standards of Business Conduct applies to staff has been appended which will enhance and strengthen the process.

Capital

An interim update PAMS was endorsed by the FPRC and approved by the NHS Fife Board in September 2022. The PAMS is required to be submitted to the SG every two years with an interim report PAMS in between. The PAMS is clear on its role as an enabling strategy as part of the Population Health and Wellbeing Strategy development.

Through the Estates, Facilities and Capital Planning SPRA process, strategic priorities have been identified for now and the future. These priorities are included in the PAMS as an action plan against which progress will be reported to the Fife Capital Investment Group and the FPRC.

We note the PAMS highlights 'the current situation and strategic and political context are enabling consideration of positive and bold changes regarding the Mental Health inpatient estate'. We commend this approach around developing mental health facilities across NHS Fife.

An external review of Primary Care Premises is at draft report stage and, as outlined in the PAMS, includes short, medium and long-term service and premises recommendations. The report will be considered by NHS Fife, Fife Health & Social Care Partnership and key stakeholders and a plan to progress actions will be developed by March 2023.

A new Corporate Risk for Prioritisation & Management of Capital Funding has been developed to support the Population Health & Wellbeing Strategy. The PAMS includes risks under the themes of capital projects; strategy; Sustainability Policy; and Estates and Facilities, with each of these to be included within the Corporate Risk.

The Capital Plan 2022/23 was endorsed at the March 2023 FPRC and approved at the NHS Fife Board meeting. There are clear links from the Capital Plan to the PAMS.

The FPRC receive regular updates on current major capital projects. It has been reported in the recent IPQR, that the capital programme is expected to be delivered in full and will include the completion of the National Treatment Centre – Fife Orthopaedics.

Asset Verification

Physical checking of a sample of assets is a management requirement within the NHS Fife Financial Operating Procedures. Internal Audit have been informed that due to covid physical checking of equipment has not been undertaken however plans are in place to have this done before financial year end.

Action Point Reference 8 – Finance Risks – Corporate Risk Register	
Finding:	
We have been informed that the current Financial Sustainability BAF will be split into two new corporate risks. One will focus on in year delivery of the current financial plan and the second will consider the wider delivery of the 3 year financial plan. This approach should provide a more detailed and focussed management of financial risks as part of the updating of the NHS Fife Risk Framework. The 3 year Financial Plan did list a number of constituent risks and assumptions to financial balance, not all of which were reflected in the previous BAF.	
Audit Recommendation:	
The risks and assumptions included in the 3 year Financial Plans should be incorporated within the new, bifurcated corporate financial risks.	
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:	
Action by:	**Date of expected completion:**

INFORMATION GOVERNANCE

Information Governance

Corporate Risks:

Risk 17 – Cyber Resilience – High Risk (16); Target (12) Moderate

There is a risk that NHS Fife will be overcome by a targeted and sustained cyber attack that may impact the availability and / or integrity of digital and information required to operate a full health service.

Risk 18 – Digital and Information – High Risk (15);Target (10) Moderate

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.

Previous ICE and Annual Report Internal Audit Recommendations

Action had been completed to address all Information Governance (IG) related recommendations from our previous ICE and Annual Reports. We commend the work undertaken to improve assurance and governance arrangements for this important area. The establishment of regular reporting to the CGC on Information Governance & Security and on the delivery of the Digital and Information Strategy, in addition to the minutes of the relevant groups being presented, allows CGC members to more effectively scrutinise the assurance provided.

Work is underway to further improve the quality of the assurance provided on IG and Security, including obtaining better data (eg on IG Training) and developing a combined report following a mapping exercise to identify commonality between the various legislative and directive requirements primarily focussed on the Information Commissioner's Office Accountability Framework (ICOAF) and the Network & Information System Regulations (NISR). A draft approach to this revised reporting will be discussed at the IG & Security Group in January 2023. Given the significant workload involved in the mapping and developing reporting on the 338 ICO Accountability Framework controls and 434 NISR controls, there may well be benefit in approaching the SG to consider a rationalised and streamlined approach across NHS Scotland, learning from the approach taken by NHS Fife.

Governance

The Information Governance and Security Steering Group (IG&SSG) and Digital and Information Board (D&IB) continue to provide assurance to the CGC with the latest IG&S update presented to CGC in September 2022 and an update on the D&I Strategy provided in July 2022 with further updates on both scheduled on the CGC workplan for March and January 2023 respectively.

Risk Management

The format of risk reporting to IG&SSG continues to evolve and the overall NHS Fife approach to Risk Management has been revised with a new Corporate Risk Register replacing BAFs. Reporting to IG&SSG is well structured and promotes discussion on whether current and planned mitigations will be sufficient to reduce the risk score to its target level before the risk materialises, including helpful consideration of risk velocity, a key consideration for IG risks.

The latest risk report presented to IG&SSG included graphical representation of the 29 risks recorded with 8 scored as high, 18 scored as medium and 3 scored as low. This showed that 8 risks had improved scores and 1 risk had deteriorated. Further analysis is provided of high level risks

including details on root cause and mitigating actions and status against target implementation timescales for these.

The latest risk report presented to D&IB included graphical representation of the 42 risks recorded with 12 scored as high, 20 scored as medium and 10 scored as low. This showed that 17 risks had improved scores and no risks had deteriorated. Further analysis is provided of high level risks including details on root cause and mitigating actions and status against target implementation timescales for these.

The two Information Governance corporate risks have been aligned to the CGC for scrutiny. We did note that in the initial presentation of these risks to CGC at their 4 November 2022 meeting that the mitigations to the D&I Strategy risk (risk 18) do not include the D&I Workforce Plan which we would see as a key control.

We will consider the papers presented to CGC during the remainder of 2022/23 to determine whether the new deep dive reports and enhanced scrutiny at CGC meetings allows the CGC to provide reasonable assurance on these risks at year-end, including accuracy of scores, adequacy and effectiveness of key controls and key actions. We will also consider how the risk management reporting at CGC interacts with the reporting to IG&SSG and D&IB.

Digital and Information Strategy

The update presented to CGC on 1 July 2022 highlighted those elements of the D&I Strategy which will not be delivered by 31 March 2024 and acknowledged that '*The financial impact alone identifies the requirement for re-prioritisation to take place over the remaining term of the strategy and through the organisation's SPRA process*' and '*The primary focus will be to agree a prioritised workplan for the remaining 2 year of the strategy, that matches the resource and finance availability and to raise general visibility and identify support necessary for digital projects at an SLT level*'. A revised delivery plan was presented to the Digital and Information Board in October 2022 with an update to the NHS Fife Clinical Governance Committee scheduled for January 2023. It is vital that this update identifies the impact of any areas which will not be delivered on the Strategic Objectives of the Health Board and IJB.

The regular portfolio and project updates provided to the D&IB outline the status of projects and their strategic alignment.

Information Governance Responsibilities

An NHS Fife Senior Information Risk Owner (SIRO) and Data Protection Officer (DPO) are in place and the SIRO is an Executive member of the Board.

Information Governance Policies and Procedures

The status of IG related policies is now reported to IG&SSG with the most recent report presented in October 2022 indicating that all 5 policies were within their review date. The two key policies that had lapsed review dates have been updated, approved and published on Stafflink:

- GP/I5 - Information Security Policy NHS Fife – review date January 2025
- GP/D3 – NHS Fife Information Governance and Data Protection Core Policy review date August 2023

Superseded GP/D3 policy - NHS Fife Data Protection & Confidentiality Policy was still published on Stafflink.

Information Governance Incidents and Reporting

The latest IG&S update report presented to CGC on 2 September 2022 includes an appended table that shows the overall number of IG related incidents, the number of these reported to the ICO and

the number of these reported within the 72 hour statutory timescale and the number that required an ICO follow-up. This reporting could be improved by adding a short narrative section in the report including information on compliance with the 72-hour statutory timescale for reporting to the ICO and an opinion regarding whether any of the incidents reported to date will require to be included as disclosures in the Board's Governance statement.

Action Point Reference 9 – IG&S Assurance Reporting	
Finding:	
Work is underway to further improve the quality of the assurance provided on IG and Security including developing a combined report following a mapping exercise identifying commonality between the various legislative and directive requirements primarily focussed on the Information Commissioner's Office Accountability Framework (ICOAF) and the Network & Information System Regulations (NISR). A draft approach to this revised reporting is to be discussed at the Information Governance & Security Group in January 2023.	
Audit Recommendation:	
Given the significant workload involved in the mapping and developing reporting on the 338 ICO Accountability Framework controls and 434 NISR controls, there may well be benefit in approaching the SG to consider a rationalised and streamlined approach across NHS Scotland, learning from the approach taken by NHS Fife.	
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:	
Action by:	**Date of expected completion:**

Action Point Reference 10 – IG Incident Reporting to CGC	
Finding:	
The latest IG&S update report presented to CGC on 2 September 2022 does not include any narrative on IG Incident Management.	
Audit Recommendation:	
A section on IG Incident Management should be added to the narrative section in the report including: • Reasons for any instances of non-compliance with the 72 hour statutory timescale for reporting to the ICO and what has been done to prevent this from happening in future • Sufficient information to allow an opinion on whether any of the incidents reported to date should be considered for disclosure within the Board's Governance statement.	
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:	
Action by:	**Date of expected completion:**

Action Point Reference 11 – D&I Strategy Risk	
Finding:	
The report to November 2022 CGC on the D&I Strategy risk (risk 18) did not include the D&I Workforce Plan as a key control over a fundamental risk component.	
Audit Recommendation:	
The D&I Workforce Plan should be added to the Corporate Risk Register as a mitigation to risk 18 – regarding the D&I Strategy to allow assessment of its implementation and effectiveness.	
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:	
Action by:	**Date of expected completion:**

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.**	1 (Ref 3)
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.**	10 (Ref 1, 2, 4, 5, 6, 7, 8, 9, 10 & 11)

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**5 December 2022**
Title:	**External Audit – Follow Up Report on Audit Recommendations**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Report Author:	**Kevin Booth, Head of Financial Services & Procurement**

1 Purpose

This is presented to the Committee for:

- Assurance

This report relates to a:

- Government policy/directive
- Legal requirement
- Local policy

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

- Effective

2 Report summary

2.1 Situation

This paper provides a progress report against the recommendations from the External Audit Annual Report on the 2021/22 Accounts.

2.2 Background

The table below sets out the external audit recommendations and the agreed management actions along with anticipated timings.

2021/22 recommendations

Issue/risk	Recommendation	Agreed management action/timing
1. **Integration Joint Board adjustments** A considerable amount of time was spent by the auditors in agreeing IJB figures in the draft accounts to the ledger and the IJB draft accounts due to the lack of supporting schedules provided by Management and issues with the accounting for the movement in NHS Fife's share of surpluses resulted in a significant adjustment in the audited accounts. Risk – the figures in the accounts submitted for audit do not agree to the ledger or IJB accounts.	IJB figures should be supported by detailed working papers and early agreement of figures in the accounts should be obtained from the IJB. Paragraph 18	Whilst the adjustment was significant it resulted from a technical accounting interpretation and did not arise from an error in the overall calculation of the cumulative share. Management will ensure that the correct treatment for any future in year IJB reserves are correctly presented. **Responsible officer: Margo McGurk** **Agreed date 31 December 2022**
2. Year end accruals During our audit testing, we identified a number of accruals where audit evidence could be improved and in some cases, we believe that evidence was insufficient to support a year end accrual, but this did not represent a risk of material misstatement. Risk – Accruals and expenditure may be overstated	Management should implement controls to ensure all year end accruals are valid and adequately supported by working papers. Paragraph 18	Management will ensure that sufficient evidence for any future accruals is retained. **Responsible officer: Margo McGurk** **Agreed date 31 March 2023**
3. Financial sustainability – unidentified savings NHS Fife's 2022/23 financial plan was approved by the Board on 22 March 2022. The plan identifies a funding gap of £24 million (2021/22 £22 million), £14 million of which is to be met by identified efficiency savings of £12 million and a transfer from capital to revenue of £2 million. The forecast year- end financial position is a deficit of £10 million.	NHS Fife should ensure that savings plans are developed identifying how the £10 million of unidentified savings in 2022/23 will be achieved. Paragraph 53	The FIS Programme clearly focuses in the initial year on delivering a sustained and recurring level of cost improvement/saving. There is a very deliberate shift away from reliance on non-recurring savings and support from the Scottish Government. It is critical that there is a deliverable plan in place which there is for the £14 million described in this section. We are working also on a Pipeline of additional schemes which may be able

Risk – Continued reliance on non-recurring savings and support from the Scottish Government presents a risk to future financial sustainability.		to be accelerated this financial year. The focus importantly is on delivering financial balance sustainably over the medium term and this is the approach NHS Fife is embedding. There is also the added challenge that there are no UK consequentials for Covid in 2022/23 which will challenge the ability of the Board to improve on the £14 million even further. Whilst Scottish Government have made good progress in allocating resources early in the financial year there are still occasions when this does not happen and therefore the challenge locally in allocating and spending in-year. **Responsible officer: Margo McGurk** **Agreed date 30 September 2022**
b/f 1. Holiday pay accrual	NHS Fife should continue to develop the process used to calculate the accrual to ensure the medical and dental estimate is based on returns from a variety of services, reducing the risk that the estimate is subject to significant uncertainty.	**In Progress** Management will continue to develop the process to improve the accuracy of reporting. **Revised action: Margo McGurk** **Responsible officer** **Revised date 31 March 2023**
b/f 2. Discounting of annual medical negligence payments	The duration of the annual cost commitment is subject to significant uncertainty and is reimbursed to NHS Fife via the CNORIS scheme. The application of discount factors to the ongoing payment should be reviewed by 31 March 2022.	**Complete**

b/f 3. Recruitment of payroll staff	Recruitment issues in payroll services need to be addressed to prevent wider risks to service provision.	**In progress** In January 2022, a formal business case was agreed by the Board for NHS Fife to join the South East Scotland Payroll Consortium. This is made up of eight NHS Boards and NHS NSS will become the single employer of Payroll Services across these Boards. The provisional date for NHS Fife payroll staff being transferred to NHS NSS is 1 November 2022.
b/f 4. Savings for 2021/22 still need to be identified	NHS Fife needs to prepare contingency plans if the unachieved legacy gap is not to be funded by the Scottish Government.	**Complete**
b/f 5. Transformation	We have noted progress with the development of a Financial Improvement and Sustainability (FIS) Programme. This has been established to set up projects to ensure long term financial improvement and sustainability in NHS Fife. Its objectives include establishing a clear medium term financial plan and developing savings plans for 2022/23. NHS Fife needs to accelerate transformation by ensuring it is embedded within the FIS Programme and the development of a new Health and Wellbeing Strategy for Fife. Paragraph 59	**In progress** Over the past 15 months, NHS Fife has demonstrated its commitment to the transformation agenda and has taken positive steps to identify initiatives and invest in new technology to improve performance in the future

2.3 Assessment

Progress continues towards the 2021/22 External audit recommendations as well as those continued from 2020/21 and progress can be summarised as follows:

1 – Integration Joint Board adjustments

The technical accounting treatment of Integrated Joint Board reserves is understood and will be able to be appropriately accounted for in the 2022/23 Annual Accounts process should a surplus again be reported. In addition, there has been an increased senior financial resource committed to

monitoring NHS Fife's interest in the IJB and as a result the year end position will be understood on a timelier basis.

2 – Year End Accruals

The relevant members of the Finance Team have been briefed on the audit feedback with regards to the expected supporting evidence for any future accruals. Ahead of the 2022/23 External Audit process and provision of working papers, an exercise will be undertaken to ensure the appropriate paperwork is included ahead of the commencement of the assignment.

3 – Financial sustainability – unidentified savings

The financial plan at the start of 2022/23 which includes a programme of Financial Improvement and Sustainability aims to deliver £12.7m of savings in 2022/23. The Financial Improvement and Sustainability Programme continues to drive financial improvement across the organisation and the programme has been aided by the recruitment of a senior Finance Manager to support the progress.

As of 11th November, the Scottish Government have requested NHS Fife deliver its financial plan which reflects a financial gap of £10.4m as a minimum, at the financial year end. Scottish Government have confirmed that they are returning to their 2018 commitment in relation to the Medium-Term Financial Framework regarding a three-year reporting period to deliver financial balance. A three-year financial plan was submitted to the Scottish Government in August detailing our plans to achieve financial balance by the end of the three-year period under review.

b/f1 – Holiday Pay Accrual

Whilst the process for calculating and ensuring sufficient coverage remains the same. Management continues to proactively engage with the services to ensure that any known uncertainties are minimised where possible.

b/f3 – Recruitment of Payroll Staff

The Payroll team has successfully recruited two Payroll Officers to the team during 2022/23, leaving one vacancy at present. Whilst the two new Payroll Officers are continuing with their extensive internal training, their recruitment has brought and continues to provide the service with additional reliance.

The present position with regards to the South East Payroll Consortium is that the NHS Fife Payroll staff will all TUPE over to NSS on 01/02/22 and a programme of works is underway at present to minimise any effects potentially felt by NHS Fife as the service transitions from its day-to-day management.

b/f5 - Transformation

Transformation retains its place on the NHS Fife agenda and is being focused on as part of the 2022/23 SPRA process and the development of the new Population Health and Wellbeing Strategy.

2.3.1 Quality/ Patient Care

N/A

2.3.2 Workforce

The External Annual Accounts Audit report was widely shared with members of the Finance directorate to ensure that lessons were learned from any areas brought to attention during the 2021/22 process.

2.3.3 Financial

The Financial Risks and the need to ensure an appropriate response has been widely communicated and continues to be monitored across the Directorate.

2.3.4 Risk Assessment/Management

It is important to ensure that all audit recommendations receive appropriate attention to ensure risks associated with them can be managed timeously.

2.3.5 Equality and Diversity, including health inequalities

A separate EDA has not been completed in relation to this report however the financial planning and financial governance arrangements in place across the organisation include the appropriate assessments.

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

Updates on the progress towards the 2021/22 Audit recommendation have been formed following consultations with relevant members of the finance Directorate.

2.3.8 Route to the Meeting

Progress on the 2021/22 External Audit Annual Accounts recommendations is regularly provided to the Director of Finance and Strategy.

2.4 Recommendation

The Audit & Risk committee is asked to take assurance from the progress made against the 2021/22 External Audit recommendations.

3 List of appendices

N/A

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NHS Fife

External Audit Strategy 2022/23

Azets

November 2022

Table of Contents

Introduction

Azets have been appointed by Audit Scotland as the external auditor to NHS Fife for the period 2022/23 to 2026/27.

At the Audit and Risk Committee meeting on 12 September 2022, we presented a high level introduction to Azets. This document provides an introduction to our audit team and sets out our audit strategy for 2022/23.

We expect that our audit will have a similar underlying approach to that of your previous external auditor, Audit Scotland, although there are some changes to the Code of Audit Practice and auditing standards that come into effect for the first time in 2022/23. These are reflected in this document.

We firmly believe that the best and most effective audits are underpinned by strong, professional working relationships with key client contacts right from the outset and this will be our key aim over the duration of our appointment. The benefits of our audit approach include:

- Full compliance with the Audit Scotland Code of Audit Practice
- Sector expertise from dedicated public sector external audit specialists
- Proactive, open and constructive planning and communication
- A risk-based audit approach tailored to NHS Fife
- Clear and concise reporting
- Proactive liaison with internal audit
- Responsiveness and independence of thought.

Adding value

All of our clients quite rightly demand of us a positive contribution to meeting their ever-changing business needs. We aim to add value by being constructive and forward looking, by identifying areas of improvement and by recommending and encouraging good practice. In this way we aim to help you promote improved standards of governance, better management and decision making and more effective use of public money.

Any comments you may have on the service we provide would be greatly appreciated.

Your Azets audit team

The NHS Fife external audit team will be led by Chris Brown and managed by Karen Jones. We will draw upon the expertise of our wider public sector management team during the course of our audit appointment.

Chris Brown: Engagement Lead

chris.brown@azets.co.uk

Chris is the partner in charge of our audit of NHS Fife. Chris has over 25 years' experience in NHS auditing and leads most of our external audit appointments in the health sector. Chris is a recognised specialist in public sector governance and risk management and is always available to provide accounting and other advice to the Board.

Karen Jones: Engagement Manager

karen.jones@azets.co.uk

Karen is one of the directors responsible for our Audit Scotland appointments. She has considerable experience in planning and delivering public sector audits, producing management reports and liaising with senior management and audit committees.

Our experience

Our portfolio of new and previous Audit Scotland appointments is set out below. We have also included selected clients from across our wider public sector client base.

New Audit Scotland appointments

Local Government	NHS	Further Education
Clydeplan	NHS Fife	Ayrshire College
Fife Council	Public Health Scotland	Borders College
Fife Integration Joint Board	Scottish Ambulance Service	Dumfries and Galloway College
Fife Pension Fund		West College Scotland
Lothian Pension Fund		
Renfrewshire Council		
Renfrewshire Valuation Joint Board		
Scotland Excel		

Previous Audit Scotland appointments

Local Government	NHS	Further Education	Central Government
City of Edinburgh Council	NHS Lothian	City of Glasgow College	Disclosure Scotland
Lothian Pension Fund	Mental Welfare Commission for Scotland	Glasgow Kelvin College	Scottish Housing Regulator
Edinburgh Integration Joint Board	NHS 24	Glasgow Colleges Regional Board	Police Investigation and Review Commissioner
Lothian Valuation Joint Board	National Waiting Times Centre Board	Glasgow Clyde College	Scottish Courts Service
SESTRAN	The State Hospitals Board for Scotland	Dumfries and Galloway College	Scottish Prison Service
Strathclyde Partnership for Transport		Borders College	Scottish Road Works Commissioner
Strathclyde Concessionary Travel Scheme Joint Committee			

The table below lists some of our wider Scottish health sector clients.

Client	Service provision
NHS Greater Glasgow and Clyde	Internal audit, Risk workshops
NHS Highland	Internal audit, Governance workshops
NHS Shetland	Internal audit, Risk workshops
NHS Western Isles	Internal audit, Governance workshops
NHS Orkney	Internal audit, Governance workshops, Lean reviews

Our responsibilities

The Auditor General and Audit Scotland

The Auditor General for Scotland is a Crown appointment and independent of the Scottish Government and Parliament. The Auditor General is responsible for appointing independent auditors to audit the accounts of the Scottish Government and most Scottish public bodies, including NHS bodies, and reporting on their financial health and performance.

Audit Scotland is an independent statutory body that co-ordinates and supports the delivery of high-quality public sector audit in Scotland. Audit Scotland oversees the appointment and performance of auditors, provides technical support, delivers performance audit and Best Value work programmes and undertakes financial audits of public bodies.

The Auditor General appointed Azets as external auditor of NHS Fife for the five year period commencing 2022/23.

Auditor responsibilities

Code of Audit Practice

The Code of Audit Practice (the Code) describes the high-level, principles-based purpose and scope of public audit in Scotland. The 2021 Code replaces the Code issued in 2016 and came into effect from 2022/23.

The Code of Audit Practice outlines the responsibilities of external auditors appointed by the Auditor General for Scotland and it is a condition of our appointment that we follow it.

Our responsibilities

Auditor responsibilities are derived from the Code, statute, International Standards on Auditing (UK) and the Ethical Standard for auditors, other professional requirements and best practice, and guidance from Audit Scotland.

We are responsible for the audit of the accounts and the wider-scope responsibilities explained below. We act independently in carrying out our role and in exercising professional judgement. We report to the Board and others, including Audit Scotland, on the results of our audit work.

Weaknesses or risks, including fraud and other irregularities, identified by auditors, are only those which come to our attention during our normal audit work in accordance with the Code and may not be all that exist.

Wider scope audit work

Reflecting the fact that public money is involved, public audit is planned and undertaken from a wider perspective than in the private sector.

The wider scope audit specified by the Code broadens the audit of the accounts to include additional aspects or risks in areas of financial management; financial sustainability; vision, leadership and governance; and use of resources to improve outcomes.

Financial management

Financial management means having sound budgetary processes. Audited bodies require to understand the financial environment and whether their internal controls are operating effectively.

Auditor considerations

Auditors consider whether the body has effective arrangements to secure sound financial management. This includes the strength of the financial management culture, accountability, and arrangements to prevent and detect fraud, error and other irregularities.

Financial sustainability

Financial sustainability means being able to meet the needs of the present without compromising the ability of future generations to meet their own needs.

Auditor considerations

Auditors consider the extent to which audited bodies show regard to financial sustainability. They look ahead to the medium term (two to five years) and longer term (over five years) to consider whether the body is planning effectively so it can continue to deliver services.

Vision, leadership and governance

Audited bodies must have a clear vision and strategy, and set priorities for improvement within this vision and strategy. They work together with partners and communities to improve outcomes and foster a culture of innovation.

Auditor considerations

Auditors consider the clarity of plans to implement the vision, strategy and priorities adopted by the leaders of the audited body. Auditors also consider the effectiveness of governance arrangements for delivery, including openness and transparency of decision-making; robustness of scrutiny and shared working arrangements; and reporting of decisions and outcomes, and financial and performance information.

Use of resources to improve outcomes

Audited bodies need to make best use of their resources to meet stated outcomes and improvement objectives, through effective planning and working with strategic partners and communities. This includes demonstrating economy, efficiency and effectiveness through the use of financial and other resources, and reporting performance against outcomes.

Auditor considerations

Auditors consider the clarity of arrangements in place to ensure that resources are deployed to improve strategic outcomes, meet the needs of service users taking account of inequalities, and deliver continuous improvements in priority services.

Audit quality

The Auditor General and the Accounts Commission require assurance on the quality of public audit in Scotland through comprehensive audit quality arrangements that apply to all audit work and providers. The audit quality arrangements recognise the importance of audit quality to the Auditor General and the Accounts Commission and provide regular reporting on audit quality and performance.

Audit Scotland maintains and delivers an Audit Quality Framework.

The most recent audit quality report can be found at https://www.audit-scotland.gov.uk/publications/quality-of-public-audit-in-scotland-annual-report-202122

Audit strategy

Risk-based audit approach

We follow a risk-based approach to audit planning that reflects our overall assessment of the relevant risks that apply to the Board. This ensures that our audit focuses on the areas of highest risk. Our audit planning is based on:

Discussions with senior officers	**Our understanding of the health sector, its key priorities and risks**	**Attendance at the Audit & Risk Committee**
Guidance from Audit Scotland	**Discussions with Audit Scotland and other NHS auditors**	**Discussions with internal audit and reviews of their plans and reports**
Review of the Board's corporate strategies and plans	**Review of the Board's corporate risk register**	**Consideration of the work of other inspection bodies**

Planning is a continuous process and our audit plans are updated during the course of our audit to take account of developments as they arise.

Professional standards and guidance

We perform our audit of the financial statements in accordance with International Standards on Auditing UK (ISAs (UK)),Ethical Standards, and applicable Practice Notes and other guidance issued by the Financial Reporting Council (FRC).

Partnership working

We coordinate our work with Audit Scotland, internal audit, other external auditors and relevant scrutiny bodies, recognising the increasing integration of service delivery and partnership working within the public sector.

Audit Scotland

Although we are independent of Audit Scotland and are responsible for forming our own views and opinions, we do work closely with Audit Scotland throughout the audit. This helps identify common priorities and risks, treat issues consistently across the sector, and improve audit quality and efficiency. We share information

about identified risks, good practices and barriers to improvement so that lessons to be learnt and knowledge of what works can be disseminated to all relevant bodies.

Audit Scotland undertakes national performance audits on issues affecting the public sector. We may review the Board's arrangements for taking action on any issues reported in the national performance reports which may have a local impact. We also consider the extent to which the Board uses the national performance reports as a means to help improve performance at the local level.

During the year we may also be required to provide information to Audit Scotland to support the national performance audits.

Sharing intelligence for health and social care

The Sharing Intelligence for Health and Social Care Group enables seven national agencies[1] to share and consider intelligence about the quality of health and social care systems across Scotland. The aim of the group is to support improvement in the quality of health and social care. When any of the agencies has a potentially serious concern about a health and social care system, the group ensures this is shared and acted upon appropriately.

We are required to complete an intelligence return and attend the group meeting when the Board is being considered. Attendance at the meeting also provides us with the opportunity to hear intelligence from other agencies.

Internal Audit

As part of our audit, we consider the scope and nature of internal audit work and look to minimise duplication of effort, to ensure the total audit resource to the Board is used as efficiently and effectively as possible.

Shared systems and functions

Audit Scotland encourages auditors to seek efficiencies and avoid duplication of effort by liaising closely with other external auditors, agreeing an appropriate division of work and sharing audit findings. Assurance reports are prepared by service auditors in the health sector covering the national systems / arrangements. We consider the audit assurance reports when evaluating the Board's systems.

[1] The seven national agencies referred to are: Healthcare Improvement Scotland, NHS Education for Scotland, the Care Inspectorate, Audit Scotland, the Scottish Public Services Ombudsman, the Mental Welfare Commission for Scotland, and Public Health Scotland.

Delivering the audit – post pandemic

Hybrid audit approach

We intend to adopt a hybrid approach to our audit which combines on-site visits with remote working; learning from the better practices developed during the pandemic.

All of our people have the equipment, technology and systems to allow them to work remotely or on-site, including secure access to all necessary data and information.

All of our staff are fully contactable by email, phone call and video-conferencing.

Meetings can be held over Skype, Microsoft Teams or by telephone.

We employ greater use of technology to examine evidence, but only where we have assessed both the sufficiency and appropriateness of the audit evidence produced.

Secure sharing of information

We use a cloud-based file sharing service that enables users to easily and securely exchange documents and provides a single repository for audit evidence.

Regular contact

During the 'fieldwork' phases of our audit, we will arrange regular catch-ups with key personnel to discuss the progress of the audit. The frequency of these meetings will be discussed and agreed with management.

Signing annual accounts

Audit Scotland recommends the electronic signing of annual accounts and currently uses a system called DocuSign.

Electronic signatures simplify the process of signing the accounts and are acceptable for laying in Parliament. Accounts can be signed using any device from any location. There is no longer a need for duplicate copies to be signed, thus reducing the risk of missing a signature and all signatories have immediate access to a high-quality PDF version of the accounts.

Key audit developments in 2022/23

Revised auditing standards[2], which come into effect from the current year, will have a significant impact on the way we perform our audit, particularly how we assess the risk of material misstatement, our approach to the audit of fraud, and the ways we ensure our audits are performed in line with regulatory requirements and to a high

[2] Revisions to ISA (UK) 315 on auditors' responsibility to identify and assess the risks of material misstatement in the financial statements and ISA (UK) 240 on material misstatements caused by fraud came into effect for audits of financial statements with periods commencing on or after 15 December 2021.

standard. The in-depth nature of these additional procedures, as well as updated tools and techniques that may come into scope, will also offer additional opportunity to provide insights and constructive feedback on the way the Board manages risks. The table below provides further detail on the implications of these new requirements.

Key change	Potential impact on the Board & our approach
Enhanced risk identification and assessment, promoting more focused auditor responses to identified risks	Management and those charged with governance may receive more up-front questions as we plan the audit and identify and assess risks of material misstatement. We may conduct planning and risk assessment procedures at a different time to ensure that our understanding is comprehensive, and that information is leveraged effectively and efficiently. To facilitate a more robust risk-assessment, we may request additional information to enhance our understanding of systems, processes and controls. For example, we may request: • a better understanding of the Board's structure and operations and how it integrates information technology (IT) • more information about the Board's processes for assessing risk and monitoring its system of internal control • more detailed narratives about how transactions are initiated, recorded, processed and reported • policies and procedure manuals, flowcharts and other supporting documentation to validate our understanding of the information systems relevant to the preparation of the financial statements • more information to support our inherent risk assessment. This information not only informs our risk assessment but also assists us in determining an appropriate response to risks identified, including any new significant risks which require a different response.

Key change	Potential impact on the Board & our approach
Understanding and acting on risks associated with IT	We will be asking tailored questions and making information requests to understand the IT environment, including: • IT applications • supporting IT infrastructure • IT processes • personnel involved in the IT processes. Combined with the controls that may be needed to address the identified and assessed risks of material misstatement, this understanding may also identify existing and new risks arising from the use of IT. Therefore, we will be asking more focused questions and requesting additional information to understand the general IT controls that address such risks. For example, we may have questions in relation to general IT controls over journal entries (e.g., segregation of duties related to preparing and posting entries) to address risks arising from the use of IT. Depending on our assessment of the complexity of systems and associated risks, we may also involve additional team members, such as IT specialists.
Enhanced procedures in connection with fraud	We will be asking targeted questions as part of an enhanced approach to fraud, including discussing with the Board: • any allegations of fraud raised by employees or related parties • the risks of material fraud, including those specific to the health sector. Combined with other information, and any inconsistencies in responses from those charged with governance and management, we determine implications for further audit procedures. Work in connection with fraud may also now include the use of audit data analytics, or the inclusion of specialists in our engagement team to ensure we obtain sufficient appropriate audit evidence to conclude whether the financial statements are materially misstated as a result of fraud. In addition to existing communication and reporting requirements relating to irregularities and fraud, there may be

Key change	Potential impact on the Board & our approach
	further matters we report in connection with management's process for identifying and responding to the risks of fraud in the entity and our assessment of the risks of material misstatement due to fraud. These enhanced requirements may assist in the prevention and detection of material fraud, though do not provide absolute assurance that all fraud is detected or alter the fact that the primary responsibility for preventing and detecting fraud rests with the Board and management.
Enhanced requirements for exercising professional scepticism	Challenge, scepticism and the application of appropriate professional judgement are key components of our audit approach. You may receive additional inquiries if information is found that contradicts what our team has already learned in the audit or in instances where records or documents seen in the course of the audit appear to have been tampered with, or to not be authentic.
Using the right resources, in the right way, at the right time	One of our new strategic quality objectives sets out that we will strive to use the right resource, in the right way, at the right time. This may mean increasing the use of specialists (for example in relation to general IT controls) or changing the shape of the audit engagement team to ensure that we are able to provide appropriate challenge and feedback in specialist areas. This will include appropriate use of technology, including data analytics.

Communication with those charged with governance

Auditing standards require us to make certain communications throughout the audit to those charged with governance. We have agreed with the Board that these communications will be through the Audit & Risk Committee (which reports to the Board). The annual report and accounts and our annual report on the audit will also be reported to the Board.

Audit timetable

The submission deadline for the annual accounts is normally set to be consistent with the administrative deadline set by the Scottish Government. It was moved to 30 September for 2019/20 and 2020/21, and 31 August for 2021/22, but is returning to the pre-pandemic 30 June from 2022/23.

The Auditor General is required to send the audited annual accounts to the Scottish Ministers who are then required to lay the accounts in the Scottish Parliament by 31 December.

We have set out below target months which align to the Board's schedule of Audit and Risk Committee and Board meetings. We will aim to meet these scheduled meetings however this will be monitored during the audit process and may require to be revised to reflect emerging issues.

Audit work/ output	Description	Target month	Audit and Risk C'tee	Deadline
Audit strategy	Onboarding and initial engagement, introductory meetings and presentation of audit strategy.	November	5 Dec 2022	N/A
Audit plan	Planning meetings, understanding the entity, risk assessment. Audit plan setting out the scope of our audit, including key audit risks, presented to ARC.	December – March	15 March 2023	31 March 2023
Interim audit	Interim audit including review of accounting systems and wider scope work. We will provide a verbal update to the Audit and Risk Committee on work carried out during our interim audit.	December - March	18 May 2023	N/A

Audit work/ output	Description	Target month	Audit and Risk C'tee	Deadline
Final audit	Accounts presented for audit and final audit visit begins	May	TBC	N/A
Independent Auditor's Report	This report will contain our opinion on the financial statements, the audited part of the remuneration and staff report, annual governance statement and performance report.	June	TBC	30 June 2023
Annual Report to the Board and the Auditor General for Scotland	At the conclusion of each year's audit we issue an annual report setting out the nature and extent of our audit work for the year and summarise our opinions, conclusions and the significant issues arising from our work. This report pulls together all of our work under the Code of Audit Practice.	June	TBC	30 June 2023

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**5 December 2022**
Title:	**Audit Scotland Technical Bulletin 2022/3**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Kevin Booth, Head of Financial Services & Procurement**

1 Purpose

This is presented to the Committee for:

- Assurance

This report relates to a:

- Emerging issue
- Government policy/directive
- Legal requirement

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

- Effective

2 Report summary

2.1 Situation

The Audit Scotland Technical Bulletin 2022/3 is a resource shared across members of the Finance Directorate and is provided to the Audit and Risk committee to raise awareness of emerging developments from an Audit perspective.

2.2 Background

The Audit Scotland Technical Bulletins are prepared on a quarterly basis and are provided to support auditors appointed by the Auditor General for Scotland and Accounts Commission for Scotland with:

- Information on the main technical developments across the public sector in the quarter.
- Information on professional matters during the quarter that are expected to have applicability to the public sector.

- Summaries of responses to any requests from auditors for technical consultations with Audit Scotland Professional Support.

2.3 Assessment

The Audit Scotland Technical Bulletin 2022/3 is arranged by sector with content applicable to each sector and across the public sector as a whole.

From a Health Board perspective there is no specific chapter this quarter for any direct content.

Chapter five references the new framework to assist auditors in making professional judgements and is a useful guide for members of the finance team involved in decision making.

In addition, chapter six brings to attention a number of fraud and irregularities that were picked during the NFI (National Fraud Initiative) assignment and highlights the need to ensure internal controls remain sufficient and are routinely followed across NHS Fife.

2.3.1 Quality/ Patient Care

N/A

2.3.2 Workforce

The Technical Bulletin is shared widely across the Finance Directorate.

2.3.3 Financial

Technical and Financial developments are addressed from Audit Scotland's perspective.

2.3.4 Risk Assessment/Management

Emerging Risks relating to the Health Sector are addressed from Audit Scotland's perspective.

2.3.5 Equality and Diversity, including health inequalities

N/A

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

The Audit Scotland Technical Bulletins are provided to Boards through the Technical Accounts Group meetings and any impending issues are discussed.

2.3.8 Route to the Meeting

This paper has been provided following discussions between the Head of Corporate Governance and the Head of Financial Services & Procurement

2.4 Recommendation

- **Assurance**

3 List of appendices

The following appendices are included with this report:

- Appendix 1, Audit Scotland Technical Bulletin 2022/3

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Technical Bulletin 2022/3

Technical developments and emerging risks from July to September 2022

AUDIT SCOTLAND

Prepared by Audit Scotland for appointed auditors and audited bodies in all sectors

20 September 2022

Contents

1: Introduction

Contact: Paul O'Brien, Pobrien@audit-scotland.gov.uk

Purpose

The purpose of Technical Bulletins from Audit Scotland's Professional Support is to provide auditors appointed by the Auditor General for Scotland and Accounts Commission for Scotland with:

- information on the main technical developments in each sector during the quarter
- information on professional matters during the quarter that are expected to have applicability to the public sector
- summaries of selected responses to requests from auditors for technical consultations with Professional Support.

Appointed auditors are required by the Code of Audit Practice to pay due regard to Technical Bulletins. The information on technical developments is aimed at highlighting the key points that Professional Support considers auditors in the Scottish public sector require generally to be aware of. It may still be necessary for auditors to read the source material if greater detail is required in the circumstances of a specific audited body. Source material can be accessed by using the hyperlinks, where provided.

Any specific actions that Professional Support recommends that auditors take are highlighted in green.

Technical Bulletins are also published on the Audit Scotland website and therefore are available for audited bodies and other stakeholders to access. However, hyperlinks to source material indicated with an asterisk (*) link to files on Audit Scotland's SharePoint* and are only accessible by auditors.

Highlighted items

The following table highlights a selection of items in this Technical Bulletin:

Highlighted items		
Professional Support has published guidance for auditors on examining and reporting on the 2020/21 WGA returns [paragraph 1].	CIPFA/LASAAC has issued a statement on its consultation on infrastructure assets [paragraph 8].	The Scottish Government has issued statutory overrides in respect of accounting for infrastructure assets in local government [paragraph 11].
The Scottish Government has issued revised statutory guidance on accounting for service concession arrangements and leases in local government [paragraph 14].	CIPFA/LASAAC has issued the local government accounting code for 2022/23 [paragraph 18].	CIPFA/LASAAC has issued an exposure draft of the accounting code for 2023/24 [paragraph 25].
Professional Support has published guidance on certifying the 2021/22 HB subsidy claim [paragraph 34].	Professional Support has provided responses to requests for technical consultations from auditors [paragraph 38].	Professional Support has published guidance on risks of misstatement in the 2021/22 annual report and accounts of colleges [paragraph 39].
Professional Support has published model forms of Independent Auditor's Reports for colleges for 2021/22 [paragraph 42].	The SFC has issued the 2021/22 accounts direction for colleges [paragraph 47].	The SFC has issued guidance on the 2021/22 accounts direction [paragraph 49].
The FRC has issued a new framework to assist auditors in making professional judgements [paragraph 51].	The FRC has issued a report on current practice in auditor reporting [paragraph 60].	The FRC has issued an updated thematic review on the disclosure of judgements and estimates [paragraph 61].
The FRC has issued a thematic review on information on climate change in the annual accounts [paragraph 64].	The FRC has issued a report on the disclosure of digital security risks in the annual accounts [paragraph 67].	The FRC has issued a report on producing ESG data [paragraph 70].

2: All sectors

Contact: Paul O'Brien, Pobrien@audit-scotland.gov.uk

TGN on 2020/21 WGA returns

1. Professional Support has published a Technical Guidance Note (TGN) to provide appointed auditors with guidance on examining and reporting on the 2020/21 Whole of Government Accounts (WGA) returns of public bodies in Scotland. The TGN is provided with supporting material to auditors on SharePoint* and also on the Audit Scotland website

2. HM Treasury prepare WGA for the UK and are responsible for managing the production process. The National Audit Office (NAO) are the group auditor for WGA. The process has been running progressively later over the last few years and, as a result of delays in the preparation of the 2019/20 WGA, the NAO were not able to issue their Group Audit Instructions until July 2022.

3. In order to ameliorate the impact of the delay, Treasury increased the threshold for auditor assurance in England to £2 billion for 2020/21. Professional Support has agreed with the Scottish Government that threshold should also apply for all public bodies in Scotland. This increase from £500 million in previous years greatly reduces the number of bodies above the threshold.

4. Testing and reporting procedures that auditors are required to undertake in respect of providing assurance to the NAO on 2020/21 WGA returns above the threshold is included in the TGN. The procedures are consistent with the NAO's Group Audit Instructions but tailored to Scottish bodies. Reporting procedures include the submission of an Assurance Statement in a form prescribed by NAO.

5. No examination is required for bodies below the threshold, although auditors are required to complete the first eight sections of the Assurance Statement (except for minor bodies) and submit it to the NAO.

6. Treasury and the NAO originally set a date of 31 August 2022 for the submission of the audited WGA returns and Assurance Statements for 2020/21. Subsequent to the publication of the TGN, they revised the submission date to 30 September. Auditors are not expected by Professional Support to meet that date if doing so would compromise the completion of 2021/22 audits of the annual accounts, which should take priority.

7. Auditors should examine and report on the 2020/21 WGA returns of public bodies in Scotland in accordance with the TGN, and make the required submissions as soon as reasonably practicable.

3: Local government sector

Contact: Paul O'Brien, Pobrien@audit-scotland.gov.uk

Update on accounting for infrastructure assets

8. The CIPFA/LASAAC Local Authority Code Board (CIPFA/LASAAC) has issued a statement on the outcome of its consultation on proposed temporary adaptations to be included in the Code of Practice on Local Authority Accounting in the UK (accounting code) in respect of infrastructure assets (explained in Technical Bulletin 2022/2 – paragraph 17).

9. Although there was general support from consultees, concerns were raised by key stakeholders about the proposal that the accounting code should assume that the net book value of replaced parts of infrastructure assets is zero. For example:

- Many respondents were looking for a more positive framing of the assumption about the nil value of derecognised parts.
- Other respondents were of the view that the value of derecognised parts should be based on the best available information.

10. CIPFA/LASAAC was not able to agree an approach that addressed the concerns of all stakeholders while also supporting high quality financial reporting. CIPFA/LASAAC therefore requested the Scottish Government (and governments in England and Wales) for a temporary statutory override while a permanent solution is developed.

11. The Scottish Government has therefore issued Finance Circular 9/2022 which contains temporary statutory overrides of some of the accounting code's requirements in so far as they relate to infrastructure assets. The statutory overrides are summarised in the following table:

Number	Accounting code para and requirement	Statutory overrides
1	Paragraph 4.1.4.3 1) d) requires disclosure of the gross carrying amount and accumulated depreciation at the beginning and end of the year for each class of property, plant and equipment.	For accounting periods commencing from 1 April 2021 until 31 March 2024, a local authority is not required to report the gross carrying amount and accumulated depreciation for infrastructure assets.
2	Paragraph 4.1.2.51 requires the carrying amount of a replaced part of an item of property, plant and equipment to be derecognised.	For the accounting periods from 1 April 2010 to 31 March 2024, a replaced part of an infrastructure asset is to be derecognised at a nil carrying amount, and no subsequent adjustment can be made to the carrying amount of the asset with respect to that part.

12. A local government body may choose not to apply the overrides. Where the body chooses to apply either or both, paragraph 33 of the circular requires that choice to be disclosed in a note.

13. Auditors should:

- establish whether each local government body is intending to apply one or both overrides
- where the body is not applying both overrides, evaluate whether the relevant accounting code requirements have been complied with
- where the body is applying one or both overrides, evaluate whether the body has made the required disclosures.

Revised statutory guidance on service concession arrangements and leases from 2022/23

14. The Scottish Government has issued Finance Circular 10/2022* to provide revised statutory guidance on accounting for service concession arrangements, leases and similar arrangements. The circular replaces Finance Circular 4/2010 from 2022/23, and provides three options for accounting for these arrangements.

15. The options include no change to the calculation of the statutory charge for the repayment of debt originally set out in Finance Circular 4/2010, which would continue to be charged over the life of the arrangement in equal instalments of principal. The provisions are included at section 2.1 of the new circular.

16. The new circular at section 2.2 sets out a temporary optional flexibility for calculating the statutory charge for the repayment of debt for service concession arrangements entered into prior to 1 April 2022. Key aspects of the flexibility related to this option are explained in the following table:

Aspect	Aspects of flexibility
Nature	The annual charge for the repayment of debt may be calculated: • in accordance with the useful life of the asset • using either equal instalments of principal or the annuity method.
Applicable years	The flexibility may be applied in either 2022/23 or 2023/24. It may have either prospective or retrospective application.
Cumulative statutory adjustment	The cumulative statutory adjustment is from the Capital Adjustment Account to the General Fund and is made as at 1 April in (depending on the year applied) either 2022 or 2023. There is no prior year restatement of statutory adjustments. The service concession arrangement liability will continue to be written down by the contractual principal repayments.

Aspect	Aspects of flexibility
Applicable arrangements	The flexibility must be applied consistently to all service concession arrangements entered into prior to 1 April 2022 with the exception of agreements with less than 5 years until completion provided the annual charge is not materially different. A body should separately identify the value of each service concession arrangement. If not, the asset and liability must be restated at market values. The flexibility does not apply to leases or any similar arrangement.
Governance	The decision to apply the flexibility must be approved by the full Council.
Prepayments	Where a prepayment was originally funded from a revenue or capital source, the body may revisit that decision and choose to fund the prepayment from borrowing. Borrowing should be recognised by a loans fund advance.
Disclosures	The reason for the change should be disclosed, along with an explanation of the movement in both the Balance Sheet and the General Fund. Where the annuity method has been applied, narrative should explain how this method links to the flow of benefits from the asset. Where an arrangement is excluded as it has fewer than five years until expiry, an explanation should be disclosed that the statutory repayment continues to be based on the contract life. Disclosure is required of the: • cumulative value charged to the General Fund prior to applying the flexibility • revised cumulative value charged to the General Fund in adopting the flexibility • funds released as a result of the flexibility.

17. The third option is set out at section 1 of the new circular and involves local government bodies adopting the accounting code requirements in full for service concession arrangements, leases and similar arrangements without any statutory adjustments. Key aspects of this option are explained in the following table:

Aspect	Summary of guidance
Cumulative statutory adjustment	All statutory charges would be reversed, such that only the accounting entries required by the accounting code remain. The cumulative financial effect of all the reversals will be a statutory adjustment from the Capital Adjustment Account to the General Fund. There is no prior year restatement of statutory adjustments.

Aspect	Summary of guidance
Applicable years	The option can be exercised in any financial year from 1 April 2022 and has retrospective application. The statutory adjustment is made as at 1 April in the year the revised arrangements are applied.
Applicable arrangements	The option applies to all service concession arrangements, leases and similar arrangements with the exception of agreements with fewer than 5 years until completion. Once this approach is taken, it should not be reversed in subsequent years.
Disclosures	An explanation should be disclosed of the basis for the accounting policy change and the impact on the balances reported within the annual accounts.

2022/23 accounting code

18. CIPFA/LASAAC has issued the accounting code* to set out local government accounting requirements for 2022/23. The financial reporting framework is based on International Financial Reporting Standards (IFRS) as adopted by the UK, adapted for the local government context where necessary.

19. The most significant change is Appendix F which sets out the requirements for accounting for leases based on IFRS 16 Leases. Although adoption of IFRS 16 is not mandatory until 2024/25, adoption before then is strongly encouraged in which case Appendix F applies.

20. Under IFRS 16, a local government body is required to assess whether a contract meets the definition of a lease. The definition is met where the contract conveys the right to control the use of an identified asset for a period of time. It should be noted that:

- Controlling the use of an identified asset involves having the right to obtain substantially all of the economic benefits and service potential from use of the asset throughout the period of use. Paragraphs B9 to B31 of IFRS 16 provide guidance in this assessment.
- The accounting code adapts the definition of a lease in IFRS 16 to remove the phrase ‘in exchange for consideration’. This means that leases include those agreements that do not include the provision of consideration (nil consideration leases).
- The assessment should take place at inception of a contract, which is usually the date of the lease agreement.
- A body should not make a reassessment on the date of implementation except in relation to leases for nil consideration. Instead, the body is required to apply IFRS 16 only to contracts that were previously identified as leases under the previous standards.

- Reassessment is required only where the terms and conditions of the contract are changed.

21. For lessees, there is no longer a distinction between finance leases and operating leases. A lessee is required to recognise a right-of-use asset and a lease liability. The following table provides a summary of the requirements:

	Right of use asset	Lease liability
Definition	An asset that represents a lessee's right to use the asset that is the subject of the lease (the underlying asset) for the lease term.	The obligation to make lease payments over the lease term.
Initial measurement – commercial terms	At cost, i.e. the amount of the initial measurement of the lease liability.	The discounted present value of outstanding lease payments.
Initial measurement – peppercorn or for nominal lease payments, or for nil consideration	At fair value.	The difference between the fair value and the lease liability is recognised in the surplus or deficit on the provision of services.
Recognition date	The date on which a lessor makes an underlying asset available for use by a lessee (commencement date).	
Subsequent measurement	Current value in accordance with section 4.1 of the accounting code. The cost model can be used as a proxy for current value unless inappropriate (such as for property assets).	The carrying amount of the lease liability is: • increased to reflect interest • reduced to reflect the lease payments made.
Exemptions	A lease that, at the commencement date, has a lease term of 12 months or less (a short-term lease) is exempt, unless it contains a purchase option. A lessee may elect to exempt leases where the underlying asset is of low value.	

22. On transition at 1 April 2022, a local government body as lessee is required to apply IFRS 16 to its leases retrospectively with the cumulative effect of initially applying IFRS 16 recognised at that date. The body should:

- not restate comparative information
- recognise the cumulative effect of initial application as an adjustment to the opening balance of reserves.

23. Appendix C of the accounting code requires a local government body that chooses to adopt IFRS 16 in 2022/23 to disclose information relating to the impact of that accounting change in 2021/22. A body should disclose:

- a statement that IFRS 16 will be adopted on a voluntary basis
- the nature of the impending changes
- a discussion of the impact that initial application of IFRS 16 is expected to have on the body's financial statements (or a statement that the impact is not known or reasonably estimable).

24. Auditors should:

- establish whether the local government body is intending to adopt IFRS 16 in 2022/23
- where adoption is planned for 2022/23, evaluate whether the required disclosures have been made in 2021/22.

Consultation on 2023/24 accounting code

25. CIPFA/LASAAC has issued an exposure draft of the accounting code for 2023/24. There are proposals related to:

- new accounting standards
- sustainability reporting
- changes to the structure or format of the accounting code.

26. Responses to the consultation should be sent to cipfalasaac@cipfa.org by 14 October 2022.

New accounting standards

27. Section A4 of the Invitation to Comment (ITC) sets out two proposed changes to the accounting code as a result of changes to accounting standards. These changes are summarised in the following table:

Accounting standard	Change to standard	Proposed change to code
Definition of Accounting Estimates, Amendments to IAS 8 Accounting Policies, Changes in Accounting Estimates and Errors	The 'change in accounting estimates' definition has been replaced with a definition of accounting estimates which describes them as "monetary amounts in financial statements that are subject to measurement uncertainty"	The revised definition of accounting estimates is included at paragraph 3.3.2.2 of the exposure draft.

Accounting standard	Change to standard	Proposed change to code
	Accounting estimates are developed if accounting policies require items to be measured in a way which involves measurement uncertainty. The effects of a change in input or a measurement technique are changes in estimates provided they do not result from the correction of a prior period error.	It is proposed that paragraphs 3.3.2.14 and 15 of the accounting code are amended to explain that: • an accounting policy may require items to be measured at monetary amounts that cannot be observed directly and must instead be estimated • a local government body is therefore required to develop an accounting estimate to achieve the objective set out by the accounting policy • a body uses measurement techniques and inputs to develop an accounting estimate. In addition, paragraph 3.3.2.18 covers the treatment of a change in an input or measurement technique.
Disclosure of Accounting Policies Amendments to IAS 1 Presentation of Financial Statements	A requirement to disclose an entity's material (rather than significant) accounting policy information. Clarification that accounting policy information may be material because of its nature, even if the related amounts are immaterial. Confirmation that if an entity discloses immaterial accounting policy information, such information must not obscure material accounting policy information.	Paragraphs 3.4.2.88 to 3.4.2.93 have been added to the exposure draft to reflect these changes. This includes at paragraph 3.4.2.90 examples of when accounting policy information is likely to be material.

28. Section B6 proposes to implement IFRS 17 Insurance Contracts from 2025/26, but expects that the standard will apply to local government bodies only in limited circumstances.

Sustainability reporting

29. Section C 7.4 advises that, although there is currently no explicit requirement for local government bodies to produce a sustainability report, sustainability matters should feature in the Management Commentary.

30. In addition to narrative reporting requirements, sustainability reporting will increasingly have a wider impact on the financial statements. A table at

paragraph 52 in the ITC provides a list of areas that may be impacted. Examples include:

- asset values
- significant risks that key assumptions may change within the next financial year (e.g. due to potential changes in the regulatory environment)
- any estimation assumptions and uncertainty created by environmental issues
- new additions capitalised to meet climate or other environmental needs
- impairment impacts because of:
  - flooding, coastal defence erosion etc
  - regulatory requirements imposing different building standards
  - assets not meeting environmental standards.
- policy commitments to meet climate change needs that create an obligating event.

31. As the impacts of environmental and sustainability reporting are already covered by the standard provisions of the accounting code, no changes are explicitly required. However, stakeholders' views are sought on the proposal to add this area to CIPFA/LASAAC's strategic plan.

Changes to the structure or format of the accounting code

32. CIPFA/LASAAC considers that it would be timely to consider the structure and format of the accounting code. Preliminary objectives for the review are listed at paragraph 61 of the ITC and include ensuring that the code:

- promotes high-quality financial reporting
- ensures that users are able to understand how a local government body reports its financial position, performance and cash flows
- supports communication of the key messages
- is structured so that its provisions are readily accessible
- clearly sets out where reporting differs from the private sector and the rest of the public sector.

33. CIPFA LASAAC is still considering the objectives for the review and is seeking views.

TGN on certifying 2021/22 HB subsidy claims

34. Professional Support has published TGN/HBS/22 on certifying the 2021/22 housing benefit (HB) subsidy claim. The TGN is provided with supporting material to auditors on SharePoint* and is also available from the Audit Scotland website. The TGN:

- provides guidance for auditors on the examination of the HB subsidy claim, including highlighting the main risk areas
- sets out and explains an overview of the certification approach, the preliminary procedures (at section 1), testing procedures (at section 2), procedures for evaluating results and agreeing amendments (section 3) completion procedures (at section 4) and post-certification procedures (at section 5) that auditors should carry out (all summarised in the checklist at Appendix 1)
- provides examples of reporting errors and observations in a letter to the Department for Work and Pensions (DWP) at Appendix 3
- provides examples of reporting the results of any post-certification procedures at Appendix 4.

35. The approach set out in the TGN is based on the Housing Benefits Assurance Procedures (HBAP) produced by the DWP and used by auditors throughout the UK. However, Professional Support has negotiated with the DWP changes to certification testing for Scottish local authorities for 2021/22. The changes are intended to rationalise the level of auditor testing required by HBAP, and are summarised as follows:

- For local authorities, where auditors have assessed the risks of inaccuracy as low, and with an HB caseload of under 5,000 cases, a smaller initial sample of 10 rent allowances and 10 rent rebates should be selected. A sample size of 20 remains for authorities above that caseload.
- There is no longer a requirement to test a separate sample of 20 modified scheme claims (although any modified scheme claims selected within the initial sample should be tested).

36. The submission deadline for the HB subsidy certification is 31 January 2023.

37. Auditors should certify 2021/22 HB subsidy claims in accordance with TGN/HBS/22.

Technical consultations with auditors

Professional Support responds to requests from auditors for technical consultations

38. The following tables summarise requests from auditors for technical consultations with Professional Support in respect of issues arising from the audit of the 2021/22 annual accounts of local government bodies, along with the advice offered:

Can indexation be used to value land and buildings in local government?

The accounting code contains an interpretation of IAS 16 which requires valuations of land and buildings to be in accordance with RICS valuation standards. The valuation of land and buildings is normally undertaken by professionally qualified valuers. Under RICS standards, a qualified valuer may carry out a:

- valuation inspection, which involves a site visit; or
- desktop investigation where digital mapping is used instead of a site visit.

In Professional Support's view, the use of indices by an accountant to approximate a change in the value of land and buildings does not constitute a valuation in accordance with RICS standards. Professional Support has discussed the matter with CIPFA who has confirmed that indexation is not supported by the accounting code.

However, indices may be used to identify cases where a valuation by a professional valuer under RICS standards is necessary. For example, the accounting code requires assets to be revalued at least every five years, but more regularly if that frequency is insufficient to keep pace with changes in current value. A five-year interval between valuations is dependent on the carrying amount of the asset not being materially different from its current value. Indices may be a useful tool to either demonstrate that is the case or, if a material change is indicated, flag that a valuation by a valuer is necessary.

How should accumulated depreciation be treated at the date of revaluation of property, plant and equipment?

When an item of property, plant and equipment is revalued, the carrying amount of that asset is adjusted to the revalued amount. At the date of the revaluation, paragraph 35 of IAS 16 sets out the following two options for how the asset should be treated:

(a) The gross carrying amount is adjusted in a manner that is consistent with the revaluation of the carrying amount of the asset. The accumulated depreciation at the date of the revaluation is adjusted to equal the difference between the gross carrying amount and the carrying amount of the asset.

(b) The accumulated depreciation is eliminated against the gross carrying amount of the asset.

For local government bodies, the accounting code has since 2016/17 contained an adaptation to IAS 16 at paragraph 4.1.1.6 which withdraws option (a). Accumulated depreciation should therefore be eliminated against the gross carrying amount of the asset.

Should a local authority be recognising a provision or disclosing a contingent liability for cases of historical child abuse in care?

The Redress for Survivors (Historical Child Abuse in Care) (Scotland) Act 2021established a scheme for financial redress for survivors of historical child abuse in relevant care settings in Scotland.

Should a local authority be recognising a provision or disclosing a contingent liability for cases of historical child abuse in care?

The scheme includes the establishment of Redress Scotland as an arm's-length, independent body to make determinations in connection with applications by individuals under the scheme. Redress Scotland advises the Scottish Government on the amount of redress payments and to whom they should be paid.

A number of public and charitable bodies contribute towards the funding of redress payments. The local government sector makes a contribution to recognise the collective responsibility of all local authorities. The contribution is to be top-spliced from the local government settlement for ten years from 2022/23; it is not allocated to individual local authorities but rather it is made at a sector level. The Act specially provides that making a contribution is not evidence of liability in connection with an allegation of abuse.

Professional Support has considered the legal form under which the scheme has been set up and has concluded that individual local authorities do not have a legal or constructive obligation to provide redress. Rather local government as a sector is simply making a financial contribution through top slicing of total revenue grant. There does not therefore appear to be any obligation that would require a local authority to recognise a provision or disclose a contingent liability. The substance of the scheme reflects that legal form so there does not appear to be any substance over form argument.

Can the statutory method for repaying Loans Fund advances be used for repayments after 31 March 2021?

Finance circular 7/2016 provides statutory guidance on the prudent repayment of Loans Fund advances. The statutory guidance allows the method required by the Local Government (Scotland) Act 1975 (the statutory method) to continue to be used for advances made up to 31 March 2021. Repayments for those advances can continue to us the statutory method until the end of the repayment period.

The statutory method is not available for new loans fund advances made after 31 March 2021. A prudent repayment method for these advances is required as set out in the statutory guidance.

It should be noted that this advice supersedes paragraph 35 in Module 3 of TGN 2021/8(LG) which incorrectly states that the statutory method is not permitted for repaying advances made after 1 April 2016 (the date referred to should have been 1 April 2021).

4: College sector

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TGN on risks of material misstatement in 2021/22

39. Professional Support has published Module 14 of TGN 2022/1. The TGN is intended to inform auditors' judgement when identifying and assessing the risks of material misstatement in the 2021/22 annual report and accounts of central government bodies generally. Module 14 provides:

- guidance on applying the other modules to the audit of the 2021/22 annual report and accounts of colleges
- supplementary guidance on the risks of misstatements in areas specific to colleges

40. Module 14 is available with the rest of the TGN and supporting material to auditors on SharePoint* and is also freely available to download from the Audit Scotland website.

41. Auditors are expected to pay due regard to Module 14 and use it as a primary reference source when performing 2021/22 audits of colleges. Auditors should advise Professional Support of any intended departures from the guidance.

TGN on 2021/22 model IARs

42. Professional Support has published TGN 2022/6(C) to provide auditors with model forms of Independent Auditor's Reports (IAR) which should be used for the 2021/22 annual report and accounts of colleges.

43. Auditors are required by the Code of Audit Practice to prepare their IARs in accordance with the TGN. The TGN is available with supporting material to auditors on SharePoint* and are also freely available from the Audit Scotland website.

44. The model form of IARs set out in Appendices 1 and 2 of the TGN have been tailored to reflect relevant public sector legislation and augmented by the reporting requirements of the Auditor General.

45. There are a number of changes to the model forms of IAR and to the application guidance in 2021/22. These are summarised in the following table:

Area	Change
Model IARs	Changes have been made in the 'Conclusions relating to going concern' and the 'Responsibilities of the Board of Management' sections of the model IARs to better explain the application of going concern in the public sector. There are also some minor wording clarifications.
Application guidance	Changes in the guidance include: • permitting auditors to amend the specified wording that explains the extent to which the audit is capable of detecting irregularities • advice for auditors to encourage bodies to use the titles specified by the Statement of Recommended Practice – Accounting for Further and Higher Education 2019 (the SORP) or Government Financial Reporting Manual (FReM) • advice on how to deal with the inclusion of any voluntary reports.

46. Auditors should for 2021/22 audits:

- use the relevant model form of IAR for each college
- follow the specified wording other than where tailoring adjustments are set out in the application guidance in the TGN
- consult with Professional Support on any modified opinion or conclusion
- complete an auditor action checklist provided at Appendix 4 for each IAR prepared.

2021/22 accounts direction

47. The Scottish Funding Council (SFC) has issued their Accounts Direction for Scotland's Colleges 2021/22. The direction requires colleges to:

- comply with the SORP in preparing their financial statements
- include a Performance Report and Accountability Report in their annual report and accounts in accordance with the FReM.

48. Specific mandatory disclosure requirements for colleges are set out in Appendix 2 to the direction. The main changes are as follows:

- Paragraph 8 has been added to require the performance analysis section of the Performance Report to include:
  - a description of the way in which the college has promoted equality of delivery of service to different groups and had due regard to public sector equality duty under the Equality Act 2010

  - brief commentary outlining the Fair Work practices that have been developed in agreement with the college's workforce and the progress the college has made in their implementation.

- A suggested table for the amended fair pay disclosure has been added to the example Remuneration Report at Appendix 8.

Guidance on 2021/22 financial statements

49. The SFC has issued guidance notes on completion of the 2021/22 financial statements which are designed to supplement the accounts direction. The guidance covers key disclosures in the financial statements, including model disclosure notes set out at Annexes A to F.

50. There are no significant changes from 2020/21.

5. Professional developments

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New framework for making professional judgements

51. The Financial Reporting Council (FRC) has issued a new framework to assist auditors in making professional judgements. Professional judgement involves applying training, knowledge and experience in making informed decisions about appropriate courses of action. The effective exercise of professional judgement is a critical feature of any audit.

52. The framework is intended to enhance the quality and consistency of professional judgements by helping auditors take account of all relevant considerations and improve their more intuitive judgement-making.

53. Although written for auditors, the framework may be useful for others in the financial reporting chain, or for specialists providing expert input into an audit. It could also be useful for audit committees in enhancing their understanding of an auditor's judgement process.

54. The framework consists of the following four components:

- An appropriate mindset for exercising professional judgement.
- A suggested professional judgement process.
- Effective consultation with a range of relevant parties.
- Factors that can impact on how challenging it is to exercise professional judgement in an appropriate manner.

Mindset

55. The guidance highlights five aspects of mindset that are especially relevant to exercising professional judgement in an effective manner. They are summarised in the following table:

Aspect	Summary of guidance
Appreciation of the purpose of audit and its public interest benefits	Understanding that the purpose of an audit is to enhance the confidence and understanding of users of the financial statements helps emphasise that the interests of the users should be paramount when making judgements. Awareness of the public interest benefits of an audit may motivate the auditor to be objective, professionally sceptical, and committed to quality.

Aspect	Summary of guidance
Professional scepticism	Professional scepticism may be especially relevant when gathering and analysing information, and when effectively challenging management.
Understanding biases and other relevant psychological factors	There are a range of biases that can subconsciously hinder objective reasoning (e.g. availability, confirmation, groupthink, and overconfidence). Certain personality traits may be detrimental to good judgement, e.g. an undue fear of conflict, unwillingness to challenge figures of authority, impatience or stubbornness. Some traits support an effective judgement process, e.g. perceptiveness and a willingness to consult and listen. An auditor's feelings and beliefs affect how susceptible they are to judgement traps such as allowing motivation to unduly influence how information is evaluated. Understanding the above factors assists the auditor in developing strategies to mitigate or cultivate such factors.
Sensitivity to uncertainty	An awareness of the presence of uncertainty can assist the auditor in identifying when they need to exercise professional judgement. An appreciation that some information sources may be more or less reliable than others allows auditors to direct their work efforts in a more effective way. An awareness that not all uncertainty can be eliminated allows the auditor to build mitigating actions into their judgement process.
Commitment to quality	it is important that the auditor is committed to making quality judgements, e.g. by being willing to delay signing the audit opinion to provide the team with enough time to perform a robust professional judgement process.

Professional judgement trigger and process

56. This portion of the framework comprises a series of steps to structure the way in which a judgement is carried out. The steps are summarised in the following table:

Step	Summary of guidance
Remain alert to situations which require the exercise of professional judgement	In deciding whether to use a formal judgement process, auditors should consider the complexity and importance of the judgement being made, their experience and any precedents.

Step	Summary of guidance
Consider who is the right person to make the judgement	Auditors consider the relevant knowledge, skills and experience required; the complexity and importance of the judgement; and the available time and resources. Where an auditor engages an expert to provide a view, the auditor remains responsible for the judgement.
Appropriately frame the issue	Taking the time to fully define and understand the problem, including relevant risks, is a key part of an effective judgement process. The main components of this step are: • articulating objectives to clarify the intended outcomes • identifying the alternatives that will be judged.
Marshal your information	This is a key step as it provides the evidence base. Page 16 of the guidance provides examples of the various enquiries, knowledge and experience from which relevant information may be drawn. Auditors should employ a questioning mindset in seeking information that may contradict as well as corroborate management assertions, while remaining alert to conditions that may indicate information may not be authentic, and to any inconsistencies between different information.
Stand back, and conclude	This includes considering whether: • a judgement step has been inappropriately skipped • all relevant alternatives have been identified and assessed • the judgement has been unduly affected by bias • the course of action decided upon might undermine some of the auditor's other objectives.
Document, communicate and reflect	Effective documentation allows others to understand how judgements were made and the rationale and quality of evidence for the decision reached. Documentation is unlikely to take place at a single point in the audit, but will iterate over time. Key audit matters reported may include significant professional judgments. Auditors should reflect on the process and assess what went well and what could be improved in future.

Consultation

57. It is important that audit teams encourage a healthy culture of debate and challenge to facilitate the input of those with relevant experience and expertise, and provide the opportunity to coach less experienced members of the team.

58. Consultation outside the team, such as with an external expert or an engagement quality reviewer, can further widen the available pool of expertise.

Environmental factors

59. There are a number of factors which may impact on how challenging it may be to exercise professional judgement in a quality manner. The factors are summarised in the following table:

Factor	Summary of guidance
Audit firm: culture, resources, training and processes	An audit firm can facilitate professional judgements by setting an appropriate culture, providing appropriate resources and training, and aligning reward structures to behaviours that demonstrate a commitment to audit quality.
Quantity and quality of relevant information available	If it is especially challenging to obtain relevant and reliable information, this could cause the auditor to place undue reliance on the few sources of information that are easily accessible. The quality of judgement reached should not suffer when information is scarce, though that judgement may have greater uncertainty attached to it which may lead to further work needing to be performed elsewhere.
Time and resources available	Auditors should push back if they feel under pressure to meet a timeline for making the judgement. Resources that can significantly improve the quality and range of information and insight available include: • the capacity and capability of the audit team • access to experts • technological resources such as automated tools and techniques.
Audited entity: management and those charged with governance	The audit committee can support or potentially undermine the auditor's attempts to promote a culture of healthy challenge of management and professional scepticism. The provision of clear and timely supporting information by management can reduce the risk of unnecessary delays, which could in turn lead to a rushed judgement process.

Review of auditor reporting practice

60. The FRC has issued a report which sets out the findings from research it commissioned into the current state of auditor reporting within the UK. A sample of nearly 400 auditor's reports for companies was selected, and the findings have been set out under six themes. The findings that are relevant to public audit are summarised in the following table:

Themes	Areas considered	Findings summary
Understandability and useability of auditor's reports	This explores how the length of reports varies between firms, industrial sectors, and market segments. Objective measures such as readability scores and measurement of standardised language have been used as a proxy for understanding how useability and understandability varies.	Most auditor's reports are located before the financial statements. The surveyed auditor's reports did not include any modified opinions, and nothing was reported by exception. 'Boilerplate' text is most prevalent in shorter auditor reports, and in reports issued by firms outside the Big 4. Proxy measures of readability suggest that longer reports with less boilerplate can be harder to read.
Communicating judgements on materiality and the scope of group audits	This reviews how auditors set out the basis of judgements for the selection of materiality and performance materiality, as well as decisions on the scoping and coverage achieved by group audits.	Profit measures remain the most common benchmark used for the determination of materiality, but are becoming less common. The use of equity as a benchmark, as well as multiple benchmarks, have become more common. A high proportion of auditor reports described the professional judgements made by the auditor for the selection of materiality and performance materiality.
Key audit matters (KAMs)	This includes a review of the number of KAMs and the most common types of risks of material misstatement.	Most reports included three KAMs but there were significant variations. There has been a reduction in the average number of KAMs since the requirement was introduced. The most common type of KAM was revenue recognition. Other common KAMs related to investments, asset impairments, and financial instruments. Very few KAMs dealt with risks arising from non-compliance with laws and regulations.
Specific risks	This reviews how auditors have communicated risks arising from climate change, the COVID-19 pandemic, and alternative performance measures (APMs), and their findings from the audit procedures addressing those risks.	Risks associated with climate change were rarely reported as KAMs. The most common response to the risks associated with the pandemic was to integrate the risk within a consideration of the underlying financial statement item. KAMs on APMs are very rare.

Themes	Areas considered	Findings summary
	It also included the use of graduated findings (the auditor describes the position of estimates and judgements by their position on a range of potential outcomes) and binary findings (the auditor compares management's point estimate with a plausible range of values). when reporting on KAMs.	The use of graduated findings is rare. Binary findings are more common, and both approaches use simple, formulaic approaches to express conclusions.
Going concern	This explores how auditors have reported on the appropriateness of the going concern basis of accounting.	KAMs were the main channel for reporting where the auditor had identified heightened risks on going concern. Paragraphs on material uncertainty relating to going concern were rarely used.
Fraud and other irregularities	This explores how auditors have responded to the new requirement to explain the extent to which their audit has been designed to detect fraud and other irregularities.	Identified fraud risks tended to be those presupposed by the auditing standards. The responses to fraud risks tend to be generic and describe procedures that the auditor is required to do for any audit, rather than being specifically tailored to the circumstances of the entity.

Updated thematic review on judgements and estimates

61. The FRC has issued an update to their thematic review on the disclosure of judgements and estimates (see Technical Bulletin 2017/4 – paragraph 20). The review relates to the requirements in IAS 1 to disclose:

- judgements made by management in applying an entity's accounting policies
- sources of estimation uncertainty.

62. The review identified good examples of detailed, granular disclosure explaining management's judgements and the nature of the uncertainties relating to significant estimates. Estimates were supported by quantification, such as information about assumptions made and the specific amount at risk of material adjustment.

63. However, the review also identified the following areas for improvement which are also relevant to public bodies:

- Disclosures should explicitly state whether estimates have a significant risk of a material adjustment to the carrying amounts of assets and liabilities within the next financial year.
- Entities should reassess whether disclosures on sources of estimation uncertainty should be revised each year.
- Where additional estimate disclosures are provided (e.g. those carrying lower risk or crystallising over a longer timeframe), they should be clearly distinguished from those with a significant short-term effect.

Thematic review of climate disclosures

64. The FRC has issued a thematic review on information on climate change in the annual accounts of a sample of premium listed companies. The report:

- assesses the quality of the Task Force on Climate-related Financial Disclosures (TCFD) in response to a new Listing Rule
- considers the extent to which the financial statements reflect the impact of climate change.

65. The review highlights five main areas in which entities could significantly improve their TCFD disclosures and reporting of climate change in the financial statements. Although TCFD does not yet apply in the public sector, it is anticipated that they will form the basis of future requirements.

66. The areas of improvement, along with a summary of the FRC's expectations for each, are set out in the following table:

Area of improvement	FRC expectations
Granularity and specificity	The granularity and specificity of climate-related disclosures should improve as processes to manage risks and opportunities become more embedded. The link with financial planning should be clearer and more quantified.
Balance	Discussion of climate-related risks and opportunities should be balanced and link the opportunities to any technological dependencies.
Interlinkage with other narrative disclosures	The interlinkages of TCFD with other narrative disclosures in the annual report should be considered.
Materiality	Entities should explain how they applied materiality to their TCFD disclosures. Where elements are excluded, it should be clear whether the entity has decided the elements were not relevant or material, or whether they had been omitted for other reasons such as a lack of robust data.

Area of improvement	FRC expectations
Connectivity between TCFD and financial statements disclosures	Entities should consider the connectivity between TCFD disclosures and the financial statements, and provide explanations to address whether: • the degree of emphasis placed on climate change uncertainties in the narrative reporting is consistent with the way they have been reflected in judgements and estimates applied in the financial statements • emissions reduction commitments and strategies described in the narrative have been appropriately reflected in the financial statements • the extent of progress against climate-related opportunities referred to in the narrative reporting is appropriately reflected in segmental disclosures • discussion of matters which may have an adverse effect on asset values or useful lives in the narrative reporting is consistent with positions taken in the financial statements.

Report on digital security risk disclosure

67. The FRC has issued a report on the disclosure of digital security risks in the annual accounts of a sample of companies. Digital security risks are defined for the purposes of the report as the operational, financial, reputational and stakeholder risks caused by cyber security threats, including the risk of major data breaches arising from internal lapses.

68. Digital security risk is fundamental to business continuity and resilience. Reporting on digital systems, processes and data should provide relevant information to assist stakeholders in assessing an entity's ability to remain viable and resilient.

69. The review identified that, while a significant proportion of the companies in the sample reported at least one digital-related principal risk, the disclosures are often 'boilerplate'. The report recommends a number of enhancements; those relevant to public bodies are summarised in the following table:

Area	Disclosure
Strategy	Explain how digital security and strategy are important to the entity's current and future business model, strategy and environment.
Governance	Detail the governance structures, culture and processes in place to support digital security and strategy.
Risk	Identify digital security and strategy risks and opportunities faced both now and in the future.
Events	Highlight the impact of internal and external events, and the actions and activities that respond to these.

Report on producing ESG data

70. The FRC has issued a report on the production of data on environmental, social and governance (ESG) matters. The report focusses particularly on climate issues.

71. The report identifies three elements of ESG data production which it uses to explore the current landscape, as well as the challenges faced and positive actions to address them. The three elements, along with recommended steps for each, are summarised in the following table:

Motivation	Method	Meaning
What motivates the entity to collect ESG data and how does it identify what it needs?	How is ESG data collected?	How is the data used within the entity and how does it impact decision-making?
Perform a materiality assessment to understand the relevant ESG topics and data points. Collaborate with peers to identify sector-relevant metrics, methods and sources. Identify and encourage internal champions to raise awareness.	Identify the data producers and owners across the entity. Identify the sources for the data and set out the methodology and frequency for gathering it. Apply controls over the data, including evidence trails, reviews and sign-offs. Assess which data should be subject to internal and external assurance.	Consider training and education on why ESG data is needed and how it can be used for effective strategic decision-making. Integrate ESG data in regular processes and embed in the culture. Review whether existing data and data quality is supporting strategic decision-making and whether investment in systems and resource is needed.

6. Fraud and irregularities

Contact: Anne Cairns, Acairns@audit-scotland.gov.uk

This chapter contains a summary of fraud cases and other irregularities facilitated by weaknesses in internal control at audited bodies that have recently been reported by auditors to Professional Support.

Auditors should consider whether weaknesses in internal control which facilitated each fraud may exist in their audited bodies and take the appropriate action.

Payroll (1)

72. A council employee failed to report a £25,000 payroll overpayment over a three-year period.

Key features
An error in processing a reduction in working hours resulted in an increase to the employee's salary. The error was not identified by the authorising officer, and the employee did not report the overpayment.
The fraud was identified during a data check carried out by the council. The fraud was not detected for three years as the normal annual data checks were suspended during the pandemic.
The council has issued instructions so staff processing and authorising payroll amendments are aware of the importance of ensuring the details are correct. A new checking process has been introduced that requires staff to verify any change of working hours requests to amendment forms, contracts, and payroll details.
Disciplinary action has been taken and recovery action is in process.

Payroll (2)

73. An ex-council employee failed to report a £10,500 payroll overpayment over a seven month period.

Key features
The employee left the council's employment and moved to a health board following a secondment period. However, the council salary continued to be paid for seven months after the employee left the council.
The fraud was identified when the health board queried an invoice for recovery of the employee's costs.
The fraud was possible as the employee's manager in the council failed to complete a termination form.

Key features
The manager has been reminded of the requirement to complete termination forms. The council has re-introduced a previously suspended monthly report requiring managers to confirm the employment status of employees in their service. The case has been referred to Police Scotland and recovery action has commenced.

Theft

74. An unidentified perpetrator stole random access memories (RAMs) valued at £12,000 from laptops stored in the office of a public body.

Key features
It was discovered during a stock check that some laptops had been opened and RAMs removed. The theft was possible due to poor security arrangements. The perpetrator has not been identified due to the absence of CCTV. Security procedures have been strengthened and a process for controlling the distribution of laptops has been developed.

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Technical Bulletin 2022/3

Technical developments and emerging risks from July to September 2022

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www.audit-scotland.gov.uk/accessibility

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NHS Fife

AUDIT & RISK COMMITTEE

ANNUAL WORKPLAN 2022 / 2023

Governance - General							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**05/12/22**	**15/03/23**
Minutes of Previous Meetings	**Chair**	✓	✓	✓	✓	✓	✓
Action Plan	**Chair**	✓	✓	✓	✓	✓	✓
Escalation of Issues to NHS Board	**Chair**	✓	✓	✓	✓	✓	✓
Governance Matters							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**05/12/22**	**15/03/23**
Committee Self-Assessment	**Board Secretary**						✓
Corporate Calendar / Committee Dates	**Board Secretary**				✓		
Review of Annual Workplan	**Board Secretary**	✓	✓	✓	✓	✓ Draft	✓ Approval
Review of Terms of Reference	**Board Secretary**						✓ Approval
Annual Review of Code of Corporate Governance	**Board Secretary**	**Deferred to next mtg**	✓				
Annual Assurance Statement 2021/22	**Board Secretary**		✓ Draft	✓			
Annual Assurance Statements from Standing Committees 2021/22	**Board Secretary**		✓				
IJB Annual Assurance Statement 2021/22	**Board Secretary**		**Deferred to next mtg**	✓			
Significant Issues of Wider Interest	**Director of Finance & Strategy**		✓ Final				
Governance Statement	**Director of Finance & Strategy**	✓ Draft	**Deferred to next mtg**	✓			
Internal Audit Review of Property Transactions Report 2021/22	**Internal Audit**				✓		

Governance Matters (cont.)							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**05/12/22**	**15/03/23**
Losses & Special Payments	**Head of Financial Services**		✓		✓	✓	✓
Risk							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**05/12/22**	**15/03/23**
Annual Risk Management Report 2021/22	**Risk Manager**	✓ Draft	✓				
Board Assurance Framework (BAF)	**Risk Manager**	✓			✓	**Replaced by Corporate Risk Register**	
Corporate Risk Register	**Director of Finance & Strategy**				✓	✓	
Risk Management Key Performance Indicators 2021/22	**Risk Manager**	**Deferred until work on framework concluded**			**Deferred until work on framework concluded**	✓ Update	✓
Risk & Opportunities Group and Progress Report *(Replaces - Risk Management Improvement Programme – Progress Report, from Dec '22)*	**Risk Manager**	✓			✓	✓	✓
Governance – Internal Audit							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**05/12/22**	**15/03/23**
Internal Audit Progress Report	**Internal Audit**	✓			✓	✓	✓
Internal Audit Annual Report	**Internal Audit**	**Draft not available due to timings**	✓				
Internal Audit – Follow Up Report on Audit Recommendations 2021/22	**Internal Audit**				✓	✓	✓
Annual Internal Audit Plan 2022/23	**Internal Audit**	✓ Draft	✓				
FTF Shared Service Agreement / Service Specification	**Internal Audit**					**Deferred to next mtg**	✓
External Quality Assessment (5 yearly)	**Internal Audit**				✓		

Governance – Internal Audit (cont.)							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**05/12/22**	**15/03/23**
Internal Controls Evaluation Report 2022/23	**Internal Audit**					✓ Draft	✓ Final
Governance – External Audit							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**05/12/22**	**15/03/23**
Annual Audit Plan 2022/23 - Azets	**External Audit**					✓ Strategy	
Patients' Private Funds - Audit Planning Memorandum	**Director of Finance & Strategy**	✓					
External Audit – Follow Up Report on Audit Recommendations	**Director of Finance & Strategy**					✓	✓
Service Auditor Reports on Third Party Services	**Director of Finance & Strategy**		✓				
Annual Accounts							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**05/12/22**	**15/03/23**
Annual Accounts & Financial Statements 2021/22	**Director of Finance & Strategy / External Audit**			✓			
Annual Audit Report (including ISA 260) 2021/22	**External Audit**			✓			
Letter of Representation (ISA 580) 2021/22	**Director of Finance & Strategy / External Audit**			✓			
Patients' Funds Accounts 2021/22	**Head of Financial Services**			✓			
Annual Statement of Assurance to the NHS Board 2021/22	**Board Secretary**			✓			

Counter Fraud							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**05/12/22**	**15/03/23**
Counter Fraud Service – Quarterly Report (Alerts & Referrals)	**Head of Financial Services**	Private Session			Private Session	Private Session	Private Session
Counter Fraud Standards Update	**Head of Financial Services**	Private Session					
Adhoc							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**05/12/22**	**15/03/23**
Private Meeting with Internal / External Auditors	**Committee**				Private Session		✓
Adhoc (cont.)							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**05/12/22**	**15/03/23**
Appointment of Patients' Funds Auditor	**Director of Finance & Strategy**	**As required**					
Progress on National Fraud Initiative (NFI)	**Head of Financial Services**	**As required**					
Legal & regulatory updates (e.g. Audit Scotland reports; Technical Bulletin etc)	**Head of Financial Services**						
Additional Agenda Items (Not on the Workplan e.g. Actions from Committee)							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**05/12/22**	**15/03/23**
Annual Accounts Preparation Timeline	**Head of Financial Services**	✓					

Additional Agenda Items (Not on the Workplan e.g. Actions from Committee) (Cont.)							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**05/12/22**	**15/03/23**
Internal Audit Framework	**Chief Internal Auditor**	✓ **Deferred from 17/03/22**					✓
Notification of External Audit Appointment from 2022/2023	**Director of Finance & Strategy**	✓					
Partnership Agreement between Health Boards & Counter Fraud – Update	**Head of Financial Services**	Private Session					
Extract from Internal Audit Framework	**Chief Internal Auditor**		✓				
Audit Scotland Technical Bulletin	**Head of Financial Services**				✓ **2022/2**	✓ **2022/3**	✓ **2022/4**
Introduction from Azets External Auditors'	**External Auditors**				✓		
Fife IJB Draft Internal Audit Joint Working and Reporting Protocol	**Chief Internal Auditor**				✓		
Training Sessions Delivered							
	Lead		**16/06/22**			**13/02/23**	
Members' Training Session – the Annual Accounts: The Role & Function of the Audit & Risk Committee	**External Auditors**		✓				
Committee Assurance Principles	**Chief Internal Auditor/Board Secretary**					✓	
Corporate Risk Register	**Director of Finance & Strategy**					✓	

NHS Fife

AUDIT & RISK COMMITTEE

ANNUAL WORKPLAN 2023 / 2024

Governance - General						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Minutes of Previous Meetings	**Chair**	✓	✓	✓	✓	✓
Action Plan	**Chair**	✓	✓	✓	✓	✓
Escalation of Issues to NHS Board	**Chair**	✓	✓	✓	✓	✓
Governance Matters						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Annual Assurance Statement 2022/23	**Board Secretary**	✓ Draft	✓ Final			
Annual Assurance Statements from Standing Committees 2022/23	**Board Secretary**		✓			
Annual Review of Code of Corporate Governance	**Board Secretary**	✓				
Committee Self-Assessment	**Board Secretary**					✓
Corporate Calendar / Committee Dates 2024/25	**Board Secretary**			✓		
Governance Statement	**Director of Finance & Strategy**	✓ Draft	✓ Final			
IJB Annual Assurance Statement 2022/23	**Board Secretary**		✓			
Internal Audit Review of Property Transactions Report 2022/23	**Internal Audit**		✓			
Losses & Special Payments	**Head of Financial Services**		✓	✓	✓	✓
Review of Annual Workplan 2024/25	**Board Secretary**				✓ Draft	✓ Approval
Review of Terms of Reference	**Board Secretary**					✓ Approval
Significant Issues of Wider Interest	**Director of Finance & Strategy**	✓ Draft	✓ Final			

Risk						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Annual Risk Management Report 2022/23	**Risk Manager**	✓ Draft	✓ Final			
Corporate Risk Register	**Director of Finance & Strategy/Risk Manager**	✓		✓	✓	✓
Risk Management Key Performance Indicators 2022/23	**Risk Manager**	✓		✓	✓	✓
Risk & Opportunities Group and Progress Report	**Risk Manager**	✓		✓	✓	✓
Governance – Internal Audit						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
External Quality Assessment (5 yearly) (Due next in ADD Month/Year)	**Internal Audit**					
FTF Shared Service Agreement / Service Specification	**Internal Audit**				✓	
Internal Audit Progress Report	**Internal Audit**	✓		✓	✓	✓
Internal Audit Annual Plan 2023/24	**Internal Audit**	✓ Final	✓			
Internal Audit Annual Report 2022/23	**Internal Audit**		✓			
Internal Audit – Follow Up Report on Audit Recommendations 2022/23	**Internal Audit**	✓		✓	✓	✓
Internal Audit Framework	**Chief Internal Auditor**					✓
Internal Controls Evaluation Report 2023/24	**Internal Audit**				✓	
Governance – External Audit						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Annual Audit Plan 2023/24	**External Audit**				✓	
External Audit – Follow Up Report on Audit Recommendations	**Director of Finance & Strategy**				✓	✓

Governance – External Audit (cont.)						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Patients' Private Funds - Audit Planning Memorandum	**Director of Finance & Strategy**	✓				
Service Auditor Reports on Third Party Services	**Director of Finance & Strategy**		✓			
Annual Accounts						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Annual Accounts Preparation Timeline	**Head of Financial Services**	✓				
Annual Accounts & Financial Statements 2022/23	**Director of Finance & Strategy / External Audit**		✓			
Annual Audit Report (including ISA 260) 2022/23	**External Audit**		✓			
Letter of Representation (ISA 580) 2022/23	**Director of Finance & Strategy / External Audit**		✓			
Patients' Funds Accounts 2022/23	**Head of Financial Services**		✓			
Annual Statement of Assurance to the NHS Board 2022/23	**Board Secretary**		✓			
For Assurance						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Audit Scotland Technical Bulletin	**Head of Financial Services**	✓ **2023/1**		✓ **2023/2**	✓ **2023/3**	✓ **2023/4**
Delivery of Annual Workplan 2023/24	**Director of Finance & Strategy**	✓	✓	✓	✓	✓
Counter Fraud						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Counter Fraud Service – Quarterly Report (Alerts & Referrals)	**Head of Financial Services**	Private Session		Private Session	Private Session	Private Session
Counter Fraud Standards Update	**Head of Financial Services**	Private Session				

Adhoc						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Private Meeting with Internal / External Auditors	**Committee**			Private Session		Private Session
Appointment of Patients' Funds Auditor	**Director of Finance & Strategy**	**As required**				
Legal & regulatory updates (e.g. Audit Scotland reports; Technical Bulletin etc)	**Head of Financial Services**					
Progress on National Fraud Initiative (NFI)	**Head of Financial Services**					
Additional Agenda Items (Not on the Workplan e.g. Actions from Committee)						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Training Sessions Delivered						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Members' Training Session – the Annual Accounts: The Role & Function of the Audit & Risk Committee	**External Auditors**	✓				