AGENDA

A MEETING OF THE NHS FIFE AUDIT & RISK COMMITTEE WILL BE HELD ON THURSDAY 15 MAY 2025 FROM 2PM TO 4.30PM VIA MS TEAMS

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

Arlene Wood
Chair

14:00	**1.**	**MEMBERS' TRAINING SESSION – THE ANNUAL ACCOUNTS: THE ROLE & FUNCTION OF THE AUDIT & RISK COMMITTEE**		
		1.1 Presentation		
14:15		1.2 Questions & Answers		
14:30		**MAIN MEETING**		
			Purpose	
	2.	Apologies for Absence ***(AW)***		
	3.	Declaration of Members' Interests ***(AW)***		
	4.	Minutes of Previous Meeting held on Thursday 13 March 2025 ***(AW)***	***(approval)***	(enc)
	5.	Chair's Assurance Report presented to Fife NHS Board on 25 March 2025 ***(AW)***	***(for information)***	(enc)
	6.	Matters Arising / Action List ***(AW)***	***(assurance)***	(enc)
14:40	**7.**	**ANNUAL ACCOUNTS**		
		7.1 Annual Accounts Preparation Timeline Update ***(KB)***	***(assurance)***	(enc)
		7.2 External Auditors Annual Accounts Progress Update ***(CB)***	***(assurance)***	(verbal)
14:50	**8.**	**INTERNAL AUDIT**		
		8.1 Global International Accounting Standards Changes in 2025 - Improvement Plan ***(JL)***	***(decision)***	(enc)
		8.2 Internal Audit Annual Plan 2025/26 ***(JL)***	***(decision)***	(enc)
		8.3 Internal Audit Framework ***(JL)***	***(decision)***	(enc)
		8.4 Internal Audit Progress Report ***(BH)***	***(assurance)***	(enc)
		8.5 Internal Audit – Follow Up Report on Audit Recommendations 2024/25 ***(AB)***	***(discussion)***	(enc)
15:20	**9.**	**RISK**		
		9.1 Draft Annual Risk Management Report 2024/25 ***(SAS)***	***(assurance)***	(enc)
		9.2 Corporate Risk Register, including Oral Health Risk ***(SAS)***	***(assurance)***	(enc)
		9.3 Risk Management Key Performance Indicators 2024/25 ***(SAS)***	***(assurance)***	(enc)

	9.4	Risks & Opportunities Group Annual Assurance Statement 2024/25 ***(SAS)***	***(assurance)***	(enc)
15:50	**10.**	**GOVERNANCE MATTERS**		
	10.1	Annual Audit & Risk Committee Assurance Statement 2024/25 ***(GM)***	***(assurance)***	(enc)
	10.2	Review of Terms of Reference ***(GM)***	***(decision)***	(enc)
	10.3	Annual Review of Code of Corporate Governance ***(GM)***	***(decision)***	(enc)
	10.4	Draft Governance Statement ***(GM)***	***(discussion)***	(enc)
	10.5	Losses & Special Payments Quarter 4 2024/25 ***(KB)***	***(assurance)***	(enc)
	10.6	Procurement Tender Waivers Compliance Quarter 4 2024/25 ***(KB)***	***(assurance)***	(enc)
	11.	**FOR ASSURANCE**		
	11.1	Audit Scotland General Practice Report ***(CM)***	***(assurance)***	(enc)
	11.2	Delivery of Annual Workplan 2025/26 ***(SD)***	***(assurance)***	(enc)
	12.	**ESCALATION OF ISSUES TO NHS FIFE BOARD**		
	12.1	Chair's comments on the Minutes / Any other matters for escalation to NHS Fife Board		(verbal)
	13.	**MEETING REFLECTIONS & AGREEMENT OF MATTERS FOR CHAIR'S ASSURANCE REPORT TO BE PRESENTED TO FIFE NHS BOARD ON 27 MAY 2025**		
	14.	**ANY OTHER BUSINESS**		
16:15	**PRIVATE SESSION**			
	15.	Apologies for Absence ***(AW)***		
	16.	Declaration of Members' Interests ***(AW)***		
	17.	Minutes of Previous Meeting held on Thursday 13 March 2025 ***(AW)***	***(approval)***	(enc)
	18.	External Quality Assessment ***(JL)***	***(for noting)***	(enc)
	19.	Counter Fraud Service – Quarterly Report ***(KB)***	***(assurance)***	(enc)
	20.	Any Other Business		

Date of Next Meeting (Annual Accounts): **Thursday 19 June 2025 from 2pm – 4.30pm** via MS Teams

Fife NHS Board

Unconfirmed

MINUTE OF THE AUDIT & RISK COMMITTEE MEETING HELD ON THURSDAY 13 MARCH 2025 AT 2PM VIA MS TEAMS

Present:
Alastair Grant, Non-Executive Member (Chair)
Anne Haston, Non-Executive Member
Cllr Mary Lockhart, Non-Executive Member

In Attendance:
Kevin Booth, Head of Financial Services & Procurement
Chris Brown, Head of Public Sector Audit (UK), Azets
Susan Dunsmuir, incoming Director of Finance *(observing)*
Andrew Ferguson, Senior Manager, Azets
Barry Hudson, Regional Audit Manager
Jocelyn Lyall, Chief Internal Auditor
Dr Gillian MacIntosh, Head of Corporate Governance & Board Secretary
Dr Chris McKenna, Medical Director
Caitlin McKenzie, Senior, Azets
Maxine Michie, Deputy Director of Finance *(deputising for the Director of Finance & Strategy)*
Pat Kilpatrick, Board Chair *(part)*
Carol Potter, Chief Executive *(part)*
Arlene Wood, Non-Executive Member and incoming Chair of the Committee *(observing)*
Hazel Thomson, Board Committee Support Officer (Minutes)

Chair's Opening Remarks

The Chair welcomed everyone to the meeting and extended a warm welcome to two observers to today's meeting: Arlene Wood, Non-Executive Member, who will take over the position as Chair of the Committee from April 2025, and Susan Dunsmuir, who will join NHS Fife on 1 April 2025 as the new Director of Finance.

The NHS Fife MS Teams Meeting Protocol was set out and a reminder given that the meeting is being recorded to aid production of the minutes.

1. Apologies for Absence

Apologies were received from member Nicola Robertson (Area Clinical Forum Representative) and routine attendees Andy Brown (Principal Auditor), Margo McGurk (Director of Finance & Strategy) and Dr Shirley-Anne Savage (Associate Director of Risk & Professional Standards). A welcome was also extended to Dr Chris McKenna, Medical Director, who has assumed the Executive lead for risk management.

2. Declaration of Members' Interests

There were no declarations of interest made by members.

3. Minute of the last Meeting held on 12 December 2024

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

4. Chair's Assurance Report Presented to Fife NHS Board on 30 January 2025

The Chair's Assurance Report to the last Board meeting was presented to the Committee for information only.

5. Action List / Matters Arising

The Audit & Risk Committee **noted** the updates on the Action Lists.

6. INTERNAL AUDIT

6.1 Global International Accounting Standards Changes in 2025

The Chief Internal Auditor updated the Committee on changes to the new Global International Accounting Standards Changes in 2025, which are fully detailed within the paper. It was noted that the Standards will be applied from a public sector perspective.

It was reported that an improvement plan will be developed, which will ensure Internal Audit's conformance with the new Standards during the forthcoming year and also ensure that actions are taken to address the recommendations from the recently undertaken External Quality Assessment (EQA). The improvement plan will be presented to the next Committee meeting, followed by updates to the Committee on a bi-meeting basis. The Board Committee Support Officer will add to the workplan.

Action: Board Committee Support Officer

It was reported that reference to the Standards will be incorporated into the Committee's Terms of Reference, which document is currently being reviewed as part of the annual review process. It was also reported that it is anticipated that the new Standards will be incorporated into the guidance within the Scottish Government Audit & Assurance Committee Handbook, and that this has been raised with the Scottish Government to enquire about timescales for this.

The Committee took a **"moderate" level of assurance** that FTF Internal Audit will develop an improvement plan to ensure conformance with the new Global International Accounting Standards during 2025/26, and to ensure actions to address recommendations from the EQA is implemented.

Members also:

- **agreed** that the Audit and Risk Committee Terms of Reference will be updated to reflect the Global International Accounting Standards requirements, to be brought to the May meeting of the Committee; and.

- **agreed** that the internal audit improvement plan will be monitored by the Audit and Risk Committee.

6.2 Internal Audit Progress Report

The Regional Audit Manager highlighted that the amendments to the 2024/25 Internal Audit Plan have been approved electronically by the members of the Audit and Risk Committee in the period since the last meeting.

An overview on the key points from the progress report were provided, and a summary of the findings from the Environmental Management internal audit review, which has concluded since the December 2024 Audit and Risk Committee, was highlighted.

It was reported that, overall, good progress has been made to implement, deliver and monitor requirements of the Directors' Letters for the Annual Accounts.

Following a question, assurance was provided that completion of prior years' audits can, on occasion, continue into the following year.

It was advised that an updated Internal Audit Framework will be presented to the Committee in May 2025.

The Committee took a "**moderate" level of assurance** and **noted** that the change to the 2024/25 Internal Audit Plan has been electronically approved by the Audit and Risk Committee after the last meeting.

6.3 Internal Audit – Follow Up Report on Audit Recommendations 2023/24

The Regional Audit Manager reported that progress continues to be made by management in implementing actions to address recommendations made in internal audit reports. It was highlighted that there are four recommendations remaining from reports published more than 12 months ago, and assurance was provided that internal audit is content that the approved revised target implementation dates are reasonable and appropriate in the stated circumstances.

The Committee took a **"significant" level of assurance** on the progress being made in implementing actions to address recommendations made in internal audit reports.

7. EXTERNAL AUDIT

7.1 External Audit – Follow Up Report on Audit Recommendations

The Head of Procurement & Financial Services reported that there were two audit recommendations included within the 2023/24 External Audit Plan, and an overview was provided on how both those recommendations have been addressed. Assurance was provided that refinement to an internal process is required, in relation to the recommendation to undertake a review of the general ledger account codes and the associated mappings into the financial statements.

The Deputy Director of Finance provided assurance that the Finance Directorate are prepared in relation to the engagement process for this year's Annual Accounts and that they have been presented with the audit expectations from the External Auditors.

The Committee took a **"moderate" level of assurance** from the report.

7.2 External Auditors' Interim Audit Report

A Ferguson, Azets, provided a verbal update and highlighted the areas of work that can be brought forward in the interim period, in preparation for the year-end Annual Accounts, including significant work around the revaluation of Victoria Hospital, income and expenditure mapping, and exploring wider pieces of work that can be brought forward. An overview was provided on the constructive session held recently with the full Finance Directorate to prepare for the Annual Accounts process.

The Committee **noted** the update.

7.3 External Annual Audit Plan

C Brown, External Auditor, advised that the report has been updated to include details of the audit fee for 2025/26, following release by Audit Scotland. The fee has been discussed and agreed with management and represents an increase of 2.3% from the previous year. It was noted that there are no further changes to the plan from that previously presented to the Committee.

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

7.4 Patients' Private Funds - Audit Planning Memorandum

The Head of Procurement & Financial Services explained that NHS Fife Board manage a number of patients' private funds, which are held separately from the NHS Fife Board Accounts, and that a stand-alone Audit Planning Memorandum is being prepared.

An explanation was provided on auditing community hospitals, and it was advised that funds held by NHS Fife are predominately for mental health patients on long-term stay, which only occurs at certain sites. The Head of Procurement & Financial Services agreed to clarify the process for auditing patients' private funds.

Action: Head of Procurement & Financial Services

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

8. ANNUAL ACCOUNTS

8.1 Initial Annual Accounts Preparation Timeline

The Head of Procurement & Financial Services presented the initial Annual Accounts preparation timeline and highlighted that the robust timescales are always a challenge in relation to ensuring maximum time for external auditors to review the Annual Accounts.

It was highlighted that the Integrated Joint Board have a slightly later submission date for their Annual Accounts, and assurance was provided that early discussions have taken place to explain NHS Fife's position, and that communication channels will remain open to share any developments, which may impact on submission dates.

The Committee took a **"significant" level of assurance** from the paper.

9. RISK

9.1 Corporate Risk Register

The Medical Director reported that a new risk for Substance Related Morbidity and Mortality has been considered by the Public Health & Wellbeing Committee, and that, following closure of the Optimal Clinical Outcomes risk, a new risk for Hospital Acquired Harm has been developed for consideration by the Board at its next meeting. Further detail is provided as an appendix and captures where the risk derives from and the mitigations that sit against it. It was reported that, through delegation within the system, subgroups are responsible for the delivery of each of the subsets of the risk and taking accountability of monitoring actions.

It was advised that the Off-Site Sterilisation and Disinfection Unit risk has been removed as a corporate risk and is now monitored as an operational risk. An overview was provided on the number of risks aligned to each strategic priority, and it was noted that an updated risk appetite statement has been included as an appendix. It was also reported that a further corporate risk is being developed for dentistry.

Discussion followed, and it was advised that work continues at Board level to identify areas of discomfort for risks that are above the risk appetite level. It was also advised that a continual area of development for the Board is in relation to making decisions in relation to resources and activity for risks that are higher than the target score. It was emphasised that a continued approach to risk, transformation work and prioritising resource across the whole system is required, and to continue those discussions. The importance of 'deep dives' was highlighted, noting the likelihood of this term being replaced by a more meaningful name, and the role of the Committee in terms of ensuring the overall systems and processes are working properly was highlighted.

The Medical Director agreed to share the deep dive on the Substance Related Morbidity and Mortality risk.

Action: Medical Director

The Committee took a **"moderate" level of assurance** that all actions, within the control of the organisation, are being taken to mitigate the risks as far as is possible to do so.

9.2 Risks & Opportunities Group Progress Report - March 2025

The Medical Director reported that the Risk & Opportunities Group continues to support the Executive Directors' Group in the ongoing development of the effective Risk Management Framework. It was advised that responsibility of the group includes considering the review of the Risk Management Framework, key performance

indicators, deep dive reviews for risks, and horizon scanning of potential future risks. It was noted an annual assurance statement for the group will be provided in May 2025, as part of the overall suite of assurance reports included within the year-end Annual Accounts.

Discussion took place on the current usage of the terminology of 'deep dives', and it was suggested to remove this to replace instead with a reference to a comprehensive re-evaluation of each risk ('risk and focus' is a term used elsewhere) and to have a rolling and prioritised programme of these detailed reviews, commencing with the highest-level risks.

It was agreed to hold a Development Session in the forthcoming year to better understand the evidence around managing corporate risks.

Action: Medical Director/Board Committee Support Officer

The Committee took a **"moderate" level of assurance** from the update provided.

10. GOVERNANCE MATTERS

10.1 Audit & Risk Committee Self-Assessment Report 2024/25

The Board Secretary advised that a self-assessment is carried out for all the Board's Standing Governance Committees on an annual basis. This paper provides the feedback for the Audit & Risk Committee.

An overview on the themes of the self-assessment was provided, and it was noted that there were some common themes identified across all the Board's Standing Governance Committees self-assessment outcomes. It was advised that a long-standing vacancy on the Committee for much of the previous year had regrettably affected attendance levels. Within the responses, there were mixed opinions on whether the required level of independent challenge and discussion is evident at the Committee, particularly around broader internal control-related matters. It was advised that the Committee could be strengthened by including a member with specific risk management experience and that would be a focus of the forthcoming Non-Executive recruitment. The length of papers was highlighted, and it was also noted that further development on the full scope of assurance responsibilities that sit with the Committee was requested. Work in the next year will attempt to address members' comments as part of a continuous improvement exercise, and a meeting has been arranged in the coming weeks with the Chair and Committee Chairs to start discussions on Board-wide enhancements.

The Chair took the opportunity to encourage members to approach the Chair, should they have any issues that they would wish to discuss on a one-to-one basis.

The Committee took a **"moderate" level of assurance** from the report.

10.2 Annual Review of Audit & Risk Committee Terms of Reference

The Board Secretary provided a verbal update and advised that a review of the Terms of Reference is carried out for all the Board's Standing Governance Committees on an

annual basis, and any updates are taken forward through the Audit & Risk Committee, followed by the Board, and are reflected in the publication of the Code of Corporate Governance.

It was reported that the Committee's Terms of Reference will be presented at the next Committee meeting, following the incorporation of the Global International Accounting Standards changes, as discussed earlier in the meeting, and feedback/comments from a scheduled Committee Development Session in April 2025 to discuss the Committee's Terms of Reference. Assurance was provided that the timing for the revised Terms of Reference to go to the NHS Fife Board is still within the required timeframe.

The Committee **noted** the update.

10.3 Blueprint for Good Governance Improvement Plan Update

The Board Secretary provided background detail, advising that a survey was undertaken in December 2023, which took the form of benchmarking against the Blueprint for Good Governance. Following on from that exercise, an action plan was developed and approved by the Board in March 2024. An update on the action plan was last presented at the September 2024 Audit & Risk Committee meeting.

Progress on a number of actions were highlighted. It was reported that one outstanding action is mainly linked to work that is ongoing at a national level, including improving diversity of Board members via this year's recruitment exercises. The second outstanding action is related to creating an assurance framework for the Board, and it was reported that NHS Scotland Board Secretaries are in discussions around good practice in this area, which will be adopted a local level. A first draft of the assurance framework is expected later in the year.

The Committee took a **"moderate" level of assurance** and **noted** progress in delivery of the Board's current Improvement Plan.

10.4 Losses & Special Payments Quarter 3 Report

The Head of Procurement & Financial Services highlighted the key points from the report and advised that the Board's losses and special payments have increased by £814,528 in quarter 3 (£1,026,309) in comparison to quarter 2 (£211,781) 2024/25. The increase was predominantly as a result of the increase in value of the clinical ex-gratia compensation payments, which will be given further scrutiny going forward. An overview was provided on the quarterly analytical review, provided within the paper.

It was questioned what systems and processes are in place to enable learning and identify patterns. In response, it was advised that the work of the Organisational Learning Group is still developing and that this will form part of consideration to share learnings across the whole system.

It was agreed to hold a Committee Development Session on losses & special payments, to enhance the understanding of reporting.

Action: Head of Procurement & Financial Services/Board Committee Support Officer

The Committee took a **"significant" level of assurance** from the report.

10.5 Procurement Tender Waivers Quarter 3 Report

The Head of Procurement & Financial Services reported that, during quarter 3, there were two waivers of competitive tender for the provision of oral nutritional supplements, with a value of £353k, and urology thulium fibre laser consumables, with a value of £78k, which have both been approved in line with NHS Fife's Standing Financial Instructions.

Discussion followed, and an explanation was provided on the reasons why tender waivers can be provided to the same suppliers on a cyclical basis, and assurance was provided that this is scrutinised by the Finance Team. An explanation was also provided on the methods of paying for assets through a contract. A further explanation was provided on provision of oral nutritional supplements and the mitigations circumstances for the tender waiver.

The Committee took a **"significant" level of assurance** that the Procurement process for the waiver of competitive tenders was correctly applied in the period.

11. FOR ASSURANCE

11.1 Audit Scotland Technical Bulletin 2024/4

The Head of Procurement & Financial Services highlighted that the bulletin is provided to the Committee for awareness around the key developments that are being highlighted to the Auditors, and that this edition of the bulletin is largely around the Annual Accounts.

The Committee took a **"significant" level of assurance** from the update.

11.2 Delivery of Annual Workplan 2024/45

The Committee took **assurance** from the tracked workplan, noting that the External Quality Assessment, Internal Audit Framework and Counter Fraud Standards Assessment have been deferred to the next meeting and added to the 2025/26 workplan.

12. ESCALATION OF ISSUES TO NHS FIFE BOARD

There were no escalations to NHS Fife Board.

13. MEETING REFLECTIONS & AGREEMENT OF MATTERS FOR CHAIR'S ASSURANCE REPORT TO BE PRESENTED TO FIFE NHS BOARD ON 25 MARCH 2025

The reflections from the meeting & agreement of matters will be considered by the Chair for onward submission to NHS Fife Board. The report will be provided to the following Committee meeting for information.

14. ANY OTHER BUSINESS

14.1 Chair

The Board Secretary, on behalf of the Board and Executive team, warmly thanked the Chair for his service and chairmanship during his time on the Committee. Members joined in thanking the Committee Chair for his input into the work of the Committee. It was advised that Arlene Wood, Non-Executive Director, will take over the role from 1 April 2025.

Date of Next Meeting: Thursday 15 May 2025 from 2pm – 4.30pm via MS Teams.

Meeting: **Audit & Risk Committee**

Meeting date: **13 March 2025**

Title: **Committee Chair's Assurance Report**

1. Committee's Performance against Annual Workplan

The Committee reviewed the workplan for the financial year 2024/25.

The following items have been deferred and rescheduled:

- External Quality Assessment
- Internal Audit Framework
- Counter Fraud Standards Assessment

2. The Committee considered the following items of business:

2.1 Global International Accounting Standards Changes in 2025

The Committee were advised on the changes to the Global International Accounting Standards and took a **"moderate" level of assurance** that FTF Internal Audit will develop an improvement plan to ensure conformance with the new Standards during 2025/26, and to ensure actions to address recommendations from the EQA is implemented. The Committee noted that the Committee's Terms of Reference will be updated to reflect the Global International Accounting Standards requirements.

2.2 Internal Audit Progress Report

The Committee took a "**moderate" level of assurance** from the report and noted that the change to the 2024/25 Internal Audit Plan has been electronically approved by the Audit and Risk Committee after the last meeting. The Committee noted that an updated Internal Audit Framework will be presented to the Committee in May 2025.

2.3 External Audit – Follow Up Report on Audit Recommendations

The Committee were updated on the two audit recommendations included within the 2023/24 External Audit Plan and took a **"moderate" level of assurance** from the report.

2.4 External Auditors' Interim Audit Report

The Committee were provided with a verbal update in relation to the areas of work that can be brought forward in the interim period, in preparation for the year-end Annual Accounts.

2.5 External Annual Audit Plan

The Committee took **assurance** from the update provided and noted that the plan includes the audit fee for 2025/26 and represents a 2.3% increase.

2.6 Patients' Private Funds - Audit Planning Memorandum

The Committee took **assurance** from the paper and were advised that a stand-alone Audit Planning Memorandum is being prepared for patients' private funds.

2.7 Blueprint for Good Governance Improvement Plan Update

The Committee took a **"moderate" level of assurance** and **noted** progress in delivery of the Board's current Improvement Plan, including the development of an assurance framework for the Board, which is expected later in the year.

3. Delegated Decisions taken by the Committee

3.1 Losses & Special Payments Quarter 3 Report

The Committee **agreed** to hold a Development Session on Losses & Special Payment, to enhance the understanding of reporting.

3.2 Risks & Opportunities Group Progress Report - March 2025

The Committee **agreed** to hold a Development Session in the forthcoming year to better understand the evidence around managing corporate risks.

4. Update on Performance Metrics

N/A.

5. Update on Risk Management

5.1 The Committee took a **"moderate" level of assurance** that all actions, within the control of the organisation are being taken to mitigate the risks as far as is possible to do so.

The Committee received an update on the new risks for Substance Related Morbidity and Mortality and Hospital Acquired Harm. The Committee were advised that work continues at Board level to identify areas of discomfort for risks that are above the risk appetite level.

6. Any other Issues to highlight to the Board:

None

Alastair Grant
Chair, Audit & Risk Committee

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

AUDIT & RISK COMMITTEE – ACTION LIST
Meeting Date: Thursday 15 May 2025

NHS Fife

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	COMMENTS / PROGRESS	RAG
1.	13/03/25	**Development Sessions**	To hold a Development Session in the forthcoming year to better understand the evidence around managing corporate risks. To hold a Committee Development Session on losses & special payments, to enhance the understanding of reporting.	**HT**	Closed. Added to workplan, and HT will co-ordinate the sessions.	(TBC - October & February)
2.	13/03/25	**Global International Accounting Standards Changes in 2025**	To add the improvement plan to the workplan for the May 2025 meeting, followed by updates to the Committee on a bi-meeting basis.	**HT**	Closed. Added to workplan.	March 2025
3.	13/03/25	**Corporate Risk Register**	To share the deep dive on the Substance Related Morbidity and Mortality risk.	**CM**	Closed. Issued via email on 04/04/25.	March 2025
4.	13/03/25	**Patients' Private Funds - Audit Planning Memorandum**	To clarify the process for auditing patients' private funds.	**KB**	Closed. The Funds External Auditors will carry out sample testing of patients, reconciling opening and closing balances to transactions included within the period, ensuring that the correct paperwork has been used and any relevant receipts are retained.	May 2025

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**15 May 2025**
Title:	**Annual Accounts Preparation Timeline Update**
Responsible Executive:	**Susan Dunsmuir, Director of Finance**
Report Author:	**Kevin Booth, Head of Financial Services & Procurement**

Executive Summary:

- This paper provides a significant level of assurance that the draft Annual Accounts have been completed and provided to the External Auditors as per the agreed timetable.
- In addition, the draft Patients Private Funds Accounts and draft Fife Health Charity Accounts which are incorporated into the Consolidated Accounts have both been prepared and submitted to the respective Auditors.

1 Purpose

This is presented for:

- Assurance

This report relates to a:

- Government policy/directive
- Legal requirement

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

- Effective

2 Report summary

2.1 Situation

As part of the objectives of the Audit & Risk Committee in supporting the Accountable Officer and NHS Fife Board in meeting their assurance needs, the committee is required to review and recommend approval of the Audited Annual Accounts to the Board.

This paper is provided as an update to the committee on the progress of the Annual Accounts process and any concerns identified with regards to the anticipated timeframe to completion by the 30th June 2025.

2.2 Background

At the Audit and Risk Committee on the 12th December 2024, Azets, the Boards External Auditors presented the NHS Fife Annual Audit Plan 2024/25. The timelines contained within this plan were formed following discussions with the Head of Financial Services & Procurement and the Director of Finance and Strategy.

In order to support the External Auditors assignment and with the requirement to have the Annual Accounts approved by the Board and presented to the Scottish Government by 30th June 2025 an internal timetable was produced to manage components and ensure key milestones are understood and met across the finance team. The internal timetable was presented to the Audit & Risk committee at the previous meeting on 13th March 2025 to provide oversight of the key dates and assurance that a sufficient plan was in place and that progress remained on track.

2.3 Assessment

The timetable was shared with the External Auditors for their awareness on 3rd March and regular progress updates, along with any supplementary information requests have been provided to them during the preparation of the draft Annual Accounts.

The draft Annual Accounts incorporating the Front-End Narrative section, the Remuneration Report and the Consolidated Financial Template have all been completed and have been provided to both the Director of Finance and Chief Executive. The full set of Draft Accounts were then provided to Azets on Monday 5th May 2025, in line with the External Audit Plan 2024/25.

In addition, the component parts being the Fife Health Charity Accounts and the Patient's Private Funds which have been incorporated into the Consolidated Accounts were provided to the auditors (Thomson Cooper) on time and the assignments for each of these is progressing on schedule.

Following the submission of the draft accounts to Azets, the Finance Team will continue to support the External Audit process to ensure that the final clearance meeting in June can be held prior to the following Audit & Risk Committee on 19th June 2025.

The final version of the internal Annual Accounts timetable (appendix1) is provided to confirm all actions have been completed with the exception of the working papers which will continue to be provided throughout the audit assignment.

This report provides the following Level of Assurance:

	Significant	Moderate	Limited	None
Level	X			
Descriptor	There is robust assurance that the system of control achieves, or will	There is sufficient assurance that controls upon which the organisation relies	There is some assurance from the systems of control in place to manage the	No assurance can be taken from the information that has been provided. There

	achieve, the purpose that it is designed to deliver. There may be an insignificant amount of residual risk or none at all.	to manage the risk(s) are suitably designed and effectively applied. There remains a moderate amount of residual risk.	risk(s), but there remains a significant amount of residual risk, which requires further action to be taken.	remains a significant amount of residual risk

2.3.1 Quality, Patient and Value-Based Health & Care

The narrative reporting contained within the draft accounts references key workstreams from a financial perspective which have supported the Boards ambition to enhance quality, patient and value-based health and care throughout the year.

2.3.2 Workforce

The Finance staff's required input for the Annual Accounts process is communicated to them at the internal planning stage. In order to support the External Audit progress, the finance team will prioritise supporting Azets reviews wherever possible.

2.3.3 Financial

The Annual Accounts process is the key part of the Boards disclosure of its Financial Performance for the year 2024/25. It is anticipated that once approved by Scottish Government, they will be made publicly available in late 2025.

2.3.4 Risk Assessment/Management

The Head of Financial Services & Procurement keeps regular contact with applicable members of the Finance Team during the process to ensure any risks are promptly identified and mitigated where possible.

2.3.5 Equality and Human Rights, including children's rights, health inequalities and Anchor Institution ambitions

Developments towards the Boards Anchor Institution ambitions are incorporated into the Annual Accounts.

2.3.6 Climate Emergency and Sustainability Impact

Developments towards the Boards response to the climate emergency and its sustainability impact are incorporated into the Annual Accounts.

2.3.7 Communication, involvement, engagement and consultation

The Head of Financial Services & Procurement has produced an internal timetable to ensure that all steps in the Annual Accounts process have been considered and are completed within the appropriate timeframe. Weekly meetings are held with Azets to inform progress and ensure timely resolution of any active matters arising.

2.3.8 Route to the Meeting

The Director of Finance is kept regularly up to date on the progress of the Annual Accounts and External Audit process.

2.4 Recommendation

- **Assurance** – Members are asked to take a **"significant" level of assurance** that the draft Annual Accounts have been prepared and provided to the External Auditors as per the planned internal timetable.

3 List of appendices

- Appendix No. 1**,** NHSF Internal Annual Accounts Timetable 2024/25 (Final)

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

NHS Fife

Annual Accounts Timetable 2024/25

Task	Owner	Day	Target Date	Complete
Distribute approved Templates & clarify Working Papers responsibility	KB	Friday	07/03/2025	
Distribute Annual Accounts Manual & Capital accounting Manual	KB	Friday	07/03/2025	
NHS Scotland bodies - Final date for purchase invoice authorisation and PECOS receipting, for payment by 24th March	AMH	Wednesday 11am	19/03/2025	
Final Inter account cash transfer to be banked (Endowment - Exchequer)	IP	Wednesday	19/03/2025	
Return of Draft Front End Narrative sections	KB	Friday	21/03/2025	
Final date for payments to Scottish NHS Scotland bodies without agreement of the recipient	AMH	Monday	24/03/2025	
Front End Narrative to DOF for Review	KB	Monday	24/03/2025	
Final date for purchase invoice authorisation and PECOS receipting, for payment by 31st March	All	Wednesday 11am	26/03/2025	
Final creditors payment before 31 March (BACS file produced)	AMH/KE	Friday	28/03/2025	
Final date for sales invoices to NHS Scotland bodies to be included in SFR30 balances agreed	KE	Monday	31/03/2025	
Purchase ledger close (month 12)	AMH/Zendesk	Monday 7pm	31/03/2025	
Registered Invoices Excel Report run	Ledger Control	Tuesday 9am	01/04/2025	
Final creditors payment before 31 March credited to bank accounts	AMH/KE	Tuesday	01/04/2025	
Petty Cash Certificates returned	KE/AW	Wednesday	02/04/2025	
Clinical/medical negligence provision	RM	Thursday	03/04/2025	
Injury benefit / Early Retirement provision	KE	Thursday	03/04/2025	
Upload Year End Stock Entries to eFin	KE	Thursday	03/04/2025	
Financial Accounts ledger entries complete	Fin A/c's	Thursday 12pm	03/04/2025	
Date first creditor payment after 31 Mar credited to bank accounts	AMH/KE	Friday	04/04/2025	
Registered Invoices year end coded & uploaded to eFin	KE	Friday 9am	04/04/2025	
Sales ledger close (month 12)	KE/Zendesk	Friday	04/04/2025	
Remuneration Report data reports from Payroll	TC/DK	Monday	07/04/2025	
Capital entries complete	TG	Thursday	10/04/2025	
Financial Management ledger entries complete	FM	Thursday	10/04/2025	
Primary Care entries complete	CS	Thursday	10/04/2025	
Final date for notifying other NHS Bodies of amounts to be charged in current Financial Year	FM	Monday	14/04/2025	
Front End Narrative submitted to Auditors	KB	Monday	14/04/2025	
Agree and obtain reassurance from Fife Health & Social Care IJB on balances for consolidation	RR	Tuesday	15/04/2025	
Control account reconciliations complete	Ledger Control	Tuesday	15/04/2025	
Primary Care control accounts reconciled	KE	Tuesday	15/04/2025	
Agreement of Earmarked Reserves & Direction Letter	AH/RR	Tuesday	15/04/2025	
Remuneration Report complete	KB	Wednesday	16/04/2025	
Remuneration Report to DOF/Chief Executive for review	KB	Thursday	17/04/2025	
Finalise FPR Return cashflow	KE/KB	Friday	18/04/2025	
Completion of PFI Entries	RM	Friday	18/04/2025	
Remuneration Report issued to Auditors	KB	Monday	21/04/2025	
Agree Debtors, creditors, income and expenditure balances with NHS Scotland bodies for SFR30	KE	Tuesday	22/04/2025	
General ledger close (month 12)	Zendesk	Tuesday	22/04/2025	
FPR Return to SGHSCD (Month 12)	RR	Tuesday (Noon)	22/04/2025	
Draft Charity Accounts/Patient Funds Accounts complete	IP/KE/CS	Wednesday	23/04/2025	
Analysis of debtors & creditors	KE	Wednesday	23/04/2025	
Revaluation figures processed in eFin	TG	Thursday	24/04/2025	
All working papers & draft Notes to be completed and available in AA folder	All	Thursday	24/04/2025	
General ledger close (month 13)	Zendesk	Tuesday 4pm	29/04/2025	
Working papers ready for auditors, confirmed to KB	All	Friday	02/05/2025	**Ongoing process**

Annual Accounts Excel Template to DOF/Chief Executive for review	KB	Friday	02/05/2025	
Draft accounts (Excel Template/Word Document) ready for auditors	KB	Monday	05/05/2025	**Provided 05/05/25**
FPR Return to SGHSCD (Month 13)	RR	Tuesday (Noon)	06/05/2025	

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**15 May 2025**
Title:	**Internal Audit Improvement Action Plan**
Responsible Executive:	**Susan Dunsmuir, Director of Finance**
Report Author:	**Jocelyn Lyall, Chief Internal Auditor**

Executive Summary:

- The purpose of this paper is to present the SMART (Specific, Measurable, Achievable, Relevant, Timebound) Internal Audit Improvement Action Plan, to be monitored by the Audit and Risk Committee as previously agreed.
- The Improvement Action Plan encompasses:
  - A gap analysis of Internal Audit's current practice against the Global Internal Audit Standards (GIAS), applicable from 1 April 2025 and the Application Note: GIAS the UK Public Sector
  - Recommendations from the External Quality Review (EQA) of Internal Audit, published on 4 March 2025.

  As this is the first iteration of the Improvement Action Plan, a RAG status has been applied only for actions that are already in progress or completed.

  No significant risks to delivery of the Improvement Action Plan have been identified.

1 Purpose

This report is presented for:

- Assurance
- Discussion

This report relates to:

- Government policy / directive
- Legal requirement
- NHS Board Strategic Priority - To Deliver Value & Sustainability

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

- Effective

2 Report summary

2.1 Situation

The Internal Audit Improvement Action Plan has been developed by the Chief Internal Auditor and encompasses actions to ensure compliance with GIAS requirements, the Application Note: GIAS the UK Public Sector, and recommendations and suggested improvements from the EQA of Internal Audit, published on 4 March 2025. The Improvement Action Plan has been agreed and is supported by the FTF Partnership Board.

The Audit and Risk Committee is asked to review and approve the Internal Audit Improvement Action Plan, which is to be monitored by the Audit and Risk Committee as previously agreed.

2.2 Background

From 1 April 2025 the requirements of GIAS and of the Application Note: GIAS in the UK Public Sector, apply to work on internal audit engagements commenced on or after this date. The Application Note provides UK public sector-specific context, interpretations of GIAS requirements in the specific circumstances expected to apply across the UK public sector and some additional requirements.

Auditors working in the UK public sector must follow the requirements of GIAS subject to the interpretations and additional requirements set out in the Application Note.

The CIPFA document 'Timeframes for the implementation of GIAS and the Application Note, GIAS in the UK Public Sector' states that while 1 April 2025 is the effective date for the new standards Internal Audit will not be expected to demonstrate full conformance on this date.

Internal Audit already comply with many GIAS requirements and the Improvement Action Plan aims to enhance existing systems and processes, and overtly demonstrate compliance during 2025/26.

2.3 Assessment

The Improvement Action Plan features 49 actions to be completed during 2025/26. Progress will be reported to the FTF Partnership Board and to the Audit and Risk Committee for monitoring.

This report provides Significant Assurance that the Improvement Action Plan is sufficient to ensure compliance with GIAS and progress toward performance objectives. No significant risks to achievement of the Improvement Action Plan have been identified at this point.

	Significant	Moderate	Limited	None
Level	X			
Descriptor	There is robust assurance that the system of control achieves, or will	There is sufficient assurance that controls upon which the organisation relies	There is some assurance from the systems of control in place to manage the	No assurance can be taken from the information that has been provided. There

	achieve, the purpose that it is designed to deliver. There may be an insignificant amount of residual risk or none at all.	to manage the risk(s) are suitably designed and effectively applied. There remains a moderate amount of residual risk.	risk(s), but there remains a significant amount of residual risk, which requires further action to be taken.	remains a significant amount of residual risk

2.3.1 Quality, Patient and Value-Based Health & Care

GIAS Standard 8.3 Quality requires that the Chief Internal Auditor develops, implements and maintains a quality assurance and improvement program that covers all aspects of the internal audit function. The program includes external and internal assessments.

GIAS Standard 12.1 Internal Quality Assessment requires that the Chief Internal Auditor develops and conducts internal assessments of the internal audit function's conformance with the GIAS and progress toward performance objectives.

When expressing conformance with standards, auditors must be clear that they are conforming to the GIAS subject to the Application Note and must refer to this as conformance with Global Internal Audit Standards in the UK Public Sector.

Audit and Risk Committee scrutiny of the Internal Audit Improvement Action Plan evidences compliance with the requirement for ongoing quality monitoring of the internal audit function's conformance with the Standards and progress toward performance objectives.

2.3.2 Workforce

GIAS Standard 10.2 Human Resources Management requires the Chief Internal Auditor to strive to ensure that human resources are appropriate, sufficient, and effectively deployed to achieve the approved internal audit plan.

Actions to ensure compliance with GIAS Standard 10.2 are within the Internal Audit Improvement Action Plan.

2.3.3 Financial

GIAS Standard 10.1 Financial Resource Management requires that the Chief Internal Auditor manages the internal audit function's financial resources. Any financial implications associated with this Improvement Action Plan will be highlighted and progressed appropriately if required.

2.3.4 Risk Assessment / Management

The risk 'Compliance with Internal Audit Framework' is recorded on the FTF risk register and was updated on 22 April 2025 to include the Improvement Action Plan as a key control to mitigate the risk. This risk is scored as 'Moderate' with a target of 'Low'.

No significant risks to achievement of the Improvement Action Plan have been identified at this stage.

2.3.5 Equality and Human Rights, including children's rights, health inequalities and Anchor Institution ambitions

GIAS Standard 1.3 Legal and Ethical Behaviour states that '*Internal auditors must not engage in or be a party to any activity that is illegal or discreditable to the organisation or the profession of internal auditing or that may harm the organisation or its employees. Internal auditors must understand and abide by the laws and/or regulations relevant to the industry and jurisdictions in which the organisation operates, including making disclosures as required'.* If internal auditors identify legal or regulatory violations, they must report such

incidents to individuals or entities that have the authority to take appropriate action, as specified in laws, regulations, and applicable policies and procedures.

Internal Audit staff have completed mandatory Equality and Diversity training. Where relevant, Equality and Humans Rights are considered in internal audit assignments.

2.3.6 Climate Emergency & Sustainability Impact

While the primary function of internal auditing is to strengthen governance, risk management, and control processes, its effects extend beyond the organisation. Internal auditing contributes to an organisation's overall stability and sustainability by providing assurance on its operational efficiency, reliability of reporting, compliance with laws and/or regulations, safeguarding of assets, and ethical culture. The Chief Internal Auditor seeks information from the Board about its perspectives and expectations related to a broad range of nonfinancial governance and risk management concerns including, for example, strategic initiatives, cybersecurity, health and safety, sustainability, business resilience, and reputation.

FTF is committed to contributing to the achievement of Corporate Risk 4: Policy obligations in relation to environmental management and climate change.

2.3.7 Communication, involvement, engagement and consultation

GIAS Principle 11 Communicate Effectively requires that the Chief Internal Auditor oversees the internal audit function's formal communications with the Audit and Risk Committee and senior management to enable quality and provide insights based on the results of internal audit services.

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

2.3.8 Route to the Meeting

This paper has been produced by the Chief Internal Auditor and has been previously considered by the FTF Partnership Board who have agreed and support the content.

2.4 Recommendation

This paper is provided to members for:

- **Assurance:** This report provides a "Significant" Level of Assurance that the Internal Audit Improvement Action Plan is sufficient to ensure the internal audit function's conformance with the GIAS and progress toward performance objectives.
- **Decision:** The Audit and Risk Committee is asked to review and approve the Internal Audit Improvement Action Plan, to be monitored by the Audit and Risk Committee as previously agreed.

3 List of appendices

The following appendices are included with this report:

- Appendix No. 1, Internal Audit Improvement Action Plan

Report Contact
Jocelyn Lyall
Chief Internal Auditor
Email jocelyn.lyall2@nhs.scot

Requirement in Standard		Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
Standard 1.1 Honesty and Professional Courage						
1	Internal auditors must perform their work with honesty and professional courage. Internal auditors must be truthful, accurate, clear, open, and respectful in all professional relationships and communications, even when expressing scepticism or offering an opposing viewpoint. Internal auditors must not make false, misleading, or deceptive statements, nor conceal or omit findings or other pertinent information from communications. Internal auditors must disclose all material facts known to them that, if not disclosed, could affect the organisation's ability to make well-informed decisions. Internal auditors must exhibit professional courage by communicating truthfully and taking appropriate action, even when confronted by dilemmas and difficult situations. The chief audit executive must maintain a work environment	Internal auditors should enhance their awareness and understanding of honesty and professional courage by seeking opportunities to obtain ethics related CPD. The CIA should arrange opportunities for education and training as well as discussions of hypothetical and real situations that require making ethical choices.	CIA to arrange appropriate training to ensure auditors' understanding of honesty and professional courage.	CIA	31 March 2026	

Requirement in Standard		Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
	where internal auditors feel supported when expressing legitimate, evidence-based engagement results, whether favourable or unfavourable.					
Standard 1.2 Organisation's ethical expectations						
2	Internal auditors must understand, respect, meet, and contribute to the legitimate and ethical expectations of the organisation and must be able to recognise conduct that is contrary to those expectations. Internal auditors must encourage and promote an ethics-based culture in the organisation. If internal auditors identify behaviour within the organisation that is inconsistent with the organisation's ethical expectations, they must report the concern according to applicable policies and procedures.	Internal auditors should consider ethics based risks and controls during individual audits. Ethics-related concerns should be reported to the Board.	The risk analysis template which is completed for each audit will be updated to include a section to document ethics based risks and controls.	CIA / Office Manager	30 September 2025	**Complete** Template updated and staff informed of update.
Standard 1.3 Legal and Ethical Behaviour						
	Internal auditors must not engage in or be a party to any activity that is illegal or discreditable to the organisation or the profession of internal	N/A – Internal Auditors are bound by the organisation's policies.	None			No further action

Requirement in Standard		Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
	auditing or that may harm the organisation or its employees. Internal auditors must understand and abide by the laws and/or regulations relevant to the industry and jurisdictions in which the organisation operates, including making disclosures as required. If internal auditors identify legal or regulatory violations, they must report such incidents to individuals or entities that have the authority to take appropriate action, as specified in laws, regulations, and applicable policies and procedures.					
Standard 2.1 Individual Objectivity						
	Internal auditors must maintain professional objectivity when performing all aspects of internal audit services. Professional objectivity requires internal auditors to apply an impartial and unbiased mindset and make judgments based on balanced assessments of all relevant circumstances. Internal auditors must be aware of and manage potential biases.	N/A – objectivity is prominent in the Internal Audit Charter and work undertaken by audit team, which is subject to quality appraisal.	None			No further action

Requirement in Standard		Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
Standard 2.2 Safeguarding Objectivity						
3	Internal auditors must recognise and avoid or mitigate actual, potential, and perceived impairments to objectivity. Internal auditors must not accept any tangible or intangible item, such as a gift, reward, or favour, that may impair or be presumed to impair objectivity. Internal auditors must avoid conflicts of interest and must not be unduly influenced by their own interests or the interests of others, including senior management or others in a position of authority, or by the political environment or other aspects of their surroundings. When performing internal audit services: Internal auditors must refrain from assessing specific activities for which they were previously responsible. Objectivity is presumed to be impaired if an internal auditor provides assurance services for an activity for which the internal auditor had	***EQA recommendation*** - Introduce a more formal annual declaration for internal auditors over and above the standard NHS staff declaration to ensure that all potential or actual conflicts are identified and declared. ***Recommendation to:*** *FTF and NHS Lanarkshire*	A more formal annual declaration for internal auditors over and above the standard NHS staff declaration will be introduced to ensure that all potential or actual conflicts are identified and declared. The CIA will monitor these declarations on an annual basis to identify any conflicts of interest. Staff will be required to advise of emerging actual or perceived conflicts as they become known.	CIA	30 April 2025	**Complete** Template updated and distributed to staff for completion.

Requirement in Standard		Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
	responsibility within the previous 12 months. If the internal audit function is to provide assurance services where it had previously performed advisory services, the chief audit executive must confirm that the nature of the advisory services does not impair objectivity and must assign resources such that individual objectivity is managed. Assurance engagements for functions over which the chief audit executive has responsibility must be overseen by an independent party outside the internal audit function. If internal auditors are to provide advisory services relating to activities for which they had previous responsibilities, they must disclose potential impairments to the party requesting the services before accepting the engagement. The chief audit executive must establish methodologies to address impairments to objectivity. Internal auditors must discuss impairments and take					

Requirement in Standard		Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
	appropriate actions according to relevant methodologies.					
Standard 2.3 Disclosing Impairments to Objectivity						
	If objectivity is impaired in fact or appearance, the details of the impairment must be disclosed promptly to the appropriate parties. If internal auditors become aware of an impairment that may affect their objectivity, they must disclose the impairment to the chief audit executive or a designated supervisor. If the chief audit executive determines that an impairment is affecting an internal auditor's ability to perform duties objectively, the chief audit executive must discuss the impairment with the management of the activity under review, the board, and/or senior management and determine the appropriate actions to resolve the situation. If an impairment that affects the reliability or perceived reliability of the engagement findings, recommendations, and/or conclusions is discovered after an	The Internal Audit Charter sets out the requirement for objectivity in the performance of internal audit work. The CIA has no concerns about the objectivity of the team and the way in which they conduct their work. Any potential conflicts of interest are openly discussed and preventative measures taken. Evidence is held by the Office Manager of instances where staff have notified potential conflicts of interest e.g. Where a family member in employed by a Client Health Board, or where there is a close personal relationship. The CIA and RAMs are also notified of any potential conflicts. If there is any uncertainty over declaring interests,	None			No further action

Requirement in Standard		Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
	engagement has been completed, the chief audit executive must discuss the concern with the management of the activity under review, the board, senior management, and/or other affected stakeholders and determine the appropriate actions to resolve the situation. (See also Standard 11.4 Errors and Omissions.) If the objectivity of the chief audit executive is impaired in fact or appearance, the chief audit executive must disclose the impairment to the board. (See also Standard 7.1 Organisational Independence.)	the relevant Board Secretary is consulted.				
Standard 3.1 Competency						
4	Internal auditors must possess or obtain the competencies to perform their responsibilities successfully. The required competencies include the knowledge, skills, and abilities suitable for one's job position and responsibilities commensurate with their level of experience. Internal auditors must possess or	***EQA recommendation*** - Undertake an analysis of the skills and competencies that will be needed to provide the future internal audit services. Use the IIA Global internal audit competency framework to help develop the skills and competency	All qualified staff have retained their membership status, however, Continual Professional Development (CPD) records for relevant staff are currently not formally collated. To further evidence this area, annual CPD records will be retained within the formal training file for each member of staff.	CIA	31 March 2026	

Requirement in Standard		Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
	develop knowledge of The IIA's Global Internal Audit Standards. Internal auditors must engage only in those services for which they have or can attain the necessary competencies. Each internal auditor is responsible for continually developing and applying the competencies necessary to fulfil their professional responsibilities. Additionally, the chief audit executive must ensure that the internal audit function collectively possesses the competencies to perform the internal audit services described in the internal audit charter or must obtain the necessary competencies. (See also Standards 7.2 Chief Audit Executive Qualifications and 10.2 Human Resources Management.)	element of the internal audit strategy, and to support staff performance and development discussions. ***Recommendation to:*** *FTF and NHS Lanarkshire*	Training and development will be included in joint team briefs. The current competency framework will be replaced by the IIA competency framework which will be used to identify training needs and support staff development. All staff will be asked to contribute to this process which will be co-ordinated by the CIA. NHS Lanarkshire has a process in place for mandatory job specific and ad hoc training, as part of Agenda for Change Protected Learning Time. A documented training programme will be put in place to ensure all internal audit staff are adequately trained in GIAS requirements.			
Standard 3.2 Continuing Professional Development						
5	Internal auditors must maintain and continually develop their competencies to improve the	The Internal Audit Framework sets out the required qualified skill-mix	As 3.1.			

Requirement in Standard		Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
	effectiveness and quality of internal audit services. Internal auditors must pursue continuing professional development including education and training. Practicing internal auditors who have attained professional internal audit certifications must follow the continuing professional education policies and fulfil the requirements applicable to their certifications.	(minimum of 50%) as well as specifying the responsibility of FTF to ensure staff are suitably trained with appropriate skills, recorded in a Personal Development Plan and where relevant fulfilling professional continual professional development requirements. Each staff member within FTF participates in the NHSF/NHSL Turas Personal appraisal. Qualified and part-qualified staff complete CPD activities related to their accreditation.				
Standard 4.1 Conformance with the GIAS						
6	Internal auditors must plan and perform internal audit services in accordance with the Global Internal Audit Standards. The internal audit function's methodologies must be established, documented, and maintained in alignment with the	Internal Audit methodologies must be aligned to GIAS.	Methodologies to be reviewed during 2025/26 and updated to align to GIAS.	CIA	31 March 2026	

Requirement in Standard		Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
	Standards. Internal auditors must follow the Standards and the internal audit function's methodologies when planning and performing internal audit services and communicating results. If the Standards are used in conjunction with requirements issued by other authoritative bodies, internal audit communications must also cite the use of the other requirements, as appropriate. If laws or regulations prohibit internal auditors or the internal audit function from conforming with any part of the Standards, conformance with all other parts of the Standards is required and appropriate disclosures must be made. When internal auditors are unable to conform with a requirement, the chief audit executive must document and communicate a description of the circumstance, alternative actions taken, the impact of the actions, and the rationale. Requirements					

Requirement in Standard		Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
	related to disclosing nonconformance with the Standards are described in Standards 8.3 Quality, 12.1 Internal Quality Assessment, and 15.1 Final Engagement Communication.					
Standard 4.2 Due Professional Care						
7	Internal auditors must exercise due professional care by assessing the nature, circumstances, and requirements of the services to be provided, including: The organisation's strategy and objectives. The interests of those for whom internal audit services are provided and the interests of other stakeholders. Adequacy and effectiveness of governance, risk management, and control processes. Cost relative to potential benefits of the internal audit services to be performed. Extent and timeliness of work needed to achieve the engagement's objectives.	Internal Audit staff are aware of the requirement to exercise Due Professional Care through, for example: • Job description • FTF Working Practices Audit Practice Notes / NHSL Audit Manual • Routine supervisory and review processes • Team briefs	Methodologies to be reviewed during 2025/26 and updated to align to GIAS.	CIA	31 March 2026	

Requirement in Standard		Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
	Relative complexity, materiality, or significance of risks to the activity under review. Probability of significant errors, fraud, noncompliance, and other risks that might affect objectives, operations, or resources. Use of appropriate techniques, tools, and technology.					
Standard 4.3 Professional Scepticism						
	Internal auditors must exercise professional scepticism when planning and performing internal audit services. To exercise professional scepticism, internal auditors must: Maintain an attitude that includes inquisitiveness. Critically assess the reliability of information. Be straightforward and honest when raising concerns and asking questions about inconsistent information. Seek additional evidence to make a judgment about information and statements that might be incomplete, inconsistent, false, or misleading.	Internal auditors demonstrate professional scepticism and this is evidenced within working papers and through the supervisory and review processes.	Appropriate training and support will be identified.	CIA	31 March 2026	

	Requirement in Standard	Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
Standard 5.1 Use of information						
	Internal auditors must follow the relevant policies, procedures, laws, and regulations when using information. The information must not be used for personal gain or in a manner contrary or detrimental to the organisation's legitimate and ethical objectives.	All staff are required to abide by NHS Fife/NHS Lanarkshire Information Governance policies including confidentiality of information, which is also set out in the Internal Audit Charter. Ongoing awareness/training - All staff complete Turas Information Governance training. Completion is monitored by the CIA for FTF staff and for NHSL staff by the Director of Finance and Head of Internal Audit.	None			No further action
Standard 5.2 Protection of information						
	Internal auditors must be aware of their responsibilities for protecting information and demonstrate respect for the confidentiality, privacy, and ownership of information acquired when performing internal audit services or as the result of professional relationships.	As Standard 5.1	None			No further action

Requirement in Standard		Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
	Internal auditors must understand and abide by the laws, regulations, policies, and procedures related to confidentiality, information privacy, and information security that apply to the organisation and internal audit function. Considerations specifically relevant to the internal audit function include: Custody, retention, and disposal of engagement records. Release of engagement records to internal and external parties. Handling of, access to, or copies of confidential information when it is no longer needed. Internal auditors must not disclose confidential information to unauthorised parties unless there is a legal or professional responsibility to do so. Internal auditors must manage the risk of exposing or disclosing information inadvertently. The chief audit executive must ensure that the internal audit function and individuals assisting the internal audit function adhere					

Requirement in Standard		Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
	to the same protection requirements.					
Standard 6.1 Internal Audit Mandate						
8	The chief audit executive must provide the board and senior management with the information necessary to establish the internal audit mandate. In those jurisdictions and industries where the internal audit function's mandate is prescribed wholly or partially in laws or regulations, the internal audit charter must include the legal requirements of the mandate. (See also Standard 6.2 Internal Audit Charter and "Applying the Global Internal Audit Standards in the Public Sector.") To help the board and senior management determine the scope and types of internal audit services, the chief audit executive must coordinate with other internal and external assurance providers to gain an understanding of each other's roles and responsibilities. (See	The Audit Charter, which is incorporated in the Internal Audit Framework, does not currently include an Internal Audit mandate.	An Internal Audit mandate will be developed and incorporated into the Internal Audit Charter and Framework. The Internal Audit Framework, including the mandate will be presented to the Audit and Risk Committee for annual approval.	CIA	30 June 2025	In progress - Internal Audit Framework updated for presentation to Audit and Risk Committees in May / June 2025.

Requirement in Standard		Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
	also Standard 9.5 Coordination and Reliance.) The chief audit executive must document or reference the mandate in the internal audit charter, which is approved by the board. (See also Standard 6.2 Internal Audit Charter.) Periodically, the chief audit executive must assess whether changes in circumstances justify a discussion with the board and senior management about the internal audit mandate. If so, the chief audit executive must discuss the internal audit mandate with the board and senior management to assess whether the authority, role, and responsibilities continue to enable the internal audit function to achieve its strategy and accomplish its objectives.					
Standard 6.2 Internal Audit Charter						
9	The chief audit executive must develop and maintain an internal audit charter that specifies, at a minimum, the internal audit function's:	***EQA recommendation*** - Where internal auditors provide a fraud liaison role for a client, ensure that this is set out in the internal	The Charter will be updated to set out the Fraud Liaison role, including how any conflict would be managed.	CIA	30 June 2025	In progress - Internal Audit Framework updated for presentation to Audit and Risk

Requirement in Standard		Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
	Purpose of Internal Auditing. Commitment to adhering to the Global Internal Audit Standards. Mandate, including scope and types of services to be provided, and the board's responsibilities and expectations regarding management's support of the internal audit function. (See also Standard 6.1 Internal Audit Mandate.) Organisational position and reporting relationships. (See also Standard 7.1 Organisational Independence.) The chief audit executive must discuss the proposed charter with the board and senior management to confirm that it accurately reflects their understanding and expectations of the internal audit function.	audit charter including how any conflict is managed. ***Recommendation to:*** *FTF and NHS Lanarkshire*	The Internal Audit Framework will be presented to the Audit and Risk Committee for annual approval.			Committees in May / June 2025.
10		***EQA recommendation*** - Include an overview of the nature of advisory work undertaken within the Internal Audit Charter for each client. This should include activities such as attending governance forums as well as advisory assignments. ***Recommendation to:*** *FTF and NHS Lanarkshire*	An overview of the nature of independent advisory work undertaken will be included within the Internal Audit Charter for each client. This will include activities such as attending governance forums as well as advisory assignments. The Internal Audit Framework will be presented to the Audit and Risk Committee for annual approval.	CIA	30 June 2025	In progress - Internal Audit Framework updated for presentation to Audit and Risk Committees in May / June 2025.
11		***EQA recommendation*** - Ensure there is a regular review of the internal audit charter, and that the updated charter is signed by the chief executive and audit committee chair as well as by internal audit.	The NHS Lanarkshire internal audit charter will be updated and reviewed annually, for sign off by the Chief Executive, Director of Finance, Audit and Risk Committee chair and CIA. The Charter will be presented to the Audit and	CIA	30 June 2025	

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		Recommendation to: *NHS Lanarkshire*	Risk Committee annually, for approval.			
Standard 6.3 Board and Senior Management Support						
12	The chief audit executive must provide the board and senior management with the information needed to support and promote recognition of the internal audit function throughout the organisation. The CIA must coordinate the internal audit function's board communications with senior management to support the board's ability to fulfil its requirements.	While the Audit and Risk Committee and senior management currently support the internal audit function, the Audit and Risk Committee must champion the internal audit function to enable it to fulfil the Purpose of Internal Auditing and pursue its strategy and objectives. Senior Management must support recognition of the internal audit function throughout the organisation. The CIA must support the Board's ability to fulfil its requirements.	Arrangements are already in place e.g. private meetings with Audit and Risk Committee. Audit and Risk Committee approval of the internal audit plan, and resource plan, Partnership Board approval of budget. The Audit and Risk Committee annual report should provide assurance on this area.	CIA / Chair of ARC	30 June 2025	
Standard 7.1 Organisational Independence						
13	The chief audit executive must confirm to the board the organisational independence of the internal audit function at least annually. This includes	Organisational positioning of the internal audit function is described within the Internal Audit Charter.	The Audit Charter will be updated to reflect arrangements to advise the Audit and Risk Committee and senior management of	CIA	30 June 2025	In progress - Internal Audit Framework updated for presentation to

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communicating incidents where independence may have been impaired and the actions or safeguards employed to address the impairment. The chief audit executive must document in the internal audit charter the reporting relationships and organisational positioning of the internal audit function, as determined by the board. (See also Standard 6.2 Internal Audit Charter.) The chief audit executive must discuss with the board and senior management any current or proposed roles and responsibilities that have the potential to impair the internal audit function's independence, either in fact or appearance. The chief audit executive must advise the board and senior management of the types of safeguards to manage actual, potential, or perceived impairments. When the chief audit executive has one or more ongoing roles beyond internal auditing, the		the types of safeguards to manage actual, potential, or perceived impairments.			Audit and Risk Committees in May / June 2025.

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	responsibilities, nature of work, and established safeguards must be documented in the internal audit charter. If those areas of responsibility are subject to internal auditing, alternative processes to obtain assurance must be established, such as contracting with an objective, competent external assurance provider that reports independently to the board. When the chief audit executive's non-audit responsibilities are temporary, assurance for those areas must be provided by an independent third party during the temporary assignment and for the subsequent 12 months. Also, the chief audit executive must establish a plan to transition those responsibilities to management. If the governing structure does not support organisational independence, the chief audit executive must document the characteristics of the governing structure limiting independence and any safeguards that may be					

Requirement in Standard		Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
	employed to achieve this principle.					
Standard 7.2 Chief Audit Executive Qualifications						
	The chief audit executive must help the board understand the qualifications and competencies of a chief audit executive that are necessary to manage the internal audit function. The chief audit executive facilitates this understanding by providing information and examples of common and leading qualifications and competencies. The chief audit executive must maintain and enhance the qualifications and competencies necessary to fulfil the roles and responsibilities expected by the board. (See also Principle 3 Demonstrate Competency and its standards.)	The Service Specification reflects the requirement for the CIA to be a member of CCAB Institute or CMIIA with appropriate experience. Client Health Board and IJB Annual Reports all confirm compliance with PSIAS for 2024/25 and will confirm compliance with GIAS for 2025/26. The Internal Audit Framework sets out the required qualified skill-mix (minimum of 50%).	None			No further action
Standard 8.1 Board Interaction						
14	The chief audit executive must provide the board with the information needed to conduct its oversight responsibilities. This information may be specifically	***EQA recommendation*** - Progress reports should include a clear update on the internal audit plan so that stakeholders can	Internal audit progress reports presented to Audit and Risk Committees will be amended to include a clear update on the internal audit	CIA	31 October 2025	

Requirement in Standard		Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
	requested by the board or may be, in the judgment of the chief audit executive, valuable for the board to exercise its oversight responsibilities. The chief audit executive must report to the board and senior management:	understand the current position, how it varies from the agreed plan, and the expected delivery by year end. ***Recommendation to:*** *FTF and NHS Lanarkshire*	plan so that stakeholders can understand the current position, how it varies from the agreed plan, and the expected delivery by year end.			
15	The internal audit plan and budget and subsequent significant revisions to them. (See also Standards 6.3 Board and Senior Management Support and 9.4 Internal Audit Plan.)	***EQA recommendation*** - All elements of the standard require to be overly reported to Audit and Risk Committee.	All elements of this standard will be overly reported to the Audit and Risk Committee.	CIA	31 March 2026	
16	Changes potentially affecting the mandate or charter. (See also Standards 6.1 Internal Audit Mandate and 6.2 Internal Audit Charter.) Potential impairments to independence. (See also Standard 7.1 Organisational Independence.) Results of internal audit services, including conclusions, themes, assurance, advice, insights, and monitoring results. (See also Standards 11.3 Communicating Results, 14.5 Engagement Conclusions, and 15.2 Confirming	***EQA improvement suggestion:*** A consistent approach to progress reporting could be developed and rolled out, in consultation with audit committee chairs and the Consortium Partnership Board. This could include greater use of visuals to signpost key information and assist stakeholders and users of this information.	A single progress report will be developed and visuals will be incorporated.	CIA	31 March 2026	

Requirement in Standard	Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
the Implementation of Recommendations or Action Plans.) Results from the quality assurance and improvement program. (See also Standards 8.3 Quality, 8.4 External Quality Assessment, 12.1 Internal Quality Assessment, and 12.2 Performance Measurement.) There may be instances when the chief audit executive disagrees with senior management or other stakeholders on the scope, findings, or other aspects of an engagement that may affect the ability of the internal audit function to execute its responsibilities. In such cases, the chief audit executive must provide the board with the facts and circumstances to allow the board to consider whether, in its oversight role, it should intervene with senior management or other stakeholders.					
Standard 8.2 Resources					

Requirement in Standard		Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
17	The chief audit executive must evaluate whether internal audit resources are sufficient to fulfil the internal audit mandate and achieve the internal audit plan. If not, the chief audit executive must develop a strategy to obtain sufficient resources and inform the board about the impact of insufficient resources and how any resource shortfalls will be addressed.	The Audit Charter already states that "If the Chief Internal Auditor or the Audit Committee consider that the level of audit resources or the Charter in any way limit the scope of internal audit or prejudice the ability of internal audit to deliver a services consistent with the definition of internal auditing, they will advise the Accountable Officer and Board accordingly". The CIA reports resource shortfalls to Audit and Risk Committee in a timely manner.	The Internal Audit plans will include an overt comment on the adequacy of the resource, allied to direct comments on any governance areas or risks which may not be covered over the audit cycle.	CIA	30 June 2025	In progress – draft Internal Audit Plan 2025/26 updated to include overt comment on the adequacy of the resource, allied to direct comments on any governance areas or risks which may not be covered over the audit cycle. To be presented to Audit and Risk Committees in May / June 2025.
18		**EQA improvement suggestion:** We suggest that the Chief Internal Auditor discusses the following with audit committees and the Partnership Board: Recognition that it may not be practical for the Chief Internal Auditor to attend every meeting of every	CIA input to Audit and Risk Committees to be discussed with Audit and Risk Committees and Partnership Board, and deputising arrangements to be put in place.	CIA	31 March 2026	

Requirement in Standard		Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
		client audit committee, and how named individuals will deputise for certain clients and meetings.				
Standard 8.3 Quality						
19	The chief audit executive must develop, implement, and maintain a quality assurance and improvement program that covers all aspects of the internal audit function. The program includes two types of assessments: External assessments. (See also Standard 8.4 External Quality Assessment.) Internal assessments. (See also Standard 12.1 Internal Quality Assessment.) At least annually, the chief audit executive must communicate the results of the internal quality assessment to the board and senior management. The results of the external quality assessments must be reported when completed. In both cases, such communications include:	EQA outcomes are reported to Partnership Board and Audit and Risk Committee.	Internal assessments will be carried out periodically and reported to Partnership Board and Audit and Risk Committee.	CIA	31 March 2027	

Requirement in Standard		Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
	The internal audit function's conformance with the Standards and achievement of performance objectives. If applicable, compliance with laws and/or regulations relevant to internal auditing. If applicable, plans to address the internal audit function's deficiencies and opportunities for improvement.					
Standard 8.4 External Quality Assessment						
20	The chief audit executive must develop a plan for an external quality assessment and discuss the plan with the board. The external assessment must be performed at least once every five years by a qualified, independent assessor or assessment team. The requirement for an external quality assessment may also be met through a self-assessment with independent validation. When selecting the independent assessor or assessment team, the chief audit executive must ensure at least one person holds an	***EQA recommendation*** - Progress to implement actions from this EQA and the gap analysis against GIAS should be reported to client audit committees, management and the Partnership Board on a regular basis. ***Recommendation to:*** *FTF and NHS Lanarkshire*	The improvement action plan will form the basis of quality assurance and Improvement Action Planning and reporting to the respective Health Board Audit and Risk Committees, who will monitor progress. Progress will also be reporting to each meeting of the Partnership Board, for monitoring purposes.	CIA	31 August 2025 and throughout the year	In progress. Improvement Action plan developed or presentation to Audit and Risk Committees in May / June 2025.

Requirement in Standard		Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
	active Certified Internal Auditor® designation.					
Standard 9.1 Understanding Governance, Risk Management and Control Processes						
	To develop an effective internal audit strategy and plan, the chief audit executive must understand the organisation's governance, risk management, and control processes. To understand governance processes, the chief audit executive must consider how the organisation: Establishes strategic objectives and makes strategic and operational decisions. Oversees risk management and control. Promotes an ethical culture. Delivers effective performance management and accountability. Structures its management and operating functions. Communicates risk and control information throughout the organisation. Coordinates activities and communications among the board, internal and external	All elements in place.	None			No further action

Requirement in Standard		Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
	providers of assurance services, and management. To understand risk management and control processes, the chief audit executive must consider how the organisation identifies and assesses significant risks and selects appropriate control processes. This includes understanding how the organisation identifies and manages the following key risk areas: Reliability and integrity of financial and operational information. Effectiveness and efficiency of operations and programs. Safeguarding of assets. Compliance with laws and/or regulations.					
Standard 9.2 Internal Audit Strategy						
21	The chief audit executive must develop and implement a strategy for the internal audit function that supports the strategic objectives and success of the organisation and aligns with the expectations of the	***EQA recommendation*** As a matter of priority, develop a strategy for FTF and its internal audit services. This should be agreed and discussed with client management and audit committees. This would	A generic Strategy for Internal Audit will be developed with a section tailored to the needs of each client. The generic Strategy will be presented to the Partnership	CIA	31 August 2025	

Requirement in Standard		Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
	board, senior management, and other key stakeholders. An internal audit strategy is a plan of action designed to achieve a long-term or overall objective. The internal audit strategy must include a vision, strategic objectives, and supporting initiatives for the internal audit function. An internal audit strategy helps guide the internal audit function toward the fulfilment of the internal audit mandate.	also be usefully discussed with the Partnership Board. A strategy would help FTF plan its future services to its client base, including NHS Lanarkshire. It will also help shape the internal audit quality activity and improvement action plans following this EQA. ***Recommendation to:*** *FTF and NHS Lanarkshire*	Board for review and comment. The client specific section will be shared with each Health Board client's lead for internal audit (normally the Director of Finance) and Board Secretary for review and comment. Each client Strategy will be presented to the respective Health Board Audit and Risk Committee for approval.			
22	The chief audit executive must review the internal audit strategy with the board and senior management periodically.	***EQA recommendation*** Update the SLA for internal audit services to NHS Lanarkshire to ensure that there is clarity on the service to be provided, and the role of the Chief Internal Auditor as Chief Audit Executive for NHS Lanarkshire. ***Recommendation to:*** *NHS Lanarkshire*	The CIA will liaise with the NHS Lanarkshire Director of Finance to update the SLA and provide clarity on the days and service to be provided, and the role of the CAE. The SLA will be based on the standard daily rate and will include both qualified audit time, administration time and Office Manager time. The SLA will cover input to NHS Lanarkshire and the two Integrated Joint Boards.	CIA	31 May 2025	

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Standard 9.3 Methodologies						
23	The chief audit executive must establish methodologies to guide the internal audit function in a systematic and disciplined manner to implement the internal audit strategy, develop the internal audit plan, and conform with the Standards. The chief audit executive must evaluate the effectiveness of the methodologies and update them as necessary to improve the internal audit function and respond to significant changes that affect the function. The chief audit executive must provide internal auditors with training on the methodologies. (See also Principles 13 Plan Engagements Effectively, 14 Conduct Engagement Work, and 15 Communicate Engagement Results and Monitor Action Plans, and their standards.)	Documentation of quality reviews of audit work demonstrating that methodologies are followed requires improvement.	Programme of quality reviews to be managed by the CIA and periodically reported to the Audit and Risk Committee.	CIA	31 March 2026	
Standard 9.4 Internal Audit Plan						
24	The chief audit executive must create an internal audit plan that supports the achievement of the organisation's objectives.	***EQA recommendation*** Adopt a consistent, streamlined approach to annual planning for all	The number of days for each audit will be carefully considered to ensure adequate depth of coverage	CIA	31 August 2025	In progress – draft Internal Audit Plan 2025/26 updated to include all

Requirement in Standard	Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
The chief audit executive must base the internal audit plan on a documented assessment of the organisation's strategies, objectives, and risks. This assessment must be informed by input from the board and senior management as well as the chief audit executive's understanding of the organisation's governance, risk management, and control processes. The assessment must be performed at least annually. The internal audit plan must: Consider the internal audit mandate and the full range of agreed-to internal audit services. Specify internal audit services that support the evaluation and improvement of the organisation's governance, risk management, and control processes. Consider coverage of information technology governance, fraud risk, the effectiveness of the organisation's compliance and	clients, including NHS Lanarkshire. As liaison with, and a map of, other assurance providers is developed, this information will also be a useful input to the planning rationale and priorities included within audit plans (see also recommendation 9). Internal audit plan documents should set out the assurance needs identified for each client, and the rationale for including / omitting each from the internal audit plan. Plans should be clearly mapped to strategic priorities and risks. ***Recommendation to:*** *FTF and NHS Lanarkshire* Requirement to overtly identify and report the necessary human, financial, and technological	with continued focus on providing valuable, good quality audit reports. The audit universe will continue to be updated annually and new areas for inclusion and areas that are removed will be highlighted in the plan. The rationale for including / omitting audits from the plan will be overtly reported. The complex scoring mechanism will be simplified and only control and inherent risk will be scored by the internal audit Management Team. Senior officers will continue to be consulted as part of the planning process and each organisation's leadership team will review and approve the plan prior to presentation to Audit and Risk Committee for final consideration and approval.			recommended changes. To be presented to Audit and Risk Committees in May / June 2025.

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	ethics programs, and other high-risk areas. Identify the necessary human, financial, and technological resources necessary to complete the plan. Be dynamic and updated timely in response to changes in the organisation's business, risks operations, programs, systems, controls, and organisational culture. The chief audit executive must review and revise the internal audit plan as necessary and communicate timely to the board and senior management: The impact of any resource limitations on internal audit coverage. The rationale for not including an assurance engagement in a high-risk area or activity in the plan. Conflicting demands for services between major stakeholders, such as high-priority requests based on emerging risks and requests to replace planned assurance engagements with advisory engagements.	resources necessary to complete the plan.				

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	Limitations on scope or restrictions on access to information. The chief audit executive must discuss the internal audit plan, including significant interim changes, with the board and senior management. The plan and significant changes to the plan must be approved by the board.					
Standard 9.5 Co-ordination and Reliance						
25	The chief audit executive must coordinate with internal and external providers of assurance services and consider relying upon their work. Coordination of services minimises duplication of efforts, highlights gaps in coverage of key risks, and enhances the overall value added by providers. If unable to achieve an appropriate level of coordination, the chief audit executive must raise any concerns with senior management and, if necessary, the board. When the internal audit function relies on the work of other	***EQA recommendation*** Until an assurance framework or assurance map is developed, internal audit plans should provide information to the reader on areas where there are known sources of assurance, in particular in those areas which have been identified as an assurance need but are not included in the internal audit plan. ***Recommendation to:*** *FTF and NHS Lanarkshire*	To inform this, when officers are consulted during the planning process they will be asked to provide details of any known sources of assurance for areas within their remit. Internal audit will maintain a database of known sources of assurance. The database will be added to over time as assurance frameworks develop and mature.	CIA	31 August 2025	In progress. Officers asked to provide details of any known sources of assurance for areas within their remit. Database developed by Internal Audit.

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	assurance service providers, the chief audit executive must document the basis for that reliance and is still responsible for the conclusions reached by the internal audit function.					
Standard 10.1 Financial Resource Management						
	The chief audit executive must manage the internal audit function's financial resources. The chief audit executive must develop a budget that enables the successful implementation of the internal audit strategy and achievement of the plan. The budget includes the resources necessary for the function's operation, including training and acquisition of technology and tools. The chief audit executive must manage the day-to-day activities of the internal audit function effectively and efficiently, in alignment with the budget. The chief audit executive must seek budget approval from the board. The chief audit executive must communicate promptly the impact of insufficient financial	Partnership Board approve the annual budget. Risks associated with audit resource are transparently reported to the Partnership Board via routine progress reports. Known pressures include the training budget, which is limited, particularly funding for professional progression. There is a risk regarding succession planning.	None			No further action

Requirement in Standard		Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
	resources to the board and senior management.					
Standard 10.2 Human Resources Management						
26	The chief audit executive must establish an approach to recruit, develop, and retain internal auditors who are qualified to successfully implement the internal audit strategy and achieve the internal audit plan. The chief audit executive must strive to ensure that human resources are appropriate, sufficient, and effectively deployed to achieve the approved internal audit plan. *Appropriate* refers to the mix of knowledge, skills, and abilities; *sufficient* refers to the quantity of resources; and *effective deployment* refers to assigning resources in a way that optimises the achievement of the internal audit plan. The chief audit executive must communicate with the board and senior management regarding the appropriateness and sufficiency of the internal audit function's human resources. If	There have been well known and well reported issues in recruiting and retaining qualified staff. This resulted in recruitment of experienced, unqualified staff.	Refer to Standard 3.1 – Competency Framework.			

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	the function lacks appropriate and sufficient human resources to achieve the internal audit plan, the chief audit executive must determine how to obtain the resources or communicate timely to the board and senior management the impact of the limitations. (See also Standard 8.2 Resources.) The chief audit executive must evaluate the competencies of individual internal auditors within the internal audit function and encourage professional development. The chief audit executive must collaborate with internal auditors to help them develop their individual competencies through training, supervisory feedback, and/or mentoring. (See also Standard 3.1 Competency.)					
Standard 10.3 Technological Resources						
27	The chief audit executive must strive to ensure that the internal audit function has technology to support the internal audit process. The chief audit executive must regularly evaluate the	Refer to Standard 13.6 re. use of Teammate. The EQA identified that Excel is not used to full	Impact of technology limitations on the effectiveness or efficiency of the internal audit function will continue to be escalated	CIA	31 March 2026	

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	technology used by the internal audit function and pursue opportunities to improve effectiveness and efficiency. When implementing new technology, the chief audit executive must implement appropriate training for internal auditors in the effective use of technological resources. The chief audit executive must collaborate with the organisation's information technology and information security functions to implement technological resources properly. The chief audit executive must communicate the impact of technology limitations on the effectiveness or efficiency of the internal audit function to the board and senior management.	potential within the Internal Audit department. CIA has reported the risk to the Partnership board that current laptops are 5-6 years old and there is no budget to replace these when they become obsolete.	to the Board and senior management.			
Standard 11.1 Building Relationships and Communication with Stakeholders						
	The chief audit executive must develop an approach for the internal audit function to build relationships and trust with key stakeholders, including the board, senior management, operational management, regulators, and	Development events for Audit and Risk Committees planned during Spring 2025.	None			No further action

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	internal and external assurance providers and other consultants. The chief audit executive must promote formal and informal communication between the internal audit function and stakeholders, contributing to the mutual understanding of: Organisational interests and concerns. Approaches for identifying and managing risks and providing assurance. Roles and responsibilities of relevant parties and opportunities for collaboration. Relevant regulatory requirements. Significant organisational processes, including financial reporting.					
Standard 11.2 Effective Communication						
28	The chief audit executive must establish and implement methodologies to promote accurate, objective, clear, concise, constructive, complete, and timely internal audit communications.					
29		Internal audit annual opinions should be amended to ensure that a clear conclusion is provided on internal control, risk	Internal audit annual reports will conclude on internal control, risk management, and governance.	CIA	30 June 2025	In progress. Requirement for conclusion on internal control, risk management, and governance

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		management, and governance. ***Recommendation to:*** *FTF and NHS Lanarkshire*				incorporated into annual report 2025/26 assignment plans and will be included in annual reports.
Standard 11.3 Communicating Results						
30	The chief audit executive must communicate the results of internal audit services to the board and senior management periodically and for each engagement as appropriate. The chief audit executive must understand the expectations of the board and senior management regarding the nature and timing of communications. The results of internal audit services can include: Engagement conclusions. Themes such as effective practices or root causes. Conclusions at the level of the business unit or organisation.	Refer to Standard 11.2 Effective Communication. Different forms of communication need to be explored e.g. PowerPoint presentations, use of visuals, shorter and sharper reports.	CIA to explore different forms of communication and review current reporting template. Root causes to be incorporated into reporting.	CIA	31 March 2026	
Standard 11.4 Errors and Omissions						
	If a final engagement communication contains a	Where an error or omission occurs, an amended report	None			No further action

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	significant error or omission, the chief audit executive must communicate corrected information promptly to all parties who received the original communication. Significance is determined according to criteria agreed upon with the board.	will be issued promptly to reflect the corrected information.				
Standard 11.5 Communicating the Acceptance of Risk						
	The chief audit executive must communicate unacceptable levels of risk. When the chief audit executive concludes that management has accepted a level of risk that exceeds the organisation's risk appetite or risk tolerance, the matter must be discussed with senior management. If the chief audit executive determines that the matter has not been resolved by senior management, the matter must be escalated to the board. It is not the responsibility of the chief audit executive to resolve the risk.	The CIA communicates the acceptance of risk either through individual reports, Annual Report, or annual Risk Management review.	None			No further action
Standard 12.1 Internal Quality Assessment						
31	The chief audit executive must develop and conduct internal	***EQA recommendation*** Undertake a gap analysis	Agreed. A gap analysis against the GIAS and UK	CIA	30 June 2025	In progress – presented to May /

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	assessments of the internal audit function's conformance with the Global Internal Audit Standards and progress toward performance objectives. The chief audit executive must establish a methodology for internal assessments, as described in Standard 8.3 Quality, that includes: Ongoing monitoring of the internal audit function's conformance with the Standards and progress toward performance objectives. Periodic self-assessments or assessments by other persons within the organisation with sufficient knowledge of internal audit practices to evaluate conformance with the Standards. Communication with the board and senior management about the results of internal assessments. Based on the results of periodic self-assessments, the chief audit executive must develop action plans to address instances of nonconformance with the	against the GIAS and UK Public Sector Application Note and use this as the basis of quality assurance and Improvement Action Planning and reporting. ***Recommendation to:*** *FTF and NHS Lanarkshire*	Public Sector Application Note will be completed by the CIA and incorporated into an improvement action plan, which will also include actions to address the EQA recommendations. This improvement action plan will form the basis of quality assurance and Improvement Action Planning and reporting to the respective Health Board Audit and Risk Committees, who will monitor progress.			June Audit and Risk Committees for approval.
32		***EQA recommendation*** Ensure that the self-assessment against GIAS is updated on an annual basis. ***Recommendation to:*** *FTF and NHS Lanarkshire*	The self-assessment against GIAS and the overarching improvement action plan will be robustly monitored during the year and updated annually.	CIA	31 May 2026	In progress. Monitoring by audit and Risk Committees agreed.

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	Standards and opportunities for improvement, including a proposed timeline for actions. The chief audit executive must communicate the results of periodic self-assessments and action plans to the board and senior management. (See also Standards 8.1 Board Interaction, 8.3 Quality, and 9.3 Methodologies.) Internal assessments must be documented and included in the evaluation conducted by an independent third party as part of the organisation's external quality assessment. (See also Standard 8.4 External Quality Assessment.) If nonconformance with the Standards affects the overall scope or operation of the internal audit function, the chief audit executive must disclose to the board and senior management the nonconformance and its impact.					
Standard 12.2 Performance Measurement						
33	The chief audit executive must develop objectives to evaluate	The FTF Partnership Board reviewed updated KPIs for	KPIs to be reviewed again in 2025/26 to ensure	CIA	31 March 2026	

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	the internal audit function's performance. The chief audit executive must consider the input and expectations of the board and senior management when developing the performance objectives. The chief audit executive must develop a performance measurement methodology to assess progress toward achieving the function's objectives and to promote the continuous improvement of the internal audit function. When assessing the internal audit function's performance, the chief audit executive must solicit feedback from the board and senior management as appropriate. The chief audit executive must develop an action plan to address issues and opportunities for improvement.	use during 2024/25. These include more qualitative measures. These are reported to quarterly Partnership Board meetings and reported in the internal audit Annual Reports. Quality questionnaire revised and updated for 2025/26. Improvement Action Plan to be monitored by Audit & Risk Committees.	qualitative measures are fully included.			
Standard 12.3 Oversee and Improve Engagement Performance						
34	The chief audit executive must establish and implement methodologies for engagement supervision, quality assurance,	***EQA recommendation*** A mechanism for demonstrating work programmes approval	The mechanism for demonstrating work programmes approval will be	CIA	30 September 2025	

Requirement in Standard		Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
	and the development of competencies. The chief audit executive or an engagement supervisor must provide internal auditors with guidance throughout the engagement, verify work programs are complete, and confirm engagement workpapers adequately support findings, conclusions, and recommendations. To assure quality, the chief audit executive must verify whether engagements are performed in conformance with the Standards and the internal audit function's methodologies. To develop competencies, the chief audit executive must provide internal auditors with feedback about their performance and opportunities for improvement. The extent of supervision required depends on the maturity of the internal audit function, the proficiency and experience of internal auditors, and the complexity of engagements.	should be designed and documented within the audit manual covering the FTF and NHS Lanarkshire to ensure consistency. ***Recommendation to:*** *FTF and NHS Lanarkshire*	documented within the audit manual.			
35		***EQA recommendation*** Evidence of the review and approval of each internal audit engagement from scope, through to work programme, testing and reports, should be retained on file for all engagements. ***Recommendation to:*** *FTF and NHS Lanarkshire*	While this happens in practice, evidence of the review and approval of each internal audit engagement from scope, through to work programme, testing and reports, will be retained on file for all audits.	CIA	31 December 2025	

Requirement in Standard		Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
	The chief audit executive is responsible for supervising engagements, whether the engagement work is performed by the internal audit staff or by other service providers. Supervisory responsibilities may be delegated to appropriate and qualified individuals, but the chief audit executive retains ultimate responsibility. The chief audit executive must ensure that evidence of supervision is documented and retained, according to the internal audit function's established methodologies.					
Standard 13.1 Engagement Communication						
	Internal auditors must communicate effectively throughout the engagement. (See also Principle 11 Communicate Effectively and its related standards and Standard 15.1 Final Engagement Communication.) Internal auditors must communicate the objectives, scope, and timing of the engagement with management. Subsequent changes must be	In place though flowcharts and Audit Practice Notes (APN)s. Final engagement communication agreed via exit meeting.	None			No further action

Requirement in Standard	Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
communicated with management timely. (See also Standard 13.3 Engagement Objectives and Scope.) At the end of an engagement, if internal auditors and management do not agree on the engagement results, internal auditors must discuss and try to reach a mutual understanding of the issue with the management of the activity under review. If a mutual understanding cannot be reached, internal auditors must not be obligated to change any portion of the engagement results unless there is a valid reason to do so. Internal auditors must follow an established methodology to allow both parties to express their positions regarding the content of the final engagement communication and the reasons for any differences of opinion regarding the engagement results. (See also Standards 9.3 Methodologies and 14.4 Recommendations and Action Plans.)					
Standard 13.2 Engagement risk Assessment					

Requirement in Standard		Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
36	Internal auditors must develop an understanding of the activity under review to assess the relevant risks. For advisory services, a formal, documented risk assessment may not be necessary, depending on the agreement with relevant stakeholders. To develop an adequate understanding, internal auditors must identify and gather reliable, relevant, and sufficient information regarding: The organisation's strategies, objectives, and risks relevant to the activity under review. The organisation's risk tolerance, if established. The risk assessment supporting the internal audit plan. The governance, risk management, and control processes of the activity under review. Applicable frameworks, guidance, and other criteria that can be used to evaluate the effectiveness of those processes.	Audit universe and documented risk assessment and planning methodology in place (updated for 2025/26). Each Client is subject to a risk maturity assessment, either through a standalone audit or through our ICE and Annual Report work, which is considered in audit planning. None are fully risk mature in our judgement and therefore we take their Risk Register into account in both the scoring of risks and in assessing the final plan, but do not solely rely on the Client Risk Register. These are specifically taken into account in consideration of inherent and control risk and in the 'A1 Risk analysis'. All plans are agreed with the Director of Finance and presented to the senior management team of the Board as a matter of good	None			No further action

Requirement in Standard		Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
	Internal auditors must review the gathered information to understand how processes are intended to operate. Internal auditors must identify the risks to review by: Identifying the potentially significant risks to the objectives of the activity under review. Considering specific risks related to fraud. Evaluating the significance of the risks and prioritising them for review. Internal auditors must identify the criteria that management uses to measure whether the activity is achieving its objectives. When internal auditors have identified the relevant risks for an activity under review in past engagements, only a review and update of the previous engagement risk assessment is required.	practice, demonstrating extensive consultation.				
Standard 13.3 Engagement Objectives and Scope						
	Internal auditors must establish and document the objectives and scope for each engagement.	All elements included in the engagement assignment plan.	None			No further action

Requirement in Standard		Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
	The engagement objectives must articulate the purpose of the engagement and describe the specific goals to be achieved, including those mandated by laws and/or regulations. The scope must establish the engagement's focus and boundaries by specifying the activities, locations, processes, systems, components, time period to be covered in the engagement, and other elements to be reviewed, and be sufficient to achieve the engagement objectives. Internal auditors must consider whether the engagement is intended to provide assurance or advisory services because stakeholder expectations and the requirements of the Standards differ depending on the type of engagement. Scope limitations must be discussed with management when identified, with a goal of achieving resolution. Scope limitations are assurance engagement conditions, such as					

Requirement in Standard		Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
	resource constraints or restrictions on access to personnel, facilities, data, and information, that prevent internal auditors from performing the work as expected in the audit work program. (See also Standard 13.5 Engagement Resources.) If a resolution cannot be achieved with management, the chief audit executive must elevate the scope limitation issue to the board according to an established methodology. Internal auditors must have the flexibility to make changes to the engagement objectives and scope when audit work identifies the need to do so as the engagement progresses. The chief audit executive must approve the engagement objectives and scope and any changes that occur during the engagement.					
Standard 13.4 Evaluation Criteria						
	Internal auditors must identify the most relevant criteria to be used to evaluate the aspects of the activity under review defined	Included in A1 Risk Analysis Adequacy of criteria to determine if objectives and	None			No further action

Requirement in Standard		Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
	in the engagement objectives and scope. For advisory services, the identification of evaluation criteria may not be necessary, depending on the agreement with relevant stakeholders. Internal auditors must assess the extent to which the board and senior management have established adequate criteria to determine whether the activity under review has accomplished its objectives and goals. If such criteria are adequate, internal auditors must use them for the evaluation. If the criteria are inadequate, internal auditors must identify appropriate criteria through discussion with the board and/or senior management.	goals have been accomplished is covered in ICE and Annual Report and in audits of Strategy and Performance Management and reporting.				
Standard 13.5 Engagement Resources						
37	When planning an engagement, internal auditors must identify the types and quantity of resources necessary to achieve the engagement objectives. Internal auditors must consider: The nature and complexity of the engagement.	Required resources are considered as part of planning and recorded on the assignment plan. The CIA discusses with senior management and the ARC the implications of	The CIA will overtly report resource pressures that may impact on achievement of engagement objectives.	CIA	31 March 2026 and ongoing.	

Requirement in Standard		Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
	The time frame within which the engagement is to be completed. Whether the available financial, human, and technological resources are appropriate and sufficient to achieve the engagement objectives. If the available resources are inappropriate or insufficient, internal auditors must discuss the concerns with the chief audit executive to obtain the resources.	resource limitations and determining the course of action to take. For example, the engagement scope may need to be reduced. The annual plans have previously been flexed and risk assessed to reflect resource pressures due to delays in recruitment or sickness absence, with audits risk assessed to the following year.				
Standard 13.6 Work Program						
38	Internal auditors must develop and document an engagement work program to achieve the engagement objectives. The engagement work program must be based on the information obtained during engagement planning, including, when applicable, the results of the engagement risk assessment. The engagement work program must identify: Criteria to be used to evaluate each objective.	***EQA recommendation*** Streamline internal audit guidance into one operating procedure or manual, drawing on the current ways of working from both teams. The manual should be mapped to GIAS and the UK Public Sector Application Note to ensure that it addresses all requirements of both documents.	The CIA will lead this work and will review the guidance used by FTF and by the NHS Lanarkshire internal audit team to identify the most appropriate guidance as the basis for each section. Materials available from the IIA will also be reviewed to ensure best practice is reflected in the guidance documentation ensuring compliance with GIAS and	CIA	31 March 2026	

Requirement in Standard		Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
	Tasks to achieve the engagement objectives. Methodologies, including the analytical procedures to be used, and tools to perform the tasks. Internal auditors assigned to perform each task. The chief audit executive must review and approve the engagement work program before it is implemented and promptly when any subsequent changes are made.	***Recommendation to:*** *FTF and NHS Lanarkshire*	the UK Public Sector Application Note. Guidance may need to be tailored to FTF and NHS Lanarkshire audit management models and way of working. Staff will be provided with training on use of the guidance.			
39		***EQA recommendation*** The Chief Internal Auditor should investigate the practicalities of arranging licenses for all internal audit team members to use TeamMate, thereby adopting one audit management system and one way of working. ***Recommendation to:*** *FTF*	The Chief Internal Auditor will investigate the practicalities of arranging licenses for all internal audit team members to use TeamMate. The CIA will review the functionality of Teammate and complete a benefits realisation. The financial implications and benefits realisation will be presented to the Partnership Board for decision regarding implementation of TeamMate across FTF.	CIA	31 March 2026	
40		**EQA improvement suggestion:** To support a consistent way of working,				

Requirement in Standard		Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
		we suggest that the possibility of the FTF team being provided licenses for TeamMate is explored.				
Standard 14.1 Gathering information for Analyses and Evaluation						
	Sufficient – when it enables internal auditors to perform analyses and complete evaluations and can enable a prudent, informed, and competent person to repeat the engagement work program and reach the same conclusions as the internal auditor. Internal auditors must evaluate whether the information is relevant and reliable and whether it is sufficient such that analyses provide a reasonable basis upon which to formulate potential engagement findings and conclusions. (See also Standard 14.2 Analyses and Potential Engagement Findings.) Internal auditors must determine whether to gather additional information for analyses and evaluation when evidence is not relevant, reliable, or sufficient to	Documented in Risk Analysis documentation and in test schedules.	None			No further action

Requirement in Standard		Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
	support engagement findings. If relevant evidence cannot be obtained, internal auditors must determine whether to identify that as a finding.					
Standard 14.2 Analyses and potential Engagement findings						
	Internal auditors must analyse relevant, reliable, and sufficient information to develop potential engagement findings. For	Analysis completed during planning and audit fieldwork (risk analysis and RACEs).	None			No further action
41	advisory services, gathering evidence to develop findings may not be necessary, depending on the agreement with relevant stakeholders. Internal auditors must analyse information to determine whether there is a difference between the evaluation criteria and the existing state of the activity under review, known as the "condition." (See also Standard 13.4 Evaluation Criteria.) Internal auditors must determine the condition by using information and evidence gathered during the engagement. A difference between the criteria and the condition indicates a	**EQA improvement suggestion:** In preparation for GIAS adoption, current NHS Scotland tools/systems should be considered to determine if they could support a development in data analysis across the team. Excel also provides many functions which can support analyses. Once agreed, the relevant internal audit manual(s) should be updated to provide guidance to internal auditors on the use of analytics, and the safeguards over the storage and use of data.	Excel training has been identified and staff have been asked to prioritise completion of this. The CIA and Regional Audit Managers will promote use of excel and other systems for analytical review. The audit manual will be updated accordingly.	CIA and Regional Audit Managers (RAMs)	31 March 2026	

Requirement in Standard		Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
	potential engagement finding that must be noted and further evaluated. If initial analyses do not provide sufficient evidence to support a potential engagement finding, internal auditors must exercise due professional care to determine whether additional analyses are required. If additional analyses are required, the work program must be adjusted accordingly and approved by the chief audit executive. If internal auditors determine that no additional analyses are required and there is no difference between the criteria and the condition, the internal auditors must provide assurance in the engagement conclusion regarding the effectiveness of the activity's governance, risk management, and control processes.					
Standard 14.3 Evaluation of Findings						
42	Internal auditors must evaluate each potential engagement finding to determine its significance. When evaluating	Methodology to risk assess findings is in place and professional judgement is applied.	CIA and RAMs to progress methodology to identify and overtly report the root causes of findings. Risks and	CIA / RAMs	31 March 2026	

Requirement in Standard		Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
	potential engagement findings, internal auditors must collaborate with management to identify the root causes when possible, determine the potential effects, and evaluate the significance of the issue. To determine the significance of the risk, internal auditors must consider the likelihood of the risk occurring and the impact the risk may have on the organisation's governance, risk management, or control processes. If internal auditors determine that the organisation is exposed to a significant risk, it must be documented and communicated as a finding. Internal auditors must determine whether to report other risks as findings, based on the circumstances and established methodologies. Internal auditors must prioritise each engagement finding based on its significance, using methodologies established by the chief audit executive.	Work to identify the root causes of findings to be progressed and to be overtly reported. **EQA improvement suggestion:** As part of the update of internal audit engagement reports, include information on root causes, and also the risks and implications of the findings being raised by internal audit.	implications of findings will continue to be progressed.			
43		**EQA improvement suggestion:** As part of the update of internal audit engagement reports, include information on root causes, and also the risks and implications of the findings being raised by internal audit.				
Standard 14.4 Recommendations and Action Plan						

Requirement in Standard		Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
44	Internal auditors must determine whether to develop recommendations, request action plans from management, or collaborate with management to agree on actions to: Resolve the differences between the established criteria and the existing condition. Mitigate identified risks to an acceptable level. Address the root cause of the finding. Enhance or improve the activity under review. When developing recommendations, internal auditors must discuss the recommendations with the management of the activity under review. If internal auditors and management disagree about the engagement recommendations and/ or action plans, internal auditors must follow an established methodology to allow both parties to express their positions and rationale and to	***EQA recommendation*** A formal exit meeting or discussion regarding internal audit findings and the actions required to address these should be mandated as part of the internal audit approach. ***Recommendation to:*** *NHS Lanarkshire*	The requirement to offer the client a formal exit meeting will be mandated and emphasised in the revised guidance gap analysis(refer to action point 3). It will also be incorporated into the performance review process for each audit). While this practice is undertaken, evidence of the exit / audit findings clearance process will be retained within the audit file.	CIA		
45		**EQA improvement suggestion:** Many internal audit functions have moved away from making recommendations. Instead actions are agreed with management. This helps reinforce the accountability of management to act, and also can help ensure that when internal audit monitor implementation, that there is a clear statement of actions that have been agreed. Adopting such an approach	The move away from recommendations is welcomed and has been trialled for an IJB client ICE report. If successful and if client feedback is favourable, this approach will be rolled out for all internal audit reports.	CIA and RAMS	31 March 2026	In progress on a trail basis.

Requirement in Standard		Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
	determine a resolution. (See also Standard 9.3 Methodologies.)	would need exit meetings to be conducted to ensure dialogue between internal audit and management regarding appropriate action.				
Standard 14.5 Engagement Conclusions						
	Internal auditors must develop an engagement conclusion that summarises the engagement results relative to the engagement objectives and management's objectives. The engagement conclusion must summarise the internal auditors' professional judgment about the overall significance of the aggregated engagement findings. Assurance engagement conclusions must include the internal auditors' judgment regarding the effectiveness of the governance, risk management, and/or control processes of the activity under review, including an acknowledgment of when processes are effective.	Requirement conclusion requirements are within the current report template. As a quality check, the CIA reviews all Limited Assurance opinion reports, Internal Control Evaluation reports, and Annual Reports.	None			No further action
Standard 14.6 Engagement documentation						
	Internal auditors must document information and evidence to	Information and documentation to support	None			No further action

Requirement in Standard		Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
	support the engagement results. The analyses, evaluations, and supporting information relevant to an engagement must be documented such that an informed, prudent internal auditor, or similarly informed and competent person, could repeat the work and derive the same engagement results. Internal auditors and the engagement supervisor must review the engagement documentation for accuracy, relevance, and completeness. The chief audit executive must review and approve the engagement documentation. Internal auditors must retain engagement documentation according to relevant laws and/or regulations as well as policies and procedures of the internal audit function and the organisation.	the engagement results are recorded in the audit working papers. All working papers are subject to a review process.				
Standard 15.1 Final Engagement Communication						
46	For each engagement, internal auditors must develop a final communication that includes the engagement's objectives, scope,	**EQA improvement suggestion:** Ensuring a more streamlined and efficient internal audit	Progress review of report template and develop shorter and more concise style of report.	CIA	31 March 2026	

Requirement in Standard		Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
47	recommendations and/or action plans if applicable, and conclusions. The final communication for assurance engagements also must include: The findings and their significance and prioritisation. An explanation of scope limitations, if any. A conclusion regarding the effectiveness of the governance, risk management, and control processes of the activity reviewed. The final communication must specify the individuals responsible for addressing the findings and the planned date by which the actions should be completed. When internal auditors become aware that management has initiated or completed actions to address a finding before the final communication, the actions must be acknowledged in the communication. The final communication must be accurate, objective, clear,	approach may assist the efficiency and delivery of timely internal audit reports, as would the Chief Internal Auditor's plans to introduce a shorter and more concise report template. See section regarding other suggestions relating to internal audit reporting.	CIA and RAM focus on KPI for timely issue of draft reports. Barriers to issue of timely reports to be identified.	CIA	31 March 2026	
48		**EQA improvement suggestion:** We support the Chief Internal Auditor's view that the ICE should be streamlined. Given the scale and frequency of such work, coverage could be planned on a risk-based cycle rather than full coverage every year. Internal auditors could work with other colleagues across clients to provide training and support to a self-assessment approach to the ICE, with internal auditors providing some independent challenge and verification of	CIA and Management Team to review approach to ICE report and consult with stakeholders. Risk based cycle to be introduced.	CIA / RAMS	31 January 2027	
49			Clients to be consulted with the aim of introducing a self-assessment approach with internal audit validation.	CIA / RAMs	31 January 2027	

Requirement in Standard	Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
concise, constructive, complete, and timely, as described in Standard 11.2 Effective Communication. Internal auditors must ensure the final communication is reviewed and approved by the chief audit executive before it is issued. The chief audit executive must disseminate the final communication to parties who can ensure that the results are given due consideration. (See also Standard 11.3 Communicating Results.) If the engagement is not conducted in conformance with the Standards, the final engagement communication must disclose the following details about the nonconformance: Standard(s) with which conformance was not achieved. Reason(s) for nonconformance. Impact of nonconformance on the engagement findings and conclusions.	management's conclusions.				
Standard 15.2 Confirming the Implementation of Recommendations or Action Plans					

Requirement in Standard		Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
50	Internal auditors must confirm that management has implemented internal auditors' recommendations or management's action plans following an established methodology, which includes: • Inquiring about progress on the implementation. • Performing follow-up assessments using a risk-based approach. • Updating the status of management's actions in a tracking system. The extent of these procedures must consider the significance of the finding. If management has not progressed in implementing the actions according to the established completion dates, internal auditors must obtain and document an explanation from management and discuss the issue with the chief audit executive. The chief audit executive is responsible for determining whether senior	***EQA recommendation*** Review and refresh the approach to action tracking and follow up testing as part of the refresh of the internal audit methodology and update the manual and provide training accordingly. ***Recommendation to:*** *FTF*	The CIA will review the audit follow up processes across FTF, taking cognisance of the Blueprint for Good Governance 2022, to identify efficiencies and to understand which parts of the system take the most time, also taking into account GIAS requirements in this area. Any identified efficiencies and GIAS requirements will feature in discussion with the Partnership Board and Audit and Risk Committees with a view to refreshing and streamlining the AFU process, ensuring the time spent on follow up is risk based and considers the significance of finding. This should result in fewer days needing to be allocated to Audit Follow Up.	CIA	30 June 2025 and monitoring thereafter	In progress. Actions to improve efficiency agreed by FTF on 22 April 2024. To be discussed and agreed with client and reflected in Audit Follow up protocols.

Requirement in Standard		Gaps / EQA recommendation	Required Action	Responsible Officer	Timescale	Update & RAG status 30 April 2025
	management, by delay or inaction, has accepted a risk that exceeds the risk tolerance. (See also Standard 11.5 Communicating the Acceptance of Risks.)					

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**15 May 2025**
Title:	**Internal Audit Annual Plan 2025/26**
Responsible Executive:	**Jocelyn Lyall, Chief Internal Auditor**
Report Author:	**Jocelyn Lyall, Chief Internal Auditor**

Executive Summary:

Standard 9.4 Internal Audit Plan of the Global Internal Audit Standards (GIAS), applicable from 1 April 2025, sets out the requirement for the Chief Internal Auditor (CIA) to create an internal audit plan that supports achievement of the organisation's objectives.

GIAS requires an organisation wide risk assessment to be completed at least annually as the basis for the plan. The internal audit function must independently review and validate the key risks identified from the organisation's risk management system. This should be supported by recently completed internal audit assignments and discussions with members of the Board and senior management.

The Application Note: GIAS in the UK Public Sector states that the requirement for an overall conclusion must also inform planning carried out under GIAS and that it must be clear to senior management and the board that the planning process supports the overall annual conclusion.

Internal Audit has produced a revised and updated audit universe for 2025/26 (Appendix 1). Each area has been risk assessed by Internal Audit and the audit universe has been mapped to the organisation's strategic objectives, strategic risks, Reform, Transform and Perform (RTP) priorities, and the RTP Organisational Portfolio of change. A rationale for inclusion or exclusion of each area is also provided. Potential other sources of internal and external assurance for each governance strand have been included.

The CIA wrote to Executive Leadership Team (ELT) members and attended the ELT meeting on 17 April 2025 to obtain input from senior management on areas for inclusion in the 2025/26 internal audit plan, to complement Internal Audit's understanding of the organisation's governance, risk management and control processes and to help develop our understanding of the other providers of assurance and advisory services from within and external to the Board, which Internal Audit and the Audit and Risk Committee may wish to rely upon as a source of additional or speciality competencies not available within the internal audit function.

The objective of audit planning is to direct audit resources in the most efficient manner to provide sufficient assurance that key risks are being managed effectively and to support the overall conclusion.

The purpose of this paper is for the Audit and Risk Committee (ARC) to consider and approve the draft Strategic Plan 2024/25 – 2026/27 and draft Operational Internal Audit Plan 2025/26, as required by the ARC Terms of Reference and workplan.

1 Purpose

This report is presented for:

- Assurance
- Discussion
- Decision

This report relates to:

- Legal requirement

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Strategic Internal Audit Plan 2024/25 – 2026/27 was approved by the Audit and Risk Committee on 12 September 2024. The annual 2025/26 plan has been reviewed and revised to reflect current requirements, requests from Management and emerging risks. Each area has been risk assessed by Internal Audit and the audit universe has been mapped to the organisation's strategic objectives, strategic risks, Reform, Transform and Perform (RTP) priorities, and the RTP Organisational Portfolio of Change. A rationale for inclusion or exclusion of each area is provided and potential other sources of internal and external assurance for each governance strand have been included.

2.2 Background

GIAS Standard 9.4 Internal Audit Plan states that 'the Chief Audit Executive must base the internal audit plan on a documented assessment of the organisation's strategies, objectives and risks. This assessment must be informed by input from the board and senior management, as well as the chief audit executive's understanding of the organisation's governance, risk management and control processes'.

The internal audit plan must:

- *Consider the internal audit mandate and the full range of agreed to internal audit services*
- *Specify internal audit services that support the evaluation and improvement of the organisation's governance, risk management and control processes*
- *Consider coverage of information technology governance, fraud risk, the effectiveness of the organisation's compliance and ethics programmes, and other high risk areas*
- *Identify the necessary human, financial and technological resources necessary to complete the plan*
- *Be dynamic and updated timely in response to changes in the organisation's business, risks, operations, programmes, systems, controls and organisational culture.*

The Chief Audit Executive must review and revise the internal audit plan as necessary and communicate timely to the board and senior management:

- *The impact of any resource limitations no internal audit coverage*
- *The rationale for not including an assurance engagement in a high risk area or activity in the plan*
- *Conflicting demands for services between major stakeholders, such as high priority requests based on emerging risks and requests to replace planned assurance engagements with advisory engagements*
- *Limitations on scope or restrictions on access to information.*

The Chief Audit Executive must discuss the internal audit plan, including significant interim changes, with the board and senior management. The plan and significant changes to the plan must be approved by the board.

The Draft Strategic and Operational Plans have been developed in accordance with GIAS, to enable the Chief Internal Auditor to meet the following key objectives:

- The need to establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organisation's goals.
- Provision to the Accountable Officer of an overall independent and objective annual opinion on the organisation's governance, risk management, and control, which will in turn support the preparation of the Annual Governance Statement.
- Complete audits of the organisation's governance, risk management, and control arrangements which afford suitable priority to the organisation's objectives and risks.
- Drive improvement of the organisation's governance, risk management, and control arrangements by providing line management with findings arising from audit work.
- Ensure effective co-operation with external auditors and other review bodies functioning in the organisation.

The internal audit service will be delivered in accordance with the Internal Audit Framework. Our Strategic Internal Audit Plan is designed to provide NHS Fife, through the Audit and Risk Committee, with the Internal Audit assurance it needs to prepare an Annual Governance Statement that complies with best practice in corporate governance. We also support the continuous improvement of governance, risk management and internal control processes by using a systematic and disciplined evaluation approach.

The objective of audit planning is to direct audit resources in the most efficient manner to provide sufficient assurance that key risks are being managed effectively.

2.3 Assessment

There are **473** days available for 2025/26 and **342** days have provisionally been allocated to cover:

- GIAS requirements.
- The audit of Fife IJB, noting that the NHS Fife Internal Audit team will fulfil the lead auditor role for the IJB for 2025/26. This responsibility is scheduled to pass to the Fife Council Internal Audit team in 2026/27.
- Audits required by legislation, for example, Post Transaction Monitoring and the Annual Report.

- Key sources of assurance, for example the Internal Control Evaluation and Risk Management.
- Audits not completed in the 2024/25 audit plan and risk assessed for inclusion in the 2025/26 audit plan.
- An audit of Endowments.

The remaining **131** days are therefore available for allocation to specific audit engagements.

The Chartered Institute of Internal Auditors published their External Quality Assessment of FTF Internal Audit on 4 March 2025. The report recommended that internal audit plans be refocused to include fewer engagements which provide greater depth of coverage. The CIA's opinion is that a minimum of 25 days is required for each audit to provide the required depth of coverage. In addition to the requirements detailed above, the draft annual plan 2025/26 includes audits of:

- Performance Management and Reporting
- Medicines Management
- Supplementary Staffing
- Financial Sustainability
- Financial Management
- Service Contract Income or Expenditure
- Digital Strategy and Governance

Our Strategic Internal Audit Plan 2024/25 – 2026/27 is structured around an updated audit universe based on a 3-year cycle (Appendix 1). The Three-Year cycle allows Internal Audit to respond to emerging risks, changes within the organisation, its structure, and how its services are delivered, whilst also ensuring that key controls are effective.

2.3.1 Environmental and change risk

We actively consider ongoing projects, forthcoming changes and our wider knowledge of the NHS to ensure we provide an appropriate level of audit coverage across all key areas and risks. This includes consideration of the following key sources of information:

- Public Health and Wellbeing Strategy / Annual Delivery Plans / Financial Sustainability Plans
- Themes / risks emerging from our Internal Control Evaluation
- Previous internal audit reports
- External Audit reports and plans
- Board website, internal policies, and procedures
- Our NHS knowledge and experience
- Discussions with the ELT and the Audit and Risk Committee
- NHS Fife's Corporate risk profile
- Audit engagements required by laws or regulations
- Audit engagements critical to the organisation's mission or strategy
- Areas and activities with significant levels of risk
- Whether all significant risks have sufficient coverage by assurance providers
- Advisory and ad hoc requests
- The time and resources required for each potential engagement

- Each engagement's potential benefits to the organisation

2.3.2 Assurance providers

To understand governance processes, the Chief Internal Auditor must consider how the organisation coordinates activities and communications among the board, other internal and external providers of assurance services, and management.

The Chief Internal Auditor must understand the competencies of other providers of assurance and advisory services and consider relying upon those providers as a source of additional or specialty competencies, if not available within the internal audit function.

Documentation such as an assurance map can be helpful in indicating the competencies of other providers of assurance and advisory services upon which the internal audit function may rely.

The March 2025 External Quality Assessment of FTF Internal Audit recommended that *'until an assurance framework or assurance map is developed, internal audit plans should provide information to the reader on areas where there are known sources of assurance, in particular in those areas which have been identified as an assurance need but are not included in the internal audit plan'.*

Potential other sources of assurance for each strand of governance are included at Appendix 1. Internal Audit has started to develop a database of assurance providers, and the ELT has been asked to assist in providing relevant information. The Director of Planning and Transformation is leading work on the NHS Fife Assurance Information System to develop a Performance and Assurance Framework and Internal Audit will work with Management to ensure there is no duplication of work and that all aspects are documented.

2.3.3 Other stakeholders

There is congruence between Health Board internal audit plans and those of the Integrated Joint Board (IJB) Partner. The NHS Fife Internal Audit Plan currently includes days for Internal Audit of Fife IJB, with the IJB Plan agreed with the IJB Chief Officer and Chief Finance Officer and approved by the IJB Audit and Assurance Committee. The IJB Chief Officer had the opportunity to consider the Health Board Plan as a member of the ELT and there is a sharing protocol that allows for Health Board and Council Internal Audit Plans to be shared with the IJB and vice-versa.

This report provides Significant Assurance that the draft 2025/26 plan will be sufficient to allow the Chief Internal auditor to conclude on governance, risk management and internal controls at year end.

	Significant	Moderate	Limited	None
Level	X			
Descriptor	There is robust assurance that the system of control achieves, or will achieve, the purpose that it is designed to deliver. There may be an insignificant	There is sufficient assurance that controls upon which the organisation relies to manage the risk(s) are suitably designed and effectively applied. There remains a	There is some assurance from the systems of control in place to manage the risk(s), but there remains a significant amount of residual risk,	No assurance can be taken from the information that has been provided. There remains a significant amount of residual risk

	amount of residual risk or none at all.	moderate amount of residual risk.	which requires further action to be taken.	

2.3.4 Quality, Patient and Value-Based Health & Care

GIAS Standard 8.3 Quality requires that the Chief Internal Auditor develops, implements and maintains a quality assurance and improvement program that covers all aspects of the internal audit function. The program includes external and internal assessments.

When expressing conformance with standards, auditors must be clear that they are conforming to the GIAS subject to the Application Note: Global Internal Audit Standards in the UK Public Sector.

The Internal Audit Charter reflects the Chief Internal Auditor's responsibility to develop, implement, and maintain a quality assurance and improvement program that covers all aspects of the internal audit function, to be reported to Audit and Risk Committee.

2.3.5 Workforce

GIAS Standard 10.2 Human Resources Management requires the Chief Internal Auditor to strive to ensure that human resources are appropriate, sufficient, and effectively deployed to achieve the approved internal audit plan.

Due consideration is given to the appropriate staff skill mix and is provided in the service specification.

2.3.6 Financial

GIAS Standard 10.1 Financial Resource Management requires that the Chief Internal Auditor manages the internal audit function's financial resources. All financial implications are included within the FTF Budget.

2.3.7 Risk Assessment / Management

The risk 'Compliance with Internal Audit Framework' is recorded on the FTF risk register and was updated on 22 April 2025. This risk is scored as 'Moderate' with a target of 'Low'.

2.3.8 Equality and Human Rights, including children's rights, health inequalities and Anchor Institution ambitions

GIAS Standard 1.3 Legal and Ethical Behaviour states that '*Internal auditors must not engage in or be a party to any activity that is illegal or discreditable to the organisation or the profession of internal auditing or that may harm the organisation or its employees. Internal auditors must understand and abide by the laws and/or regulations relevant to the industry and jurisdictions in which the organisation operates, including making disclosures as required'.* If internal auditors identify legal or regulatory violations, they must report such incidents to individuals or entities that have the authority to take appropriate action, as specified in laws, regulations, and applicable policies and procedures.

Internal Audit staff have completed mandatory Equality and Diversity training. Where relevant, Equality and Humans Rights are considered in internal audit assignments.

2.3.9 Climate Emergency & Sustainability Impact

While the primary function of internal auditing is to strengthen governance, risk management, and control processes, its effects extend beyond the organisation. Internal auditing contributes to an organisation's overall stability and sustainability by providing assurance on its operational efficiency, reliability of reporting, compliance with laws and/or regulations, safeguarding of assets, and ethical culture. The Chief Internal Auditor seeks information from the Board about its perspectives and expectations related to a broad range of nonfinancial governance and risk management concerns including, for example, strategic initiatives, cybersecurity, health and safety, sustainability, business resilience, and reputation.

FTF is committed to contributing to the achievement of Corporate Risk 4: Policy obligations in relation to environmental management and climate change.

2.3.10 Communication, involvement, engagement and consultation

GIAS Principle 11 Communicate Effectively requires that the Chief Internal Auditor oversees the internal audit function's formal communications with the Audit and Risk Committee and senior management to enable quality and provide insights based on the results of internal audit services.

This paper has been produced by the Regional Audit Manager and the Chief Internal Auditor. The ELT contributed to the draft plan through discussion at their meeting on 12 April 2025. The draft internal audit strategic and annual plan was reviewed and approved by the Director of Finance, and the draft final version was circulated to the wider ELT for information.

2.3.11 Route to the Meeting

The ELT contributed to the draft internal audit plan through discussion at their meeting on 12 April 2025. Subsequent to this, the draft internal audit strategic and annual plan was reviewed and approved by the Director of Finance and the draft final version was circulated to the wider ELT for information.

2.4 Recommendation

This paper is provided to members for:

- **Assurance** – This report provides a **"significant" level of assurance**, that the Draft Strategic and Operational Plans preparation and assessment process is conducted in accordance with the Global Internal Audit Standards (GIAS) and the Application Note: GIAS in the UK Public Sector. The report provides assurance that the strategic and operational plans provide sufficient coverage to allow the Chief Internal Auditor to provide required year end assurances.

- **Discussion** – Members are asked to **consider** the potential sources of assurance for each strand of governance included at Appendix 1 and note that Internal Audit has started to develop a database of assurance providers and will work with Management developing the Performance and Assurance Framework to ensure there is no duplication of work and that all aspects are documented.

- **Discussion** – Members are asked to **consider** the draft 3-year Strategic Plan and the draft 2025/26 Operational Plan.

- **Decision – Approve** the 3-year Strategic and the 2025/26 Operational Plans.

3 List of appendices

- Appendix No. 1, Internal Audit 3-year Strategic Plan
- Appendix No. 2, Draft Internal Audit Annual Plan 2025/26

Report Contact
Jocelyn Lyall
Chief Internal Auditor
Email jocelyn.lyall2@nhs.scot

NHS Fife
FTF Audit and Management Services
Strategic Plan 2024/27

Assurance/Activity Area	Broad Outline	2024/25	2025/26	2026/27	Rationale	Strategic Risk	Risk Current Score	Strategic Objective	Reform Transform Perform	RTP Organisational Portfolio of change	Other Assurance Sources
		Days									
A GIAS Requirement		**79**	**90**	**88**							
Audit Risk Assessment & Operational Planning	Risk Assessment, Strategic and Operational Planning	7	7	7	Global Internal Audit Standards (GIAS) Requirement	**n/a**	**n/a**	**n/a**	**n/a**		
Audit Management & Liaison with Directors	Audit Management, liaison with Director of Finance and other officers	15	16	14	GIAS Requirement	**n/a**	**n/a**	**n/a**	**n/a**		
Liaison with External Auditors and other review bodies	Liaison with External Audit	4	4	4	GIAS Requirement	**n/a**	**n/a**	**n/a**	**n/a**		
Audit and Risk Committee (ARC)	Preparation of papers, presentation and action points	18	18	18	GIAS Requirement	**n/a**	**n/a**	**n/a**	**n/a**		
Board, Operational Committees and Accountable Officer	Attendance and input / provision of advice at Standing Committees and other Groups.	10	10	10	GIAS Requirement	**n/a**	**n/a**	**n/a**	**n/a**		
Self-Assessment / External Quality Assessment (EQA)	Internal Audit EQA/GIAS improvement plan	10	10	10	GIAS Requirement	**n/a**	**n/a**	**n/a**	**n/a**		
Contingency	Time to accommodate requests from ARC and Management.		10	10	Time to accommodate in year requests						
Clearance of Prior Year	Provision for clearance and reporting of prior year audit reports	15	15	15	Time to complete prior year audits	**n/a**	**n/a**	**n/a**	**n/a**		
B HEALTH & SOCIAL CARE INTEGRATION		**38**	**38**	**15**							
Delivery of Integrated Joint Board internal audit plan	Delivery of IJB Internal Audit Plan	38	38	15	Legislation	**n/a**	**n/a**	**n/a**	**n/a**		
C CORPORATE GOVERNANCE		**154**	**155**	**180**							**External Auditors, Audit Scotland, Scottish Government, Health & Safety Executive, Scottish Environment Protection Agency, Self-Assessment, Externally Commissioned Reviews**
Annual Internal Audit Report & Governance Statement	CIA annual assurance, review of Governance Statement and supporting evidence	30	30	30	Scottish Public Finance Manual (SPFM)	**Full risk profile**	**Various**	**To Improve Health and Wellbeing** **To Improve the Quality of Health & Care Services** **To Improve Staff Experience & Wellbeing** **To Deliver Value & Sustainability**	**n/a**		
Internal Control Evaluation	Mid-year assurance on governance and operation of controls	40	40	35	Key source of assurance. ICE process to be streamlined and days reduced in 2026/27	**Full risk profile**	**Various**	**To Improve Health and Wellbeing** **To Improve the Quality of Health & Care Services** **To Improve Staff Experience & Wellbeing** **To Deliver Value & Sustainability**	**n/a**		
Audit Follow-up	Follow up of action points and validation of evidence, provision of reports to the Audit and Risk Committee	40	35	30	GIAS Requirement. Process to be streamlined and days reduced in 2025/26 and 2026/27	**n/a**	**n/a**	**n/a**	**n/a**		
Structures of assurance	Review of assurance structures. Development of assurance mapping	4			Coverage in 2024/25	**n/a**	**n/a**	**n/a**	**n/a**		
Compliance with laws & regulations	Review of process to ensure compliance with Laws and Regulations			25	Robust system in place. Included for 2026/27. Audit will include review of relevant policies.	**n/a**	**n/a**	**n/a**	**n/a**		
Risk Management Strategy, Standards and Operations	Review of Risk Management Framework. Provision of advice as required	10	25	10	GIAS Requirement	**Full risk profile**	**Various**	**To Improve Health and Wellbeing** **To Improve the Quality of Health & Care Services** **To Improve Staff Experience & Wellbeing** **To Deliver Value & Sustainability**	**n/a**		
Culture and Leadership	Compliance with Blueprint for Good Governance			25	Included in 2026/27. Audit will review effectiveness of the NHS Fife Leadership Framework.	**n/a**	**n/a**	**n/a**	**n/a**		
Physical Environment	Review of relevant areas e.g. Health and Safety, Fire, Security, and healthcare environment.				Area is risk ranked at 20. Alternative sources of assurance to be identified.	**9 – Quality and Safety** **22 – Hospital Acquired Harm**	**Moderate** **High**	**To Improve the Quality of Health & Care Services**	**n/a**		
NHS Resilience; Business Continuity and Emergency Planning	Compliance with NHS Scotland Resilience: Preparing for Emergencies guidance				Area is risk ranked at 27. Alternative sources of assurance to be identified.	**17 – Cyberesilience**	**High**	**To Deliver Value & Sustainability**	**n/a**		
Environmental management	Compliance with environmental legislation - DL 2021(38)	15			Coverage in 2024/25	**4 – Policy obligations in relation to environmental management and climate change**	**Moderate**	**To Improve Health and Wellbeing**	**n/a**	**Energy Efficiency Schemes**	
Strategic planning	Review of governance aspects of Strategy including sustainability and transformation			25	Review of strategy and sustainability - high risk area	**1 - Population Health and Wellbeing Strategy** **21 – Pandemic risk**	**Moderate** **High**	**To Improve Health and Wellbeing** **To Improve Health and Wellbeing**	**Unscheduled Care Bundle / Legacy COVID costs / Business Transformation / Surge Reduction / Planned Care**	**Procedures of low clinical value / Theatres Optimisation / Remote Outpatient Appointments / Length of Stay Reductions**	
Operational planning	Operational planning to support achievement of corporate objectives	15			Coverage in 2024/25	**2 – Health Inequalities** **6 – Whole system capacity**	**High** **High**	**To Improve Health and Wellbeing** **To Improve the Quality of Health & Care Services**	**Unscheduled Care Bundle / Legacy COVID costs / Business Transformation / Surge Reduction / Planned Care**	**Procedures of low clinical value / Theatres Optimisation / Remote Outpatient Appointments / Length of Stay Reductions**	
Performance management and reporting	Review of performance management systems and processes to achieve targets. Adequacy and effectiveness of performance reporting.		25		Director of Finance request	**7 – Access to Outpatient, Diagnostic and Treatment Services** **8 – Cancer Waiting Times** **23 – Substance related morbidity and mortality**	**High** **High** **High**	**To Improve the Quality of Health & Care Services** **To Improve the Quality of Health & Care Services** **To Improve Health and Wellbeing**	**n/a**	**PLICS Rollout (Patient Level Information and Costing Systems)**	
D CLINICAL GOVERNANCE		**40**	**25**	**50**							**Healthcare Improvement Scotland, Scottish Public Services Ombudsman, Mental Welfare Commission, Care Inspectorate, ISO (International Organisation for Standardisation), clinical audit**
Clinical Governance Framework	Clinical and care governance, risk and assurance arrangements				Coverage in ICE and Annual Reports	**1 - Population Health and Wellbeing Strategy** **9 – Quality and Safety**	**Moderate** **Moderate**	**To Improve Health and Wellbeing** **To Improve the Quality of Health & Care Services**	**n/a**		
Complaints	Review of risks and actions to drive improvement and triangulation of data with other assurance sources			25	Clear link to strategic risk and key area to allow triangulation	**9 – Quality and Safety**	**Moderate**	**To Improve the Quality of Health & Care Services**	**n/a**		
Adverse Event Management	Review of relevant areas e.g. recording and learning from incidents, triangulation and implementation of remedial action and mortality and morbity reviews. Reporting of KPIs. Application of Duty of Candour				Coverage in ICE and Annual Reports	**9 – Quality and Safety** **23 – Substance related morbidity and mortality**	**Moderate** **High**	**To Improve the Quality of Health & Care Services** **To Improve Health and Wellbeing**	**n/a**		
Primary Care Sustainability	Review of risk, governance and strategy to maintain sustainable services			25	Coverage in 2026/27	**1 - Population Health and Wellbeing Strategy** **2 – Health Inequalities**	**Moderate** **High**	**To Improve Health and Wellbeing** **To Improve Health and Wellbeing**	**n/a**		
Medical Equipment and Devices	Review of relevant area e.g. governance arrangements, maintenance, control and acquisition of medical devices				Alternative sources of assurance to be identified	**9 – Quality and Safety** **15 – Prioritisation and management of Capital Funding** **20 – Reduced Capital Funding**	**Moderate** **Moderate** **High**	**To Improve the Quality of Health & Care Services** **To Deliver Value & Sustainability** **To Deliver Value & Sustainability**	**n/a**		
Population Health	Review of relevant area e.g. governance arrangements for population health and well being, including implementation of Strategy, health inequalities	20			Coverage in 2024/25 plan.	**1 - Population Health and Wellbeing Strategy,** **2 – Health Inequalities**	**Moderate** **High**	**To Improve Health and Wellbeing** **To Improve Health and Wellbeing**	**n/a**		
Medicines Management	Arrangements for efficient and effective prescribing and compliance with Accountable Officer duties e.g. controlled drugs	20	25		ELT request	**n/a**	**n/a**	**n/a**	**Medicines Optimisation**	**Medicines of low clinical value** **Medicines Wastage** **Polypharmacy Reviews** **Medicines Switches**	
E STAFF GOVERNANCE		**58**	**25**	**25**							**Scottish Government, External Auditors, Health & Safety Executive, Independent National Whistleblowing Officer**
Staff Governance Committee	Assurances to relevant committees				Coverage in ICE and Annual Reports	**11 – Workforce Planning and Delivery**	**High**	**To Improve Staff Experience &**	**n/a**		

						12 – Staff Health and Wellbeing	**High**	**Wellbeing**			
Workforce planning, including capable and effective workforce	Review of development and implementation of Workforce Plan. Management of workforce risks.			25	Coverage in 2026/27	**11 – Workforce Planning and Delivery**	**High**	**To Improve Staff Experience & Wellbeing**	**Non Compliant rotas / Corporate Directorates**	**Non compliant rotas review / Central functions Job Family review**	
						19 – Implementation of Health and Care Staffing Scotland Act	**Moderate**	**To Improve the Quality of Health & Care Services**			
Recruitment and retention	Compliance with policy May include review of support for staff wellbeing arrangements	20			Coverage in 2024/25 plan	**11 – Workforce Planning and Delivery**	**High**	**To Improve Staff Experience & Wellbeing**	**n/a**		
Supplementary staffing	Controls to monitor and report demand, acquisition and use of supplementary staffing, focusing on financial sustainability	20	25		High risk area risk asesed from 2024/25.	**11 – Workforce Planning and Delivery**	**High**	**To Improve Staff Experience & Wellbeing**	**Supplementary Staffing**	**Nurse Agency Reduction / Medical Locum Reduction**	
						13 – Delivery of a Balanced in year position	**High**	**To Deliver Value & Sustainability**			
						14 – Delivery of Recurring Financial Balance over the Medium Term	**High**	**To Deliver Value & Sustainability**			
Whistleblowing	Effectiveness of Whistleblowing governance, systems and processes				Low risk ranked area	**n/a**	**n/a**	**n/a**	**n/a**		
Management of performance and development (inc Remuneration Committee)	Review of arrangements for personal development plans and appraisal e.g. executive, medical and dental, GPs, agenda for change				Coverage in ICE and Annual Reports	**11 – Workforce Planning and Delivery**	**High**	**To Improve Staff Experience & Wellbeing**	**n/a**		
Management of sickness absence	Controls to manage, monitor and report sickness absence May include review of support for staff wellbeing arrangements	18			Coverage in 2024/25 plan	**12 – Staff Health and Wellbeing**	**High**	**To Improve Staff Experience & Wellbeing**	**n/a**	**Sickness Absence Reduction**	
F FINANCIAL GOVERNANCE		**38**	**90**	**40**							**External Audit, Audit Scotland, Scottish Government, Service Auditor**
Fraud Liaison role	Fraud liaison responsibilities/FLO/Depute FLO	0	0	0		**n/a**	**n/a**				
Fraud & Probity Arrangements	Responding to fraud risk assessment, including staff fraud				Low risk area	**n/a**	**n/a**				
Financial Sustainability	Review of RTP. Financial planning and sustainability arrangements to deliver services	18	25		High risk area and corporate and ELT priority	**1 - Population Health and Wellbeing Strategy**	**Moderate**	**To Improve Health and Wellbeing**			
						13 – Delivery of a Balanced in year position	**High**	**To Deliver Value & Sustainability**			
						14 – Delivery of Recurring Financial Balance over the Medium Term	**High**				
						15 – Prioritisation and management of Capital Funding	**Moderate**				
						20 – Reduced Capital Funding	**High**				
Financial Management	Review of budgetary control processes and reporting including the strength of the financial management culture. Ensuring 'Grip and Control'.		25		ELT request and high risk area	**13 – Delivery of a Balanced in year position**	**High**	**To Deliver Value & Sustainability**			
						14 – Delivery of Recurring Financial Balance over the Medium Term	**High**				
						15 – Prioritisation and management of Capital Funding	**Moderate**				
						20 – Reduced Capital Funding	**High**				
Savings	Savings governance and delivery of plans	20		25	Coverage in 2024/25 and 2026/27 plans	**13 – Delivery of a Balanced in year position**	**High**	**To Deliver Value & Sustainability**			
						14 – Delivery of Recurring Financial Balance over the Medium Term	**High**				
Compliance with core financial procedures	Review of compliance with key financial controls e.g. delegation, authorisation.				No material issues reported via 2023/24 Financial Statements audit. Low risk area	**n/a**	**n/a**				
Whole System Plan for asset investment	Assessment of progress towards development of Whole System Plan Review of governance arrangements				Alternative sources of assurance to be identified e.g. Scottish Government scrutiny	**1 - Population Health and Wellbeing Strategy**	**Moderate**	**To Improve Health and Wellbeing**	**PFI Contract / Estates Rationalisation**		
						15 – Prioritisation and management of Capital Funding	**Moderate**	**To Deliver Value & Sustainability**			
						20 – Reduced Capital Funding	**High**				
Property Transaction Monitoring and Property disposals	Post Transaction Monitoring compliance. Efficient effective planning for property disposal.	0	15	15	Mandatory requirement	**15 – Prioritisation and management of Capital Funding**	**Moderate**	**To Deliver Value & Sustainability**			
						20 – Reduced Capital Funding	**High**				
Service Contract income or expenditure	Review of relevant areas, e.g. contracts for services and SLAs with Health Boards.		25		ELT request and key aspect of RTP	**13 – Delivery of a Balanced in year position**	**High**	**To Deliver Value & Sustainability**	**PFI Contract / Estates Rationalisation / SLA External Activity**		
						14 – Delivery of Recurring Financial Balance over the Medium Term	**High**				
Procurement	Adherence to the procurement control framework e.g. use of Management Consultants				Low risk area with robust controls in place. Other sources of assurance to be identified.	**13 – Delivery of a Balanced in year position**	**High**	**To Deliver Value & Sustainability**	**Procurement**		
						14 – Delivery of Recurring Financial Balance over the Medium Term	**High**				
G ENDOWMENT FUNDS/PATIENT FUNDS		**0**	**25**	**25**							**OSCR Scottish Charity Regulator, External Audit**
Charitable Funds (endowment funds)	Programme of agreed work		25		Audit of systems and processes.	**n/a**	**n/a**	**n/a**			
Patients' Funds and Property	Compliance with patients' funds and property control framework			25	Audit of systems and processes.	**n/a**	**n/a**	**n/a**			
H DIGITAL & INFORMATION GOVERNANCE		**18**	**25**	**50**							**Scottish Government - Network and Information Systems Regulations audit, External Audit, Audit Scotland**
Information Assurance/Information Security Framework	Information assurances to relevant committees and groups including risks, incidents and external reports				Timing related to NIS review cycle to avoid duplication with alternative sources of assurance	**17 – Cyberesilience**	**High**	**To Deliver Value & Sustainability**			
						18 - Digital and Information	**High**				
Data Protection and Freedom of Information	Provision of relevant, reliable and sufficient evidence of compliance with legislation and identification of gaps				Alternative sources of assurance to be identified	**18 - Digital and Information**	**High**	**To Deliver Value & Sustainability**			
Records Management	Review of compliance with Records Management Policy			25	Coverage in 2026/27	**18 - Digital and Information**	**High**	**To Deliver Value & Sustainability**			
Digital Strategy and Governance	Alignment of local Digital strategic plans with the Board's overall strategy, the National eHealth Strategy and review of supporting governance processes	18	25		Coverage in 2025/26 - risk assessed from 2024/25 plan	**18 - Digital and Information**	**High**	**To Deliver Value & Sustainability**			
Cyber Resilience	Implementation of Cyber Resilience Framework and risk and governance arrangements			25	Coverage in 2026/27	**17 – Cyberesilience**	**High**	**To Deliver Value & Sustainability**			
TOTAL		**425**	**473**	**473**							
			473	473							

Audit	Audit Process	Scope	Days
Governance and Assurance			**283**
B01/26	Audit Risk Assessment & Operational Planning	Risk Assessment, Strategic and Operational Planning	7
B02/26	Audit Management & Liaison with Directors	Audit Management, liaison with Director of Finance and other officers	16
B03/26	Liaison with External Auditors and other review bodies	Liaison with External Audit	4
B04/26	Audit and Risk Committee (ARC)	Preparation of papers, presentation and action points	18
B05/26	Board, Operational Committees and Accountable Officer	Attendance and input / provision of advice at Standing Committees and other Groups.	10
B06/26	Self-Assessment / External Quality Assessment (EQA)	Internal Audit EQA/GIAS improvement plan	10
B07/26	Contingency	Time to accommodate requests from ARC and Management.	10
B08/26	Clearance of Prior Year	Provision for clearance and reporting of prior year audit reports	15
B09/26	Delivery of Integrated Joint Board internal audit plan	Delivery of IJB Internal Audit Plan	38
B10/26	Annual Internal Audit Report & Governance Statement	CIA annual assurance, review of Governance Statement and supporting evidence	30
B11/26	Internal Control Evaluation	Mid-year assurance on governance and operation of controls	40
B12/26	Audit Follow-up	Follow up of action points and validation of evidence, provision of reports to the Audit and Risk Committee	35
B13/26	Risk Management Strategy, Standards and Operations	Review of Risk Management Framework. Provision of advice as required.	25
B14/26	Performance management and reporting	Review of performance management systems and processes to achieve targets. Adequacy and effectiveness of performance reporting.	25
Clinical Governance			**25**
B15/26	Medicines Management	Arrangements for efficient and effective prescribing and compliance with Accountable Officer duties e.g. controlled drugs	25
Staff Governance			**25**
B16/26	Supplementary staffing	Controls to monitor and report demand, acquisition and use of supplementary staffing, focusing on financial sustainability	25
Financial Governance			**90**
B17/26	Financial Sustainability	Review of RTP. Financial planning and sustainability arrangements to deliver services	25
B18/26	Financial Management	Review of budgetary control processes and reporting including the strength of the financial management culture. Ensuring 'Grip and Control'.	25
B19/26	Post Transaction Monitoring	Post Transaction Monitoring compliance. Efficient effective planning for property disposal.	15
B20/26	Service Contract income or expenditure	Review of relevant areas, e.g. contracts for services and SLAs with Health Boards.	25
Endowment Funds			**25**
B21/26	Charitable Funds (endowment funds)	Programme of agreed work	25
Information Governance			**25**
B24/26	Digital Strategy and Governance	Alignment of local Digital strategic plans with the Board's overall strategy, the National eHealth Strategy and review of supporting governance processe	25
Total Days for 2025/26 Internal Audit Plan			**473**

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**15 May 2025**
Title:	**Internal Audit Framework**
Responsible Executive:	**Jocelyn Lyall, Chief Internal Auditor**
Report Author:	**Jocelyn Lyall, Chief Internal Auditor**

Executive Summary:

The purpose of this paper is to present the updated Internal Audit Framework to the Audit and Risk Committee for approval.

The Internal Audit Framework, encompassing the Internal Audit Charter, Service Specification and NHS Fife Reporting Protocol is updated annually. This May 2025 version has been significantly revised to ensure the Internal Audit Framework fully complies with the Institute of Internal Auditors (IIA) Global Internal Audit Standards (GIAS), the Application Note: GIAS in the UK Public Sector, applicable from 1 April 2025, and incorporates recommendations from the 4 March 2025 External Quality Assessment of Internal Audit.

1 Purpose

This report is presented for:

- Assurance
- Decision

This report relates to:

- Legal requirement
- Local policy

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

- Safe
- Effective

2 Report summary

2.1 Situation

The Internal Audit Framework brings together a standard Audit Charter and Service Specification, and the Reporting Protocol tailored for NHS Fife, reflecting local arrangements.

The Audit Charter is based on the Institute of Internal Auditors (IIA) template to ensure it fully complies with the requirements of GIAS.

2.1 Background

Internal Audit Framework

Global Internal Audit Standards require each organisation to agree an Internal Audit Charter, which is a formal document that includes the internal audit function's mandate, organisational position, reporting relationships, scope of work, types of services, and other specifications.

The Internal Audit Mandate forms part of the Internal Audit Charter and sets out the internal audit function's authority, role, and responsibilities, which may be granted by the Audit and Risk Committee and/or laws and regulations.

The Internal Audit Charter is complementary to the relevant provisions included in the Board Standing Orders and Standing Financial Instructions.

The Service Specification sets out the responsibilities of Internal Audit and that Internal Audit agree to deliver the Internal Audit Service in accordance with the provisions set out in the specification.

The Reporting Protocol describes the internal audit reporting process from planning through to the presentation of internal audit reports to Audit and Risk Committee.

2.2 Assessment

The Internal Audit Charter has been revised to comply with Global Internal Audit Standards and the Application Note: GIAS in the UK Public Sector, and to incorporate recommendations from the External Quality Assessment of Internal Audit, published on 4 March 2025.

A 'tracked' changes master version of the Charter and Service Specification has not been provided because the change in template and subsequent revision to the Internal Audit Charter and the complementary Service Specification has resulted in significant amendments to the format and content, with elements of the Service Specification now included in the Charter.

The key amendments are detailed below:

Compliance with the requirements of the Global Internal Audit Standards and the Application Note: GIAS in the UK Public Sector

- Reference to Internal Audit's commitment to complying with Global Internal Audit Standards
- Inclusion of the Internal Audit Mandate
- Clarification of the Audit and Risk Committee oversight role
- Clarification of the Chief Internal Auditor role
- Inclusion of the requirement for a Quality Assurance and Improvement Program

- Requirement for formal approval by the Chair of the Audit and Risk Committee and Chief Executive, in addition to approval by the Director of Finance.

Compliance with EQA recommendations:

- Description of the Fraud Liaison role, including how any conflict would be managed.
- An overview of the nature of independent advisory work undertaken, including activities such as attending governance forums as well as advisory assignments.

This report provides Significant Assurance that the Internal Audit Framework complies with GIAS requirements.

	Significant	Moderate	Limited	None
Level	X			
Descriptor	There is robust assurance that the system of control achieves, or will achieve, the purpose that it is designed to deliver. There may be an insignificant amount of residual risk or none at all.	There is sufficient assurance that controls upon which the organisation relies to manage the risk(s) are suitably designed and effectively applied. There remains a moderate amount of residual risk.	There is some assurance from the systems of control in place to manage the risk(s), but there remains a significant amount of residual risk, which requires further action to be taken.	No assurance can be taken from the information that has been provided. There remains a significant amount of residual risk

2.3.1 Quality / Patient Care

GIAS Standard 8.3 Quality requires that the Chief Internal Auditor develops, implements and maintains a quality assurance and improvement program that covers all aspects of the internal audit function. The program includes external and internal assessments.

When expressing conformance with standards, auditors must be clear that they are conforming to the GIAS subject to the Application Note and must refer to this as conformance with Global Internal Audit Standards in the UK Public Sector.

The Internal Audit Charter reflects the Chief Internal Auditor's responsibility to develop, implement, and maintain a quality assurance and improvement program that covers all aspects of the internal audit function, to be reported to Audit and Risk Committee.

2.3.2 Workforce

GIAS Standard 10.2 Human Resources Management requires the Chief Internal Auditor to strive to ensure that human resources are appropriate, sufficient, and effectively deployed to achieve the approved internal audit plan.

Due consideration is given to the appropriate staff skill mix and is provided in the service specification.

2.3.3 Financial

GIAS Standard 10.1 Financial Resource Management requires that the Chief Internal Auditor manages the internal audit function's financial resources. All financial implications are included within the FTF Budget.

2.3.4 Risk Assessment / Management

The risk 'Compliance with Internal Audit Framework' is recorded on the FTF risk register and was updated on 22 April 2025. This risk is scored as 'Moderate' with a target of 'Low'.

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

GIAS Standard 1.3 Legal and Ethical Behaviour states that '*Internal auditors must not engage in or be a party to any activity that is illegal or discreditable to the organisation or the profession of internal auditing or that may harm the organisation or its employees. Internal auditors must understand and abide by the laws and/or regulations relevant to the industry and jurisdictions in which the organisation operates, including making disclosures as required'.* If internal auditors identify legal or regulatory violations, they must report such incidents to individuals or entities that have the authority to take appropriate action, as specified in laws, regulations, and applicable policies and procedures.

Internal Audit staff have completed mandatory Equality and Diversity training. Where relevant, Equality and Humans Rights are considered in internal audit assignments.

2.3.6 Climate Emergency & Sustainability Impact

While the primary function of internal auditing is to strengthen governance, risk management, and control processes, its effects extend beyond the organisation. Internal auditing contributes to an organisation's overall stability and sustainability by providing assurance on its operational efficiency, reliability of reporting, compliance with laws and/or regulations, safeguarding of assets, and ethical culture. The Chief Internal Auditor seeks information from the Board about its perspectives and expectations related to a broad range of nonfinancial governance and risk management concerns including, for example, strategic initiatives, cybersecurity, health and safety, sustainability, business resilience, and reputation.

FTF is committed to contributing to the achievement of Corporate Risk 4: Policy obligations in relation to environmental management and climate change.

2.3.7 Communication, involvement, engagement, and consultation

GIAS Principle 11 Communicate Effectively requires that the Chief Internal Auditor oversees the internal audit function's formal communications with the Audit and Risk Committee and senior management to enable quality and provide insights based on the results of internal audit services.

All elements of this framework have been updated by the Chief Internal Auditor with input from the FTF Management Team.

2.3.8 Route to the Meeting

This framework has been updated by the Chief Internal Auditor.

2.4 Recommendation

This paper is provided to members for:

- **Assurance** - this report provides a **"significant" level of assurance** that the Internal Audit Charter complies with GIAS.
- **Decision -** to **approve** the updated Internal Audit Charter and Service Specification for presentation and formal approval by the Audit and Risk Committees of each Client Board.

3 List of appendices

The following appendix is included with this report:

- Appendix A, Internal Audit Framework - Internal Audit Charter, Service Specification and Reporting Protocol.

Report Contact
Jocelyn Lyall
Chief Internal Auditor
Email: Jocelyn.lyall2@nhs.scot

Internal Audit Framework

Version: May 2025

Update: May 2026

Internal Audit Charter

1. Purpose

1.1 The purpose of the internal audit function is to strengthen NHS Fife's ability to create, protect, and sustain value by providing the Audit and Risk Committee and management with independent, risk-based, and objective assurance, advice, insight, and foresight.

The internal audit function enhances NHS Fife's:

- Successful achievement of its objectives.
- Governance, risk management, and control processes.
- Decision-making and oversight.
- Reputation and credibility with its stakeholders.
- Ability to serve the public interest.

NHS Fife's internal audit function is most effective when:

- Internal auditing is performed by competent professionals in conformance with The Institute of Internal Auditor's (IIA's) Global Internal Audit Standards, which are set in the public interest.
- The internal audit function is independently positioned with direct accountability to the Audit and Risk Committee.
- Internal auditors are free from undue influence and committed to making objective assessments.

1.2 **Commitment to Adhering to the Global Internal Audit Standards in the UK Public Sector**

NHS Fife's internal audit function will adhere to the mandatory elements of the Institute of Internal Auditors' International Professional Practices Framework, which are the Global Internal Audit Standards and Topical Requirements. The Application Note: GIAS in the UK Public Sector provides UK public sector-specific context, interpretations of GIAS requirements in the specific circumstances expected to apply across the UK public sector and some additional requirements which the Relevant Internal Audit Standard Setters consider essential for the practice of internal audit in the UK public sector.

The Chief Internal Auditor (CIA) will report to each meeting of the Audit and Risk Committee and senior management regarding the internal audit function's conformance with the Global Internal Audit Standards in the UK Public Sector Standards, which will be assessed through a quality assurance and improvement programme.

2. Mandate

2.1 The Scottish Public Finance Manual (SPFM) provides guidance on internal audit arrangements and procedures. The SPFM states that:

'Internal audit should provide an independent, objective assurance and consulting service designed to add value and improve an organisation's operations. It should provide an appraisal of an organisation's governance, risk management and internal control system and take the action needed to provide Accountable Officers with a continuing assurance that the organisation's risk management, control and governance arrangements are adequate and effective. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes'.

The Audit and Risk Committee grants the internal audit service the mandate to provide the Audit and Risk Committee and senior management with objective assurance, advice, insight and foresight.

2.2 **Authority**

Internal Audit derives its authority from the NHS Board, the Accountable Officer and Audit and Risk Committee and the relevant provisions included in the organisation's Code of Corporate Governance.

This mandate is complementary to the relevant provisions included in the organisation's own Standing Orders and Standing Financial Instructions and in the Internal Audit Service Specification.

The internal audit function's authority is created by its direct reporting relationship to the Audit and Risk Committee. Such authority allows for unrestricted access to the Audit and Risk Committee.

The Chief Internal Auditor reports on a functional basis to the Accountable Officer and to the Audit and Risk Committee on behalf of the Board. The Audit and Risk Committee authorises the internal audit function to:

- Have full and unrestricted access to all functions, data, records, information, physical property, and personnel pertinent to carrying out internal audit responsibilities. Internal auditors are accountable for confidentiality and safeguarding records and information.
- Allocate resources, set frequencies, select subjects, determine scopes of work, apply techniques, and issue communications to accomplish the function's objectives.
- Obtain assistance from the necessary personnel of NHS Fife and other specialised services from within or outside NHS Fife to complete internal audit services.

The Internal Audit Service Specification sets out specific responsibilities as Internal Auditors to NHS Fife.

2.3 **Independence, Organisational Position, and Reporting Relationships**

The CIA will be positioned at a level in the organisation that enables internal audit services and responsibilities to be performed without interference from management, thereby establishing the independence of the internal audit function. (See "Mandate" section.) The CIA will report functionally to the Audit and Risk Committee and administratively (for example, day-to-day operations) to the Director of Finance. This positioning provides the organisational authority and status to bring matters directly to senior management and escalate matters to the Audit and Risk Committee, when necessary, without interference and supports the internal auditors' ability to maintain objectivity. In addition, the shared service model of

Internal Audit provision allows further organisational independence.
The CIA will confirm to the Audit and Risk Committee, at least annually, the organisational independence of the internal audit function. If the governance structure does not support organisational independence, the CIA will document the characteristics of the governance structure limiting independence and any safeguards employed to achieve the principle of independence. The CIA will disclose to the Audit and Risk Committee any interference internal auditors encounter related to the scope, performance, or communication of internal audit work and results. The disclosure will include communicating the implications of such interference on the internal audit function's effectiveness and ability to fulfill its mandate.

2.4 **Changes to the Mandate and Charter**

Circumstances may justify a follow-up discussion between the CIA, Audit and Risk Committee, and senior management on the internal audit mandate or other aspects of the internal audit charter. Such circumstances may include but are not limited to:

- A significant change in the Global Internal Audit Standards.
- A significant reorganisation within the organisation.
- Significant changes in the CIA, Audit and Risk Committee and/or senior management.
- Significant changes to the organisation's strategies, objectives, risk profile, or the environment in which the organisation operates.
- New laws or regulations that may affect the nature and/or scope of internal audit services.

3. Audit and Risk Committee Oversight

3.1 To establish, maintain, and ensure that NHS Fife's internal audit function has sufficient authority to fulfill its duties, the Director of Finance will:

- Discuss with the CIA and senior management the appropriate authority, role, responsibilities, scope, and services (assurance and/or advisory) of the internal audit function.
- Ensure the CIA has unrestricted access to and communicates and interacts directly with the Audit and Risk Committee, including in private meetings without senior management present.
- Discuss with the CIA and senior management other topics that should be included in the internal audit charter.
- Participate in discussions with the CIA and senior management about the "essential conditions," described in the Global Internal Audit Standards, which establish the foundation that enables an effective internal audit function.
- Approve the internal audit function's charter, which includes the internal audit mandate and the scope and types of internal audit services.
- Review the internal audit charter annually with the CIA to consider changes affecting the organisation, such as the employment of a new CIA or changes in the type, severity, and interdependencies of risks to the organisation; and approve the internal audit charter

annually.

- Endorse the risk-based internal audit plan, prior to Audit and Risk Committee approval.
- Provide input to the internal audit function's human resources administration and budgets.
- Advocate to the Internal Audit Partnership Board to ensure sufficient budget and resources, allowing the internal audit function to fulfil its mandate and accomplish its audit plan.
- Provide input to senior management on the appointment and removal of the CIA, ensuring adequate competencies and qualifications and conformance with the Global Internal Audit Standards.
- Receive communications from the CIA about the internal audit function including its performance relative to its plan.
- Ensure a quality assurance and improvement program has been established and review the results annually.
- Make appropriate inquiries of senior management and the CIA to determine whether scope or resource limitations are inappropriate.

4. CIA Roles and Responsibilities

4.1 The Internal Audit Service Specification states that NHS Fife, as the host body, is responsible for appointing a CIA who is a member of the CCAB Institute or CMIIA with experience equivalent to at least five years post-qualification experience and at least three years of audit.

The Specification also sets out the required qualified skill-mix as well as specifying the responsibility of the Chief Internal Auditor to ensure staff are suitably trained with appropriate skills, recorded in a Personal Development Plan and where relevant fulfilling professional continual professional development requirements.

4.2 **Ethics and Professionalism**

The CIA will ensure that internal auditors:

- Conform with the Global Internal Audit Standards, including the principles of Ethics and Professionalism: integrity, objectivity, competency, due professional care, and confidentiality.
- Conform with the Seven Principles of Public Life (the Nolan Principles).
- Understand, respect, meet, and contribute to the legitimate and ethical expectations of the organisation and be able to recognise conduct that is contrary to those expectations.
- Encourage and promote an ethics-based culture in the organisation.
- Report organisational behavior that is inconsistent with the organisation's ethical expectations, as described in applicable policies and procedures.

4.3 **Objectivity**

The CIA will ensure that the internal audit function remains free from all conditions that threaten the ability of internal auditors to carry out their

responsibilities in an unbiased manner, including matters of engagement selection, scope, procedures, frequency, timing, and communication. If the CIA determines that objectivity may be impaired in fact or appearance, the details of the impairment will be disclosed to appropriate parties.

Internal auditors will maintain an unbiased mental attitude that allows them to perform engagements objectively such that they believe in their work product, do not compromise quality, and do not subordinate their judgment on audit matters to others, either in fact or appearance.

Internal auditors will have no direct operational responsibility or authority over any of the activities they review. Accordingly, internal auditors will not implement internal controls, develop procedures, install systems, or engage in other activities that may impair their judgment, including:

- Assessing specific operations for which they had responsibility within the previous year.
- Performing operational duties for NHS Fife or its affiliates.
- Initiating or approving transactions external to the internal audit function.
- Directing the activities of any NHS Fife employee that is not employed by the internal audit function, except to the extent that such employees have been appropriately assigned to internal audit teams or to assist internal auditors.

Internal auditors will:

- Disclose impairments of independence or objectivity, in fact or appearance, to appropriate parties and at least annually, such as the CIA, Audit and Risk Committee, management, or others.
- Exhibit professional objectivity in gathering, evaluating, and communicating information.
- Make balanced assessments of all available and relevant facts and circumstances.
- Take necessary precautions to avoid conflicts of interest, bias, and undue influence.

4.4 **Managing the Internal Audit Function**

The CIA has the responsibility to:

- At least annually, develop a risk-based internal audit plan that considers the input of the Audit and Risk Committee and senior management. Discuss the plan with the Audit and Risk Committee and senior management and submit the plan to the Audit and Risk Committee for review and approval.
- Communicate the impact of resource limitations on the internal audit plan to the Audit and Risk Committee and senior management.
- Review and adjust the internal audit plan, as necessary, in response to changes in NHS Fife's business, risks, operations, programs, systems, and controls.
- Communicate with the Audit and Risk Committee and senior management if there are significant interim changes to the internal

audit plan.

- Ensure internal audit engagements are performed, documented, and communicated in accordance with the Global Internal Audit Standards and laws and/or regulations.
- Follow up on engagement findings and confirm the implementation of recommendations or action plans and communicate the results of internal audit services to meetings of the Audit and Risk Committee and senior management and for each engagement as appropriate.
- Ensure the internal audit function collectively possesses or obtains the knowledge, skills, and other competencies and qualifications needed to meet the requirements of the Global Internal Audit Standards and fulfill the internal audit mandate.
- Identify and consider trends and emerging issues that could impact NHS Fife and communicate to the Audit and Risk Committee and senior management as appropriate.
- Consider emerging trends and successful practices in internal auditing.
- Establish and ensure adherence to methodologies designed to guide the internal audit function.
- Ensure adherence to NHS Fife's relevant policies and procedures unless such policies and procedures conflict with the internal audit charter or the Global Internal Audit Standards. Any such conflicts will be resolved or documented and communicated to the Audit and Risk Committee and senior management.
- Obtain an understanding of the organisation and its activities, encourage two way communications between internal audit and operational staff, discuss the audit approach and seek feedback on work undertaken.
- Coordinate activities and consider relying upon the work of other internal and external providers of assurance and advisory services. If the CIA cannot achieve an appropriate level of coordination, the issue must be communicated to senior management and if necessary escalated to the Audit and Risk Committee.

4.5 **Communication with the Audit and Risk Committee and Senior Management**

The CIA will report annually to the Audit and Risk Committee and senior management regarding:

- The internal audit function's mandate.
- The internal audit plan and performance relative to its plan.
- Significant revisions to the internal audit plan.
- Potential impairments to independence, including relevant disclosures as applicable.
- Results from the quality assurance and improvement program, which include the internal audit function's conformance with The IIA's Global Internal Audit Standards and action plans to address the

internal audit function's deficiencies and opportunities for improvement.

- Significant risk exposures and control issues, including fraud risks, governance issues, and other areas of focus for the Audit and Risk Committee that could interfere with the achievement of NHS Fife's strategic objectives.
- Results of assurance and advisory services.
- Human resource requirements.
- Management's responses to risk that the internal audit function determines may be unacceptable or acceptance of a risk that is beyond NHS Fife's risk appetite.

The Internal Audit Partnership Board shall comprise of the Internal Audit Stakeholder Directors of Finance, or deputies nominated by each local health system (NHS Fife, NHS Tayside, NHS Forth Valley and NHS Lanarkshire). The Internal Audit Partnership Bord will act as a link between the service and local health boards, and support, assist and advise the Chief Internal Auditor in the resolution of any service, resource and quality issues.

The CIA will report to the Partnership Board regarding:

- Internal audit budget
- The overall performance of the service
- Proposals for significant service developments

4.6 **Quality Assurance and Improvement Programme**

The CIA will develop, implement, and maintain a quality assurance and improvement program that covers all aspects of the internal audit function. The program will include external and internal assessments of the internal audit function's conformance with the Global Internal Audit Standards, as well as performance measurement to assess the internal audit function's progress toward the achievement of its objectives and promotion of continuous improvement. The program also will assess, if applicable, compliance with laws and/or regulations relevant to internal auditing. Also, if applicable, the assessment will include plans to address the internal audit function's deficiencies and opportunities for improvement.

The CIA will regularly communicate with the Audit and Risk Committee and senior management about the internal audit function's quality assurance and improvement program, including the results of internal assessments (ongoing monitoring and periodic self-assessments) and external assessments. External assessments will be conducted at least once every five years by a qualified, independent assessor or assessment team from outside NHS Fife; qualifications must include at least one assessor holding an active Certified Internal Auditor® credential, and Public Sector competencies and knowledge.

Internal Audit will operate in accordance with the Service Specification and associated key performance indicators agreed with the Internal Audit Partnership Board and reported to Audit and Risk Committee within the Annual Report.

5. Scope and Types of Internal Audit Services

5.1 The scope of internal audit services covers the entire breadth of the organisation as set out in the audit universe, including all of NHS Fife's activities, assets, and personnel. The scope of internal audit activities also encompasses, but is not limited to, objective examinations of evidence to provide independent assurance and advisory services to the Audit and Risk Committee and management on the adequacy and effectiveness of governance, risk management, and control processes for NHS Fife.

5.2 **Annual Report**

The principal report to be produced by Internal Audit will be the Annual Audit Report for each audit year. This requires to be prepared in time for submission to the Audit and Risk Committee no later than the agreed target date, in order to provide the assurance required in considering the Board's Annual Accounts.

The Annual Audit Report should contain:

- An opinion on whether:
    - ✧ Based on the work undertaken, there were adequate and effective internal control, risk management and governance arrangements in place throughout the year.
    - ✧ The Accountable Officer has implemented a governance framework in line with required guidance sufficient to discharge the responsibilities of this role.
- analysis of any changes in control requirements during the year.
- comment on the key elements of the control environment.
- summary of Internal Audit performance.
- progress in delivering the Quality Assurance Improvement Programme.

5.3 **Risk Management**

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

Through specific, periodic audits, internal audit will also review the risk management systems, associated controls, assurance processes and functions, and test the operation of controls.

Appropriate communication with the risk management function will be maintained, including provision of all audit reports and regular meetings with risk managers.

5.4 **Advisory Services**

Internal Audit may be called upon to provide advice on controls and related matters, subject to the need to maintain objectivity. Normally Internal Audit will have no executive role, nor will it have any responsibility for the development, implementation or operation of systems. The nature and scope of advisory services will be agreed and set out in an assignment plan. Opportunities for improving the efficiency of governance, risk

management, and control processes may be identified during advisory engagements. These opportunities will be communicated to the appropriate level of management.

Internal audit engagements may include evaluating whether:

- Risks relating to the achievement of NHS Fife's strategic objectives are appropriately identified and managed.
- The actions of NHS Fife's officers, directors, management, employees, and contractors or other relevant parties comply with NHS Fife's policies, procedures, and applicable laws, regulations, and governance standards.
- The results of operations and programs are consistent with established goals and objectives.
- Operations and programs are being carried out effectively, efficiently, ethically, and equitably.
- Established processes and systems enable compliance with the policies, procedures, laws, and regulations that could significantly impact NHS Fife.
- The integrity of information and the means used to identify, measure, analyse, classify, and report such information is reliable.
- Resources and assets are acquired economically, used efficiently and sustainably, and protected adequately.

Advisory engagements may include:

- Attendance at governance forums in an independent capacity
- Provision of controls and assurance expertise
- Review of draft strategic and corporate documentation
- Input into Board and Senior Management team development events
- Independent validation of self-assessments

The Audit and Risk Committee is the final reporting line for all audit reports and where it is appropriate for a report to be shared with another Governance / Standing Committee, this will be included on the audit assignment plan.

Approved by the Audit and Risk Committee at its meeting on [date].

Acknowledgments/Signatures

_____	_____
CIA	Date
_____	_____
Audit and Risk Committee Chair	Date
_____	_____
Chief Executive	Date
_____	_____
Director of Finance	Date

Specification for Internal Audit Services

CONTENTS

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1. Introduction

This document sets out a specification for the Internal Audit requirements of the Client. The specification is for the Internal Audit Service to the Client organisation over the period 1 April 2024 to 31 March 2027 and is reviewed and updated annually.

1.1 Internal Audit will agree to deliver the Internal Audit Service in accordance with the provisions set out in this specification.

1.2 Either party shall be entitled to terminate the Agreement for the Internal Audit Service. Prior to the termination of the Agreement both parties must follow any agreed management arrangements relating to termination.

1.3 It is the duty of Internal Audit to provide the Internal Audit Service to a standard that is acceptable to the Director of Finance and the Audit and Risk Committee.

1.4 Internal Audit staff will maintain confidentiality and shall not disclose, except as required by law, to any person other than a person authorised by the Client, any information acquired in connection with the provision of the Internal Audit Service concerning:

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

1.5 Subject to the availability of resources, Internal Audit shall co-operate and respond to reasonable requests or give support.

1.6 Internal Audit shall comply with the Global Internal Audit Standards (GIAS).

2. Internal Audit Responsibilities

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

3. Internal Audit Standards

3.1 Internal Audit shall comply with GIAS and regularly report on compliance to the Audit and Risk Committee. As set out in the Internal Audit Charter, Internal Audit shall maintain a system to ensure compliance with GIAS and shall adhere to an agreed timetable for undertaking and reporting external and internal quality assessment.

4. Planning

4.1 At least annually, Internal Audit will develop a risk-based internal audit plan that considers the input of the Audit and Risk Committee and senior management. The plan will be presented to the Audit and Risk Committee for review and approval.

4.2 The approved plan will be shared with External Audit.

4.3 The Strategic Audit Plan and Annual Audit Plan should include a provision for contingencies.

4.4 The Annual Internal Audit Plan will be kept under review and any required

amendments in response to emerging risks, requests by Management or other factors will be discussed with the Director of Finance before approval by the Audit and Risk Committee.

Strategic Audit Plan

4.5 The Strategic Audit Plan should cover the period agreed by the Director of Finance and Audit and Risk Committee.

The Strategic and Annual Plans will usually be presented by the Chief Internal Auditor for formal approval by the Audit and Risk Committee by 30 June. The Strategic Plan should be updated annually to inform the Annual Audit Plan.

Annual Audit Plan

4.6 The Chief Internal Auditor will submit to the Audit and Risk Committee an Annual Audit Plan, which should reflect the audit coverage identified in the Strategic Audit Plan. The Annual Audit Plan should set out the planned scope of audit work and should identify the critical areas to be covered.

Internal audit plans will provide information on areas where there are known sources of assurance, particularly where an assurance need has been identified but has not included in the internal audit plan. To inform this, when officers are consulted during the planning process they will be asked to provide details of any known sources of assurance for areas within their remit. Internal Audit will maintain a database of known sources of assurance. The database will be added to over time as assurance frameworks develop and mature.

Audit Assignment Plans

4.7 An assignment plan should be produced for each audit and agreed with the relevant Director and Director of Finance. The assignment plans will identify the following:

- ✧ Job number and title
- ✧ Relevant Corporate/operational risks
- ✧ Relevant Director and responding officer
- ✧ Audit staff
- ✧ Start date and planned number of audit days required
- ✧ Scope, objectives and other instructions
- ✧ Target draft report date and target Audit & Risk Committee - key dates may be revised to take account of significant factors that impact on audit delivery timelines, such as the availability of key client and or audit staff.
- ✧ Standing Committee that will consider the report if applicable

5. Managing Audit Work

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

5.2 The Chief Internal Auditor will perform quality, performance measurement and liaison activities. This will include Chief Internal Auditor review of

Limited assurance audit and quality review processes. The Chief Internal Auditor shall be available to meet with the Director of Finance whenever required and at least bi-annually to discuss the service.

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

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

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

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

5.5 The Chief Internal Auditor is responsible for ensuring that the internal audit service is delivered according to the terms of this specification. The Chief Internal Auditor's responsibility broadly encompasses the following areas:

- ✧ Planning logical and comprehensive coverage that reflects the agreed degree of risk associated with each system
- ✧ Identifying and selecting resources and funding
- ✧ Monitoring delivery and quality assuring the products including compliance with GIAS
- ✧ Promoting the work of Internal Audit and the Audit & Risk Committee as a contribution to the control environment within the organisation
- ✧ Audit reporting
- ✧ Attendance at Audit and Risk Committees as appropriate and to present the Strategic Plan, Internal Control Evaluation and Annual report
- ✧ Promoting the Internal Audit Service to members and officers
- ✧ Managing and risk assessing requests for unplanned work

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

6. Reporting

6.1 The main purpose of Internal Audit reports is to provide management and the Audit and Risk Committee with information on significant audit findings, conclusions and recommendations. For full Internal Audit reviews of systems carried out as part of the identified Annual Audit Plan, Internal Audit will provide an opinion on the adequacy of internal controls within the

system, except where specified within the reporting protocol e.g. Financial Process Compliance, or reviews of known areas of weakness as requested by management etc.

6.2 The aim of every internal report should be to:

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

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

6.4 The Audit and Risk Committee should approve a formal follow-up protocol for ensuring that agreed Internal Audit recommendations have been actioned by management. This is incorporated as Appendix III to this Specification.

6.5 The Regional Audit Manager should ensure that reports are sent to managers who have a direct responsibility for the activity being audited and who have the authority to take action on the subsequent internal audit recommendations.

6.6 The distribution of reports by Internal Audit should be restricted to those individuals who need the information including members of the Audit and Risk Committee and the appointed external auditors. Except as required by law or as agreed within an approved output sharing protocol with Integration Joint Board (IJB) partners, documents should not be divulged to any other third party without the written express permission of the Director of Finance and/or Audit and Risk Committee.

Individual Audit Project Reporting

6.7 For each audit, the Internal Auditor shall prepare and submit a draft report of findings in a form agreed by the Audit and Risk Committee and Director of Finance. The reporting protocol shall be approved by the Audit and Risk Committee and incorporated as Appendix II to this document and shall include target timescales for issue and responding to Internal Audit reports.

Annual Audit Project Reporting

6.8 The principal reports to be produced by Internal Audit will be the Internal Control Evaluation (ICE) and the Annual Internal Audit Report for each audit year. The ICE is normally presented to the December / January Audit and Risk Committee and the Internal Audit Annual Report needs be prepared in time for submission to the Audit and Risk Committee not later than the agreed target date, in order to provide the assurance required in considering the Board's Annual Accounts. The Internal Audit Annual Report should contain:

- ✧ An opinion on whether:
- ✧ Based on the work undertaken, there were adequate and effective risk management, governance and internal controls in place throughout the year
- ✧ The Accountable Officer has implemented a governance framework in line

with required guidance sufficient to discharge the responsibilities of this role

- ✧ analysis of any changes in control requirements during the year
- ✧ comment on the key elements of the control environment
- ✧ summary of performance against this service specification
- ✧ progress in delivering the Quality Assurance Improvement Program.
- ✧ The summary of performance will include details of staffing and skill mix in addition to the other performance measures outlined in Appendix I.

Progress Reporting

6.9 The Director of Finance will receive regular progress reports, and performance reports specific to the client detailing progress against the agreed Annual Audit Plan together with notification of any significant breaches of the timescales within the approved reporting protocol. Progress reports will also be presented to each Audit and Risk Committee in a format agreed with the Client.

7. Quality Control and Quality Measurements

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

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

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

7.4 Internal Audit shall regularly report compliance with the GIAS to the Audit and Risk Committee, including the outcomes of any External and Internal Quality Assessments and progress in implementing any required actions.

Quality Questionnaire

7.5 A quality questionnaire will be issued to key contacts at the end of each audit review in a format agreed with the Internal Audit Partnership Board. The Chief Internal Auditor shall review these questionnaires, investigate any matters of concern and take appropriate remedial action where required. The results of the questionnaires should be reported annually to the Audit and Risk Committee within the Annual Internal Audit Report.

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

8. Liaison with External Audit

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

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

9. Best Value Reviews

9.1 The Scottish Public Finance Manual states that responsibility for Best Value rests with the Accountable Officer. Internal Audit will include review of Best Value arrangements, as part of the Annual Report fieldwork.

9.2 Where relevant, identification of cost savings will be a consideration in audit assignments.

10. Suspected Criminal Offences

10.1 CEL (2013)11, an update of CEL (2008) 03 “Strategy to Combat Financial Crime in NHS Scotland” sets out further requirements on Boards and the requirements of the Bribery Act (2010) that need to be met. Whilst the key messages from CEL 11 (2013) remain relevant, the introduction of the Counter Fraud Strategy 2023-26 and the Counter Fraud Standards will assess how effectively Health Boards tackle fraud, bribery and corruption.

10.2 Where the Client wishes to nominate the Internal Audit Service to fulfil the Fraud Liaison Officer (FLO)/Deputy FLO responsibilities as set out in the Fraud Action Plan and Partnership agreement, this will be reflected in the strategic and Annual Internal Audit Plan.

11. Freedom of Information

11.1 Fife NHS Board is subject to the Freedom of Information (Scotland) Act 2002 (the Act).

11.2 As part of our duties under the Act, the Board may publish some of the information clients provide to Internal Audit in its Freedom of Information publication scheme. In accordance with the 2002 Act the Board may disclose information to anyone who makes a request.

11.3 In all cases, wherever a request for information is received, the Client's nominated Freedom of Information contact point shall be notified in sufficient time to allow an informed decision to be reached without compromising our ability to comply with the timescales set out in the Act.

11.4 If the Client considers that any of the information supplied to us should not be disclosed due to its sensitivity then this should be stated giving reasons for withholding it. Internal Audit will consult with the Client and have regard to its comments or stated reasons for withholding information.

12. Staffing

12.1 The anticipated total number of audit days required per annum to carry out the Internal Audit Service for each client is set out in the Shared Service Agreement.

12.2 The Chief Internal Auditor shall allocate a sufficient number of employees, sufficiently qualified and experienced to ensure the Internal Audit Service is provided at all times and in all respects to this specification.

12.3 The Chief Internal Auditor shall ensure that every person employed or contracted by Internal Audit is at all times properly and sufficiently trained and instructed with regard to:

- ✧ GIAS
- ✧ all relevant provisions of this specification
- ✧ all relevant rules, procedures and standards of the organisation
- ✧ security
- ✧ patient confidentiality and relevant aspects of Information Governance

12.4 The Chief Internal Auditor shall co-ordinate and keep under review the continuing training requirements of all staff and report on these within performance reports.

12.5 For the purposes of this paragraph, staff are categorised as follows:

Chief Internal Auditor: member of CCAB Institute or CMIIA with experience equivalent to at least five years post-qualification experience and three years audit experience

Qualified: member of a CCAB Institute, the Chartered Institute of Internal Auditors (CIIA) or an alternative qualification agreed with the Director of Finance including specialist support e.g. computer audit (ITAC etc.) and Risk Management.

Non-Qualified Auditors: appropriately skilled staff including those training towards CCAB or CIIA or an appropriate alternative qualification.

12.6 Internal Audit shall maintain the skill mix of staff outlined in Appendix IV. Performance against this specified skill mix should be reported within the Internal Audit Annual Report.

12.7 Internal Audit shall be required to keep records detailing actual chargeable time spent on each audit and the name and qualification of staff.

12.8 NHS Fife shall be entirely responsible for the employment and conditions of service of FTF staff and FTF will be responsible for ensuring that:

- ✧ there are sufficient staff employed at the appropriate levels to fulfil the terms of the Shared Service Agreement

INTERNAL AUDIT SPECIFICATION
PERFORMANCE MEASURES

The following performance measures shall be monitored by Internal Audit, reported to the Internal Audit Partnership Board quarterly and included within the Annual Internal Audit Report, with comparative figures for the previous year.

		Target
1	Strategic/Annual Plan presented to Audit Committee by June 30th *[1]	**June**
2	Annual Internal Audit Report presented to Audit Committee by June	**June**
3	Audit assignment plans for planned audits issued to the responsible Director at least 2 weeks before commencement of audit	**75%**
4	Draft reports issued by target date	**75%**
5	Responses received from client within timescale defined in reporting protocol	**75%**
6	Final reports presented to target Audit Committee	**75%**
7	Number of days delivered against plan	**100%**
8	Number of audits delivered to planned number of days (within 10%)	**75%**
9	Skill mix	**50%**
11	Client satisfaction surveys	**Average score of 3 or above**
12	Annual client satisfactory survey completed by Chair of Audit and Risk Committee (score range 1 – 4)	**Average score of 3 or above**
13	Percentage of internal audit recommendations agreed with management	**75%**
14	Percentage of action plans followed up	**90%**
15	Number of training days per staff member	**Five days / annum**
16	Quality Questionnaires – percentage returned	**75%**
17	Number of meetings with Chief Executive / Chief Officer and Director of Finance / Chief Financial Officer per year	**Six**
18	Number of Audit and Risk Committee private sessions per year	**Two**

INTERNAL AUDIT SPECIFICATION
INTERNAL AUDIT REPORTING PROTOCOL & FLOWCHART

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

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

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

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

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

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

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

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

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

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

The recommendations will be added to the Audit Follow Up System by Internal Audit and validated progress on implementation of appropriate action reported to the Audit and Risk Committee.

All final audit reports may be presented to the ELT, relevant Standing Committee and, where appropriate, the IJB Audit and Assurance Committee.

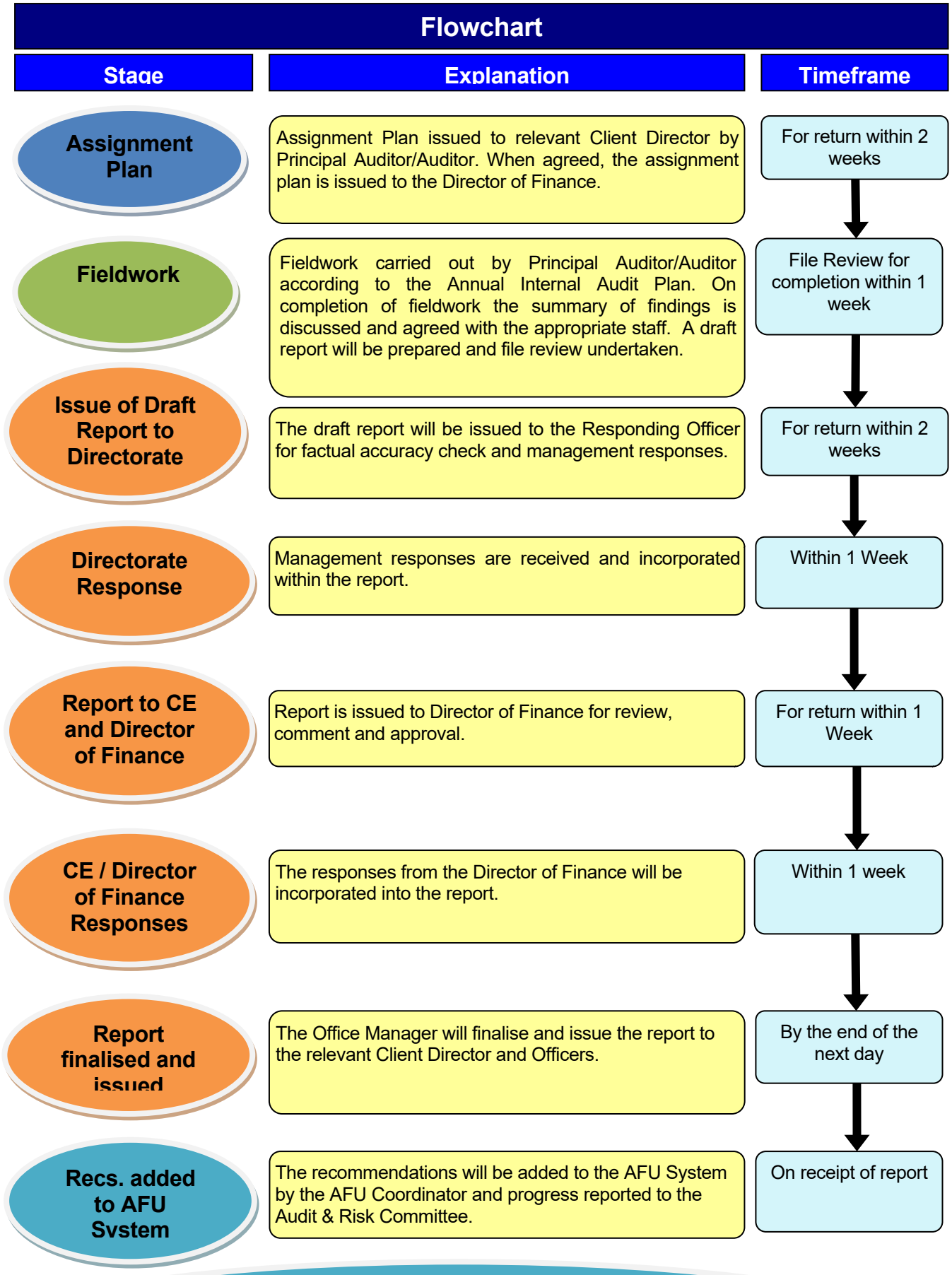
Dispute resolution

In the event of a failure to receive a timely response from the Responsible Director in relation to a draft report or assignment plan, or to reach agreement on a fundamental

recommendation, the matter will be referred to the Director of Finance and, if necessary, to the Chief Executive.

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

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


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

APPENDIX III

INTERNAL AUDIT SPECIFICATION

AUDIT FOLLOW UP PROTOCOL

INTERNAL AUDIT SPECIFICATION
AUDIT SERVICE

STAFFING SKILL MIX

For the purpose of paragraph 12.7, it is expected that at least 50% of the internal audit work shall be undertaken by qualified staff.

INTERNAL AUDIT SPECIFICATION
AUDIT SERVICE

GLOBAL INTERNAL AUDIT STANDARDS (GIAS)

Complete Global Internal Audit Standards

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

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**15 May 2025**
Title:	**Internal Audit Progress Report**
Responsible Executive:	**Jocelyn Lyall, Chief Internal Auditor**
Report Author:	**Barry Hudson, Regional Audit Manager**
	Jocelyn Lyall, Chief Internal Auditor

Executive Summary:

- Provide the Audit and Risk Committee with moderate assurance on the progress on the 2024/25 Internal Audit Plan.
- In addition, this report includes brief updates on the draft Internal Audit Plan for 2025-26, the External Quality Assessment (EQA), the Internal Audit Improvement Plan and the Internal Audit Framework, all of which are reported separately on the agenda. An update on the review of the Internal Audit Follow Up Protocol is underway.

1 Purpose

This report is presented for:

- Assurance
- Discussion

This report relates to:

- Local policy

This report 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:

- Moderate Assurance that the CIA's year end opinion on adequacy and effectiveness of internal controls will be provided through the 2024/25 ICE, the Annual Internal Audit Annual Report 2024/25 and the audits delivered during 2024/25.

2.2 Background

The internal audit year runs from May to April. Under the supervision of the Chief Internal Auditor the Internal Audit Team continues to progress the 2024/25 Internal Audit Plan. Audit work undertaken supports the Chief Internal Auditor's annual opinion on the Board's governance, risk management and internal controls.

The work of Internal Audit and the assurances provided by the Chief Internal Auditor in relation to internal control, risk management, and governance, are key assurance sources considered 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 published in the Board's Annual Accounts.

2.3 Assessment

Progress

The Internal Audit team continues to progress the 2024/25 plan, with remaining reviews to be reported to the September 2025 Audit and Risk Committee meeting.

Internal Audit Annual Plan for 2025/26

A draft audit plan for 2025/26 is included on the agenda for Committee consideration and approval. This is a separate agenda item.

External Quality Assessment (EQA)

The EQA final report of Internal Audit compliance with the Public Sector Internal Audit Standards (PSIAS) was issued on 4 March 2025 and shared with the FTF Partnership Board on 5 March 2025. The full EQA report is included on the reserved business agenda, in compliance with the Chartered Institute of Internal Auditors Disclaimer.

Internal Audit Improvement Action Plan

FTF have developed an improvement action plan based on a gap analysis against the Global Internal Audit Standards and the UK Public Sector Application Note and recommendations and suggested improvements from the March 2025 EQA report. This improvement action plan will be reported to and monitored by the Audit and Risk Committee until all actions are complete, with the improvement action plan as a separate agenda item.

Internal Audit Framework and Charter

The Internal Audit Framework, including the Charter and Mandate, has been updated to reflect both Global Internal Audit Standards, and outcomes from the EQA report. This is included as a separate agenda item.

Audit Follow Up

Progress on implementation by management of agreed internal audit actions is monitored by Internal Audit through the Audit Follow Up System and is reported regularly to the Audit and Risk Committee and the Executive Leadership Team. The May 2025 Audit Follow Up report is a separate agenda item.

This report provides the following Levels of Assurance:

	Significant	Moderate	Limited	None
Level		x		
Descriptor	There is robust assurance that the system of control achieves, or will achieve, the purpose that it is designed to deliver. There may be an insignificant amount of residual risk or none at all.	There is sufficient assurance that controls upon which the organisation relies to manage the risk(s) are suitably designed and effectively applied. There remains a moderate amount of residual risk.	There is some assurance from the systems of control in place to manage the risk(s), but there remains a significant amount of residual risk, which requires further action to be taken.	No assurance can be taken from the information that has been provided. There remains a significant amount of residual risk

2.3.1 Quality, Patient and Value-Based Health & Care

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

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 process to produce the Internal Audit Plan takes into account inherent and control risk for all aspects of the Internal 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. Legislative requirements are a core consideration in planning all internal audit reviews.

The risk 'Compliance with Internal Audit Framework and Global Internal Audit Standards' was updated on 22 April 2025.The risk is described as: 'There is a risk that internal audit may not comply fully with the Internal Audit Framework and the requirements of the Global Internal Audit Standards, applicable from 1 April 2025. The Internal Audit Framework comprises the Internal Audit Charter and Mandate, and the Specification for Internal Audit Services. This risk encompasses the requirement to:

- Take action to comply with the Global Internal Audit Standards during 2025/26.
- Take action to address the recommendations and suggested improvements set out in the March 2025 External Quality Assessment report.
- Ensure compliance with the Internal Audit Framework, specifically:
  - Delivery of the annual internal audit plan to allow the Chief Internal Auditor to provide their annual opinion.
  - Provision of assurance throughout the year
  - Achievement of quality and performance measures
  - Provision of an opinion to the Chief Executive as Accountable Officer for yearend assurance.

2.3.5 Equality and Human Rights, including children's rights, health inequalities and Anchor Institution ambitions

All internal audit reviews which involve review of policies and procedures, will check that an Equality and Diversity Impact Assessment has been completed. An impact assessment is not required for this report.

2.3.6 Climate Emergency & Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

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

2.3.8 Route to the Meeting

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

2.4 Recommendation

Members are asked to take a **"moderate" level of assurance** from the Internal Audit Progress Report.

3 List of appendices

The following appendices are included with this report:

Appendix A – Internal Audit Progress Report highlighting:

- 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
- A summary of Internal Audit Reports issued since the last Audit and Risk Committee.

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

FTF Internal Audit Service

Internal Audit Progress Report

Introduction

This report presents the progress of Internal Audit activity to 6 April 2025.

Internal Audit Activity

The following, with the audit opinion shown, has been issued since the last progress report to the Audit and Risk Committee on 13 March 2025.

NHS Fife Completed Audit Work

Audit 2024/25	Opinion on Assurance	Recommendations	Draft issued	Finalised
Corporate Governance				
B02/25 Audit Management & Liaison with Directors	Year End summary	N/A	6 May 2025	6 May 2025
B03/25 Liaison with External Auditors	Year End summary	N/A	6 May 2025	6 May 2025
B04/25 Audit and Risk Committee	Year End summary	N/A	6 May 2025	6 May 2025
B08/25 Board and Standing Committees	Year End summary	N/A	6 May 2025	6 May 2025
B09/25 Audit Follow Up	Year End summary	N/A	6 May 2025	6 May 2025
B10/25 External Quality Assessment	Generally Conforms	See Internal Audit Improvement Plan	14 January 2025	4 March 2025
B11/25 Structures of Assurance	Year End summary	N/A	6 May 2025	6 May 2025
B12/25 Risk Management	Year End summary	N/A	6 May 2025	6 May 2025
B14/25 Health and Social Care Integration	Year End summary	N/A	6 May 2025	6 May 2025

NHS Fife Draft Reports Issued

Audit 2024/25	Draft issued	Target Audit and Risk Committee
B17/25 Medicines Management	7 May 2025	18 September 2025

NHS Fife Work in Progress and Planned:

Audit 2024/25 and 2025/26		Status	Target Audit and Risk Committee
Governance and Assurance			
B10/26	Annual Report	Fieldwork	19 June 2025
B15/25	Operational Planning	Planning	18 September 2025
Clinical Governance			
B16/25	Public Health Committee	Planning	18 September 2025
B18/25	Recruitment	Fieldwork	18 September 2025
B20/25	Sickness Absence	Fieldwork	18 September 2025
B21 and 22/25	Financial sustainability and Savings	Planning	18 September 2025

Summary of Audit Findings

This section provides a summary of the findings of internal audit reviews concluded since the March 2025 Audit and Risk Committee.

B02/25 Audit Management & Liaison with Directors	**Year End summary**
Regular meetings were held with the Director of Finance and Strategy, Deputy Director of Finance and Head of Financial Services and Procurement and meetings were held with other Directors to discuss audit issues throughout the year.	

B03/25 Liaison with External Auditors	**Year End summary**
Ongoing liaison and sharing of audit reports with Azets.	

B04/25 Audit and Risk Committee	**Year End summary**
Internal Audit attended all Audit and Risk Committees and prepared required papers. Chief Internal Auditor provided a presentation on the role of internal audit to the Committee on 25 April 2025.	

B08/25 Board and Standing Committees	**Year End summary**
Internal Audit reviewed minutes and papers to inform our opinion on the control environment. Internal Audit have provided advice and assistance to officers and Board members on the following areas during 2024-25, including: • Input into Board and non-executive development events • Assurance mapping and risk advice • Attendee at the Risk and Opportunities Group and provision of advice • Attendee to Information Governance and Security Steering Group and the Digital & Information Board and provision of advice.	

B09/25 Audit Follow Up	**Year End summary**
Internal Audit provided reports detailing the Audit Follow Up Position to the Audit and Risk Committee on four occasions throughout 2024/25. Throughout the year, we liaised with officers to obtain meaningful updates on ongoing audit recommendations; obtained evidence to support the reported progress and completed validation checks to ensure the information provided to the Audit and Risk Committee is accurate and to provide assurance that appropriate action has been taken. We highlighted to the Audit and Risk Committee outstanding actions where the risk to the organisation merits particular attention, and where actions have been outstanding for more than one year. Audit Follow Up reporting includes progress on actions from Annual and Internal Control Evaluation reports.	

B10/25 External Quality Assessment	**Level of assurance: Generally Conforms**
See Reserved Business for the Full Report.	

B11/25 Structures of Assurance	**Year End summary**
Within B07/25 Internal Control Evaluation assurance structures and compliance with assurance principles was a key consideration.	

B12/25 Risk Management	**Year End summary**
Independent evaluation of the development of risk management arrangements was provided through the Internal Control Evaluation and will be further reported through the Internal Audit Annual Report 2024/25. We attend the Risk and Opportunities Group and have provided advice and feedback as the Risk Management Framework evolves, including advice on deep dives, Corporate Risk Register, risk descriptions, current risk exposure ratings and review of target risks.	

B14/25 Health and Social Care Integration	**Year End summary**
Internal Audit have provided the lead auditor service for Fife IJB. All IJB reports are shared with the NHS Fife Audit and Risk Committee as part of the Output Sharing Protocol once they have been considered by the relevant IJB Audit Committee.	

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**15 May 2025**
Title:	**Internal Audit – Follow Up Report on Audit Recommendations 2024/25**
Executive Lead:	**Jocelyn Lyall, Chief Internal Auditor**
Report Author:	**Barry Hudson, Regional Audit Manager** **Andy Brown, Principal Auditor**

Executive Summary:

- Management continues to implement actions to address internal audit recommendations.
- Overall, there are just five recommendations remaining from reports published more than 12 months ago. We are content that the approved revised target implementation dates are reasonable.
- This paper is provided to members for:
  - **Assurance** – This report provides a **Moderate** Level of Assurance on the progress being made in implementing actions to address recommendations made in internal audit reports.
  - **Discussion** – Consider the status of Internal Audit recommendations recorded within the AFU system.

1 Purpose

This report is presented for:

- Assurance
- Discussion

This report relates to:

- Legal requirement

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

Good practice guidance, as laid out in the Audit and Assurance 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.

The Blueprint for Good Governance in NHS Scotland (second edition) includes the following guidance regarding the follow-up of actions to address internal audit recommendations:

> *'It is important that the Audit and Risk Committee adopt a robust approach to the oversight of the completion of actions identified in the audit reports. Where possible, actions should be dealt with in the current financial year rather than being carried forward from one financial year to the next. Any exceptions to this should be closely scrutinised by the Audit and Risk Committee who should seek assurance that the timeline proposed for addressing the risks or issues identified by the auditors is both reasonable and achievable.' [Section D13 – page 59]*

2.2 Background

The Executive Leadership Team consider the progress on internal audit actions in line with the Audit Follow Up (AFU) protocol with Directors being reminded of the need to ensure good progress is made in clearing outstanding issues.

External Audit recommendations are followed up by the NHS Fife Finance Directorate and Internal Audit continue to review progress against External Audit recommendations where relevant to internal audit fieldwork.

Internal Audit validate the evidence supplied by responding officers for internal audit actions they have reported as complete, to confirm that those actions address the recommendations made.

Where an action is reported by the Responsible Officer as delayed, the AFU Protocol dictates that a reason for the delay must be provided, and the proposed extension is subject to approval as follows:

Finding/Recommendation Assessment of Risk	**1st Extension Approval**	**2nd Extension Approval**	**Subsequent Extension Approvals**
Merits Attention	Internal Audit	Executive Director	Director of Finance or CEO
Moderate	Executive Director	Director of Finance or CEO	
Significant	Director of Finance or CEO		
Fundamental	Director of Finance or CEO		

The tables and graphs included clearly show the actions related to recommendations that were reported more than one year ago, so that particular attention can be focussed on clearing these.

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, including ICE and Annual Report recommendations, at 30 April 2025, with comparable figures from the last Audit Follow-Up (AFU) report at 13 February 2025 (Ext = Extended, O/S = Outstanding, and NYD = Not Yet Due).

	Apr 2025			Feb 2025		
Remaining Actions	**18**			**30**		
	Ext	O/S	NYD	Ext	O/S	NYD
Recommendations more than 1 year (*Appendix C)*	4	0	0	3	1	0
Recommendations less than 1 year	11	0	5	2	12	12

Progress summary

The following reports have been removed from the follow-up process since the last follow-up report was presented:

Report Removed	Reason
B08/24 ICE 2023/24	All actions completed and validated or superseded.
B24/24 Patients' Funds	All actions completed and validated.
B06/25 Annual Report 2023/24	All actions completed and validated.

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 E records actions where we have concluded that 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 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.

Appendices C and D provide detailed information on progress with all remaining recommendations that have had their target implementation date extended. Appendix C includes those that are **more** than a year old and Appendix D includes those that have a fundamental or significant priority and are **less** than a year old.

This report provides the following Level of Assurance:

	Significant	Moderate	Limited	None
Level		X		

Descriptor	There is robust assurance that the system of control achieves, or will achieve, the purpose that it is designed to deliver. There may be an insignificant amount of residual risk or none at all.	There is sufficient assurance that controls upon which the organisation relies to manage the risk(s) are suitably designed and effectively applied. There remains a moderate amount of residual risk.	There is some assurance from the systems of control in place to manage the risk(s), but there remains a significant amount of residual risk, which requires further action to be taken.	No assurance can be taken from the information that has been provided. There remains a significant amount of residual risk

2.3.1 Quality, Patient and Value-Based Health & Care

The Institute of Healthcare Improvement Triple Aim (Better population health, better quality of patient care, financially sustainable services) is a framework that describes an approach to optimising health system performance and 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 process to produce the Internal Audit Plan considers inherent and control risk for all aspects of the Internal 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. Legislative requirements are a core consideration in planning all internal audit reviews.

The risk 'Compliance with Internal Audit Framework and Global Internal Audit Standards in the UK Public Sector' was updated on 22 April 2025.The risk is described as: 'There is a risk that internal audit may not comply fully with the Internal Audit Framework and the requirements of the Global Internal Audit Standards, applicable from 1 April 2025. The Internal Audit Framework comprises the Internal Audit Charter and Mandate, and the Specification for Internal Audit Services. This risk encompasses the requirement to:

- Take action to comply with the Global Internal Audit Standards during 2025/26.
- Take action to address the recommendations and suggested improvements set out in the March 2025 External Quality Assessment report.
- Ensure compliance with the Internal Audit Framework, specifically:
  - Delivery of the annual internal audit plan to allow the Chief Internal Auditor to provide their annual opinion.
  - Provision of assurance throughout the year
  - Achievement of quality and performance measures
  - Provision of an opinion to the Chief Executive as Accountable Officer for yearend assurance.

2.3.5 Equality and Human Rights, including children's rights, health inequalities and Anchor Institution ambitions

All internal audit reviews which involve review of policies and procedures, will check that an Equality and Diversity Impact Assessment has been completed. An impact assessment is not required for this report.

2.3.6 Climate Emergency & Sustainability Impact

Not applicable.

2.3.7 Communication, involvement, engagement and consultation

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

2.3.8 Route to the Meeting

Not applicable.

2.4 Recommendation

This paper is provided to members for:

- **Assurance** – This report provides a "**moderate" level of assurance** on the progress being made in implementing actions to address recommendations made in internal audit reports.
- **Discussion** – Consider the status of Internal Audit recommendations recorded within the AFU system.

3 List of appendices

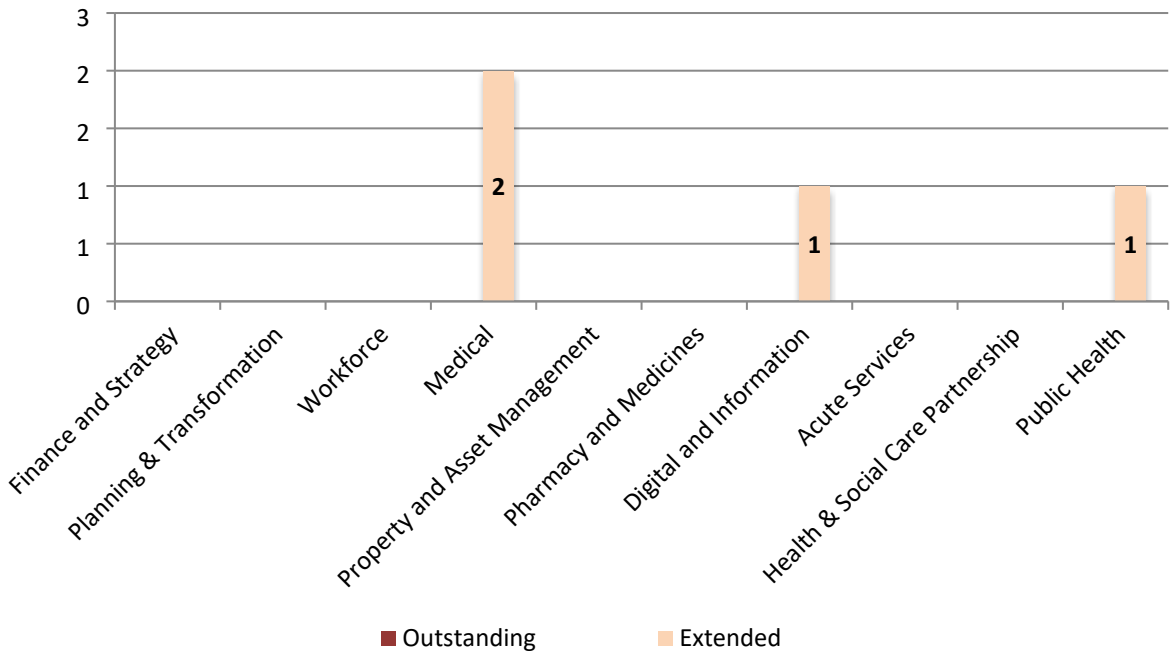
The following appendices are included with this report:

Report Contact

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

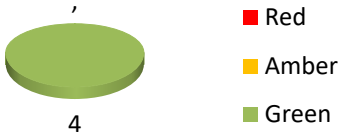
Recommendations More Than 1 Year

Outstanding and Extended by Directorate

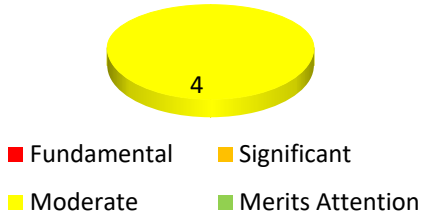


Extended Recommendations RAG Status and Priority

RAG Status

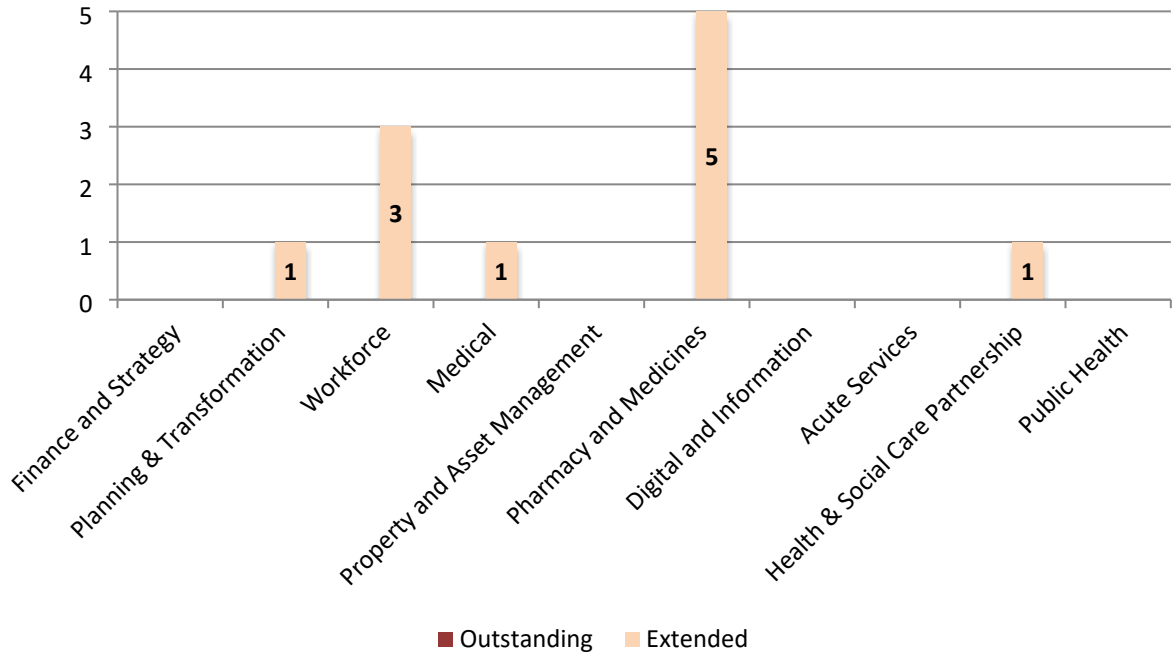


Priority

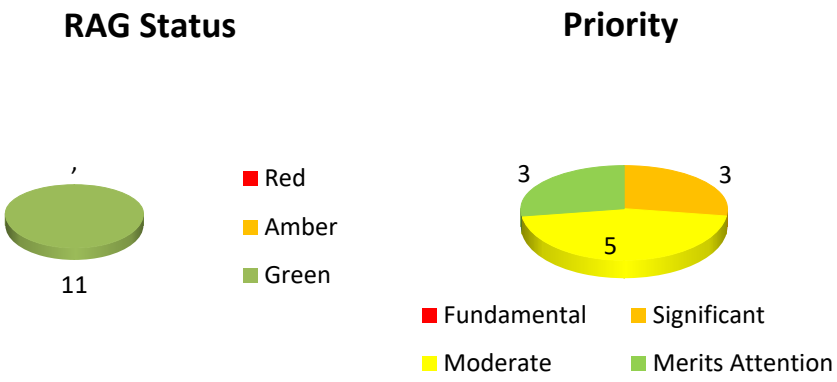


Recommendations Less Than 1 Year

Outstanding and Extended by Directorate



Extended Recommendations RAG Status and Priority



Internal Audit Reports with Remaining Actions	Date of Issue	Total Recs.	Complete	Superseded	Remaining		Extended	Outstanding	Not Yet Due		Not Validated
2022/23											
B13/23 Business Continuity Arrangements	Feb-24	5	4	0	1		1	0	0		-
B17/23 Workforce Planning	May-24	8	2	1	5		3	0	2		-
2022/23 Totals		**13**	**6**	**1**	**6**		**4**	**0**	**2**		**0**
2023/24											
B06/24 Annual Report – 2022-23	Jun-23	11	8	0	3		3	0	0		-
B20A/24 Follow-up of B21/20 Transport of Medicines	May-24	6	1	0	5		5	0	0		-
2023/24 Totals		**17**	**9**	**0**	**8**		**8**	**0**	**0**		**0**
2024/25											
B07/25 ICE – 2024-25	Jan-25	9	4	1	4		3	0	1		-
B13/25 Environmental Management	Mar-25	3	1	0	2		0	0	2		-
2024/25 Totals		**12**	**5**	**1**	**6**		**3**	**0**	**3**		**0**
Overall Totals (Actions from reports where recommendations remain unaddressed)		**42**	**20**	**2**	**20**		**15**	**0**	**5**		**0**

Report	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
2022/23 Extended							
B13/23 **Business Continuity Arrangements**	**5**	**M**	Review and revision of the NHS Fife Corporate Business Continuity Policy	**Head of Resilience** **Director of Public Health**	~~31 Oct 24~~ 31 Jul 25		Extension required to allow time for the agreed draft Business Continuity Planning Policy to be approved by the General Policies Group & be published on Stafflink.
2023/24 Extended							
B06/24 **Internal Audit Annual Report 2022/23**	1a	M	Greater use of risk appetite in decision making at standing committees.	**Associate Director for Risk and Professional Standards** **Medical Director**	~~31 Mar 24~~ ~~30 Sep 24~~ ~~31 Mar 25~~ 30 Sep 25		The Board's revised Risk Appetite was agreed in November 2024. Further time is required to allow the use of this appetite in practice to be evident in Board/Committee papers and minutes. Following discussions with responsible officers the due dates have been extended.

Report	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
	1b	M	Risk Management Deep Dive reports to include further analysis including: • further assessment as to which key management actions will impact on the target score with success criteria stated. • focusing only on key controls and providing overt assurance and an overt conclusion on the effectiveness of implemented controls. • assessing the proportionality of proposed actions and whether they should be sufficient to achieve the target score.	**Associate Director for Risk and Professional Standards** **Medical Director**	~~31 Mar 24~~ ~~30 Sep 24~~ ~~31 Mar 25~~ 30 Sep 25		This is not yet fully in place but the format of the deep dives is currently being reviewed. Following discussions with responsible officers the due dates have been extended.
	6b	M	Resource & financial assessment regarding the likelihood of the revised D&I Strategy being delivered within the stated timescale and the risks associated with non-delivery.	**Director Digital & Information**	~~31 Jul 24~~ ~~31 Jan 25~~ 30 Nov 25		The timescale for the development of the D&I Strategy (now D&I Framework) has been changed and a date for presentation of the framework to Fife NHS Board is to be determined. It is scheduled to be presented to the Clinical Governance Committee on 29 August 2025.
Total > 1 Year Extended	**4**						

Report	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
Year- Extended							
Only actions associated with recommendations that are considered Fundamental or Significant will be included in this section (ie actions that have implementation dates within 12 months from their publication that have been extended or are outstanding).							
2022/23 Extended							
B17/23 Workforce Planning	1	S	Risk Management Revision to the Deep Dive for the Workforce Planning and Delivery Risk.	**Head of Workforce Planning & Staff Wellbeing** **Board Workforce Planning Lead** **Director of Workforce**	~~31 Oct 24~~ 31 May 25		Extended pending approval from the Workforce Director and the Director of Finance to allow the presentation of the full risk review to the Staff Governance Committee on 13 May 2025.
2024/25 Extended							
B07/25 2024/25 ICE	1	S	2025/26 RTP plans based on realistic & validated data & lessons learned. 2025/26 RTP reporting format to be revised to include recommended content. Review of RTP workstreams to confirm their continued relevance for carry forward to 2025/26.	**Director of Planning & Transformation**	~~31 Mar 25~~ 30 Nov 25		Extended to allow time for the 2025/26 RTP plans to be developed and for these, and subsequent delivery monitoring reports, to be presented to the relevant standing committee(s) of the Board. Timing to allow two quarters of data to be reported so that the realistic transparent and proportionate reporting can be demonstrated.

Report	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
	3	S	Improvements to risk management related to Mental Health Risks.	**Director of Health & Social Care** **Head of Complex and Critical Care**	~~31 Jan 25~~ 31 Jul 25		The Mental Health Risk Register has been reviewed and the Mental Health Oversight Program Board has been established. Extension required to allow time for the potential addition of a Mental Health Risk to the NHS Fife Corporate Risk Register to be considered by the Mental Health Oversight Program Board.
Year Extended							
Total < 1 Year	**3**						

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*]
For this reporting cycle there were no recommendations where Internal Audit required further evidence from the validation process.						

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 C**)
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
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 E**)

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 & Risk Committee**
Meeting date:	**15 May 2025**
Title:	**Risk Management Annual Report**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
Report Author:	**Dr Shirley-Anne Savage, Associate Director for Risk and Professional Standards**

Executive Summary:

- This paper presents the draft Risk Management Annual Report for assurance.
- The Annual Report forms a component of the governance reporting arrangements for risk management in accordance with the NHS Fife Code of Corporate Governance.
- The Annual report confirms that adequate and effective risk management arrangements were in place throughout the year. It describes progress against key deliverables within the risk management improvement programme
- This report provides a moderate Level of Assurance.

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Local policy
- NHS Fife Board Strategic Priorities
  - To Improve Quality of Health & Care Services
  - To Deliver Value and Sustainability
  - To Improve Health & Wellbeing
  - To Improve Staff Experience and Wellbeing

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This paper provides ARC with the draft Risk Management Annual Report and gives an overview of the risk management activity undertaken during the period 2024-2025.

2.2 Background

The Annual Report forms a component of the governance reporting arrangements for risk management in accordance with the NHS Fife Code of Corporate Governance.

2.3 Assessment

The Annual report confirms that adequate and effective risk management arrangements were in place throughout the year. It describes progress against key deliverables within the risk management improvement programme approved in 2022, intended to enhance the effectiveness of our risk management framework arrangements.

In summary, improvement of the operational risk management approach including:

- Completing the refresh of the Risk Management Framework
- Refining risk management processes
- Reviewing and updating of the Board risk appetite statement
- Improving the content and presentation of risk management reports
- Supporting the continuing development of assurance reporting
- Reviewing the Board Strategic Risk Profile

The ARC are asked to take a moderate level of assurance.

This report provides the following Level of Assurance:

	Significant	Moderate	Limited	None
Level		x		
Descriptor	There is robust assurance that the system of control achieves, or will achieve, the purpose that it is designed to deliver. There may be an insignificant amount of residual risk or none at all.	There is sufficient assurance that controls upon which the organisation relies to manage the risk(s) are suitably designed and effectively applied. There remains a moderate amount of residual risk.	There is some assurance from the systems of control in place to manage the risk(s), but there remains a significant amount of residual risk, which requires further action to be taken.	No assurance can be taken from the information that has been provided. There remains a significant amount of residual risk

2.3.1 Quality, Patient and Value-Based Health & Care

Elevating the profile of risk management in NHS Fife will further support delivery of our strategic priorities through improved operational governance and better alignment with the Population Health and Wellbeing Strategy and associated work streams.

2.3.2 Workforce

Effective management of workforce risks will support staff health and wellbeing, and the quality of health and care services.

2.3.3 Financial

This paper does not raise, directly, financial impacts, but these do present significant elements of risk for NHS Fife to consider and manage in pursuit of our strategic priorities.

2.3.4 Risk Assessment / Management

Focus of the paper

2.3.5 Equality and Human Rights, including children's rights, health inequalities and Anchor Institution ambitions

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

2.3.6 Climate Emergency & Sustainability Impact

This paper does not raise, issues relating to climate emergency and sustainability

2.3.7 Communication, involvement, engagement and consultation

This paper reflects the input of the Risks and Opportunities Group.

2.3.8 Route to the Meeting

ELT – 24 April 2025

The report reflects the results of engagement in 2024/25 including with the following:

- Director of Finance and Strategy
- Executive Directors Group
- Governance Committees
- Fife NHS Board
- Internal Audit Team
- Risks and Opportunities Group
- Senior Leadership Teams
- Operational Teams

2.4 Recommendation

Members are asked to take a **"moderate" level of assurance** from the report.

3 List of appendices

- Appendix No. 1, Draft Risk Management Annual Report

Report Contact
Dr Shirley-Anne Savage**,** Associate Director for Risk and Professional Standards
Email shirley-anne.savage@nhs.scot

NHS Fife

Draft Annual Risk Management Report 2024-2025

www.nhsfife.org

Contents

1. Introduction

NHS Fife is committed to embracing and further developing an organisational culture which recognises the role and contribution of risk management in supporting decision making, strategic planning, and capitalising on opportunities to change in line with our ambitions, aspirations and capabilities.

This commitment is based on our core values of care, compassion, dignity and respect, openness, honesty and responsibility quality and teamwork.

During 2024/25 several initiatives have been implemented to improve the effectiveness of the risk management framework within NHS Fife. This report provides a summary of the activities undertaken and confirms that adequate and effective risk management arrangements were in place throughout the year.

2. Risk Management in 2024/2035

The Director of Finance provided strategic leadership and direction for risk management in NHS Fife during 2024/25.

The Audit & Risk Committee has responsibility for evaluating the overall effectiveness of the risk management arrangements reviewing and challenging how these are operating across the organisation.

During 2024/25, Internal Audit have continued to support the development of the risk management arrangements through constructive challenge and recommendations on specific elements of this work.

3. Risk Appetite

There was recognition that the risk appetite required to be reviewed, with the Board's previous risk appetite being set in July 2022. A dedicated Board Development Session on risk appetite was held in April 2024, followed by a second in June 2024.

This provided opportunity to discuss and reflect on the Board's appetite and consider the changes required in terms of both the risk appetite descriptors, and the levels of risk the Board is prepared to tolerate in the pursuit of its strategic priorities, especially delivery of the Population Health & Wellbeing Strategy. This was particularly relevant as the Board responded and adapted to the challenging financial outlook with new 'Re-form, Transform, Perform' Framework. The new risk appetite statement was agreed by the Board at its meeting in November 2024.

The Corporate Risk papers presented to each standing committee state if risks are within or outwith risk appetite and the reason for that position. Many of the corporate risks are currently outwith risk appetite which reflects the ongoing level of demand across all services

within the increasingly challenging financial environment. In line with the focussed work on risk appetite, consideration will be given in the year ahead to the Internal Audit recommendation on how to capture greater detail on how the risk appetite will affect strategy, decision-making, prioritisation, budget setting and organisational focus.

4. Risk Management Framework

The finalised Risk Management Framework, incorporating the new risk appetite statement, was presented to the Audit & Risk Committee in December 2024 and approved by the Fife NHS Board in January 2025. At the time of writing, work on a Delivery Plan for 2025/26 to support implementation is currently underway.

5. Corporate Risk Register

The corporate risks collectively outline the organisational risks associated with the delivery of the Board's Population Health & Wellbeing Strategy. It is recognised that all risks on the corporate risk register are impacted by and are aligned to the Strategy. All corporate risks are reviewed regularly and reported bi-monthly to the governance committees and twice a year to the Board.

During Financial Year 2024/25, developments of note in relation to corporate risks include the following:

Risks Closed

Optimal Clinical Outcomes: Following consideration of an updated deep dive review at the Clinical Governance Committee's meeting in March 2024, there was further discussion through the Risks and Opportunities Group on whether it was appropriate to close the risk and develop a revised risk or risks. Following this and further discussion at the Clinical Governance Oversight Group, the recommendation was made to the Executive Directors' Group in September 2024 to close the risk and reframe a new risk.

Offsite area Sterilisation and Disinfection Unit Service: This risk was removed from the Corporate Risk Register in November 2024 and moved onto an operational risk register held by Acute Services and the Director of Property & Asset Management.

Risks Opened

Pandemic Preparedness / Biological Threats: A report and an initial deep dive review were progressed through the Public Health Assurance Committee and the Executive Directors' Group in March / April 2024. This review was agreed at the May 2024 Board and the risk now sits under the Director of Public Health and the Board's Public Health & Wellbeing Committee.

Capital Funding - Service Sustainability: The creation of a new risk in this area was approved by the Executive Directors' Group in May 2024 and this is now included on the Corporate Risk Register, aligned to Finance, Performance & Resources Committee.

Potential Risks

A number of new potential corporate risks have been discussed for adoption:

Hospital Acquired Harm: Hospital Acquired Harm is a new risk intended to replace the closed Optimal Clinical Outcomes Risk. A draft deep dive was presented for consideration to the Clinical Governance Committee in March 2025.

Substance Related Morbidity and Mortality: Following a direction by the Public Health & Wellbeing Committee, a deep dive was assigned to a small team to ascertain the need for a specific NHS Fife risk with regards to deaths from drugs use. This aims to identify aspects of strategy, policy and delivery within the Board where there is a relevance pertaining to the prevention of drug-related deaths and to recommend actions that reduce the likelihood and consequence. The deep dive has progressed through the Risks & Opportunities Group, the Public Health Assurance Committee and the Public Health & Wellbeing Committee.

Oral Health: The Board's Public Health & Wellbeing Committee has suggested that a specific high-level corporate risk be considered regarding access to general dentistry across Fife. This risk has recently been created, is under review by the Primary Care Governance & Strategy Oversight Group and will be considered by the Public Health & Wellbeing Committee in May 2025.

The table below shows the risk score for each of the corporate risks from April to December 2024 against the target score and against the current risk appetite. Of the 20 open risks (including Substance related Morbidity and Mortality and Hospital Acquired Harm), there are still a significant number above risk appetite (2 are below risk appetite, 8 within risk appetite and 10 above risk appetite).

Risk Title	Target Score	Current Score	Dec 2024	Oct 2024	Aug 2024	June 2024	April 2024	Risk Appetite
1. Population Health & Wellbeing Strategy	12	12	12	12	12	12	12	Below
2. Health Inequalities	16	16	20	20	20	20	20	Within
4. Policy obligations in relation to environmental management and climate change	10	12	12	12	12	12	12	Below
5. Optimal Clinical Outcomes	10	N/A	N/A	15	15	15	15	Within
6. Whole System Capacity	16	20	20	20	20	20	20	Above
7. Access to outpatients, diagnostic and treatment services	16	20	20	20	20	20	20	Above
8. Cancer Waiting Times	12	15	15	15	15	15	15	Within
9. Quality & Safety	6	12	12	12	12	12	12	Within
10. Primary Care Services	12	16	16	16	16	16	16	Above
11. Workforce Planning and Delivery	8	16	16	16	16	16	16	Above
12. Staff Health and Wellbeing	8	16	16	16	16	16	16	Above
13. Delivery of a balanced in year financial position	25	25	25	25	25	25	16	Above
14. Delivery of recurring financial balance over the medium-term	20	25	25	25	25	25	16	Above
15. Prioritisation and management of capital funding	8	12	12	12	12	12	12	Within
16. Off-site area sterilisation and disinfection unit service	6	N/A	N/A	12	12	12	12	Within
17. Cyber resilience	12	16	16	16	16	16	16	Above
18. Digital and Information	12	15	15	15	15	15	15	Within
19. Implementation of Health and Care (Staffing) (Scotland) Act 2019 [HCSA]	9	9	9	9	12	12	12	Within
20. Reduced Capital Funding	12	20	20	20	20	N/A	N/A	Above
21. Pandemic Risk	20	20	20	20	N/A	N/A	N/A	Within
22. Hospital Acquired Harm	12	15	N/A	N/A	N/A	N/A	N/A	Within
23. Substance Related Morbidity and Mortality	15	20	N/A	N/A	N/A	N/A	N/A	Within

6. Strategic Risk Profile

The Strategic Risk Profile, as a dashboard set in the context of the Board's risk appetite, continues to be reported in the monthly Board Integrated Performance & Quality Report.

The full Profile is part of the introductory Corporate Risk Summary section. Extracts related to specific strategic priorities are contained within the Assessment section against the following areas of performance - clinical governance; operational; finance; staff governance; and public health and wellbeing.

7. Assurance Levels

We continue to use the four-levels of assurance model, and this continues to add consistency to our reporting. The use of the assurance levels continues to evolve, as we seek to enhance the evidence to substantiate the level of assurance being offered.

Reports to the governance committees include a statement on the latest position in relation to the management of risks linked to the respective committees, the proposed 'level' of assurance that members can take from the report and detail on mitigating actions.

8. Deep Dive Reviews

Corporate Risk Deep Dive reviews continue to form an important component of our risk assurance arrangements and provide a focus for in-depth discussion and scrutiny.

A key characteristic of a risk deep dive review is that it should be carried out at specific points during the life cycle of a risk. Criteria for undertaking a deep dive review have been agreed and include the creation of a new corporate risk, materially deteriorating risks, or the proposed de-escalation / closure of a corporate risk.

The requirement for a deep dive continues to be determined through the Executive Directors' Group and the Risks & Opportunities Group.

9. Risks & Opportunities Group

The Risks & Opportunities Group was established in September 2022 and supports and embeds an effective risk management framework and culture across the organisation. The Group meet bi-monthly to support the continued development of an effective and consistent approach to the management of operational risk, as well as the ongoing consideration of enhancements to the corporate risk management approach.

The Group has reviewed and updated its Terms of Reference, with the most recent iteration approved in August 2024. At each meeting the Risks & Opportunities Group reviews progress against its Annual Workplan, considers issues for escalation, and receives reports on any other relevant business. The Risks & Opportunities Group has reported on its work to the Audit & Risk Committee in September 2024 and in March 2025.

During 2024/25, the Group's work has included:

- Supporting the development and updates of the Risk Management Framework
- Continuing to inform and support the developments and improvements in relation to the Corporate Risk Register, recommendations on changes or additions to the corporate risks and the broader organisational risk profile, assurance levels and deep dive reviews
- Contributing to the development of a Risk Summary Dashboard and guidance to support and enhance our operational risk management approach and maintain alignment to the principles outlined within the Risk Management Framework
- Reviewing the Risk Assessment Matrix and considering the need for updates to descriptors and terminology, taking account of similar work nationally
- Considered the development of meaningful Key Performance Indicators that could be implemented to demonstrate active risk management.

The Group has undertaken a self-assessment of its own effectiveness, which has been considered at its meeting in April 2025 and thereafter will be reported to the Audit & Risk Committee in May 2025. The assessment covers elements including membership and group dynamics, role clarity and expectations, effectiveness of the scrutiny and challenge function, management of the agenda and impact of the Group in terms of outputs, as well as suggested actions to further improve the Group's effectiveness in respect of delivering its remit.

The Risks & Opportunities Group has developed a workplan for 2025/26 that will drive efforts to further develop a positive and proactive approach to risk management across the organisation.

10. Risk Management System

Datix remains the repository for risks, incidents (adverse events), safety alerts, complaints and claims within NHS Fife. It was previously reported that Datix Cloud IQ was the preferred upgrade path from DatixWeb and that a business case was being developed for NHS Fife. The development of the business case was suspended following a request to all NHS Boards from National Procurement to pause, pending the outcome of a tendering exercise which may lead to a Once for Scotland digital system. The outcome of that exercise was that a new system called Inphase has been awarded the national tender and work is underway within NHS Fife to assess the new system with a view to its adoption.

11. Risk Management Objectives 2024/25

During 2024/25 the Associate Director for Risk and Professional Standards continued to engage with the Executive Directors, Committee Chairs and the Board, and consider the support requirements to develop our risk management arrangements in order to enhance organisational risk maturity.

During 2024/25 the Director of Finance was the Executive Lead for Risk Management and reported on all of the above to the Audit & Risk Committee. From 2025/26, the Executive Lead for risk will move to the Medical Director.

Developments for the forthcoming year will focus on continual improvement of the operational risk management approach including those suggested by Internal Audit.

This will include:

- Continuing to refine risk management processes
- Implementing risk management key performance indicators
- Continuing to enhance the content and presentation of risk reports
- Supporting the continuing development of assurance reporting
- Further develop a risk management training programme for staff according to their roles and responsibilities

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NHS Fife
Hayfield House
Hayfield Road
Kirkcaldy, KY2 5AH

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Meeting:	**Audit and Risk Committee**
Meeting date:	**15 May 2025**
Title:	**Corporate Risk Register**
Responsible Executive:	**Dr Christopher McKenna, Medical Director, NHS Fife**
Report Author:	**Dr Shirley-Anne Savage, Associate Director for Risk and Professional Standards, NHS Fife**

Executive Summary

- The report highlights a number of updates to existing risks and also reflects potential risks emerging in the system.
- Hospital Acquired Harm was considered at the last meeting with Substance Related Morbidity and Mortality circulated afterwards. The deep dive for Oral Health is here for consideration by the committee. Agreement is sought for all three new risks to go forward to the May Board meeting for adoption.
- This report provides the latest position in relation to the management of corporate risks. Members are asked to take a **"moderate" level of assurance** that, all actions, within the control of the organisation, are being taken to mitigate the risks as far as is possible to do so.

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Annual Delivery Plan
- Emerging issue
- Local policy
- NHS Board / IJB Strategy or Direction / Plan for Fife
- NHS Fife Board Strategic Priorities
    - To Improve Quality of Health & Care Services
    - To Deliver Value and Sustainability
    - To Improve Health & Wellbeing
    - To Improve Staff Experience and Wellbeing

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This paper provides an update on the Corporate Risk Register since the last report to the Committee on 13 March 2025. The information reflects the risks being reported through the May 2025 round of governance committee meetings.

2.2 Background

The Corporate Risk Register aligns to the 4 strategic priorities. The format is intended to prompt scrutiny and discussion around the level of assurance provided on the risks and their management.

2.3 Assessment

The corporate risks are summarised in Table 1 below and at Appendix 1.

Risk Title	Target Score	Current Score	Feb 2025	Dec 2024	Oct 2024	Aug 2024	June 2024	April 2024	Risk Appetite
1. Population Health & Wellbeing Strategy	12	12	12	12	12	12	12	12	Below
2. Health Inequalities	16	16	16	20	20	20	20	20	Within
4. Policy obligations in relation to environmental management and climate change	10	12	12	12	12	12	12	12	Below
6. Whole System Capacity	16	20	20	20	20	20	20	20	Above
7. Access to outpatients, diagnostic and treatment services	16	20	20	20	20	20	20	20	Above
8. Cancer Waiting Times	12	15	15	15	15	15	15	15	Within
9. Quality & Safety	6	12	12	12	12	12	12	12	Within
10. Primary Care Services	12	12	16	16	16	16	16	16	Within
11. Workforce Planning and Delivery	8	16	16	16	16	16	16	16	Above
12. Staff Health and Wellbeing	8	16	16	16	16	16	16	16	Above
13. Delivery of a balanced in year financial position	25	25	25	25	25	25	25	16	Above
14. Delivery of recurring financial balance over the medium-term	20	25	25	25	25	25	25	16	Above
15. Prioritisation and management of capital funding	8	12	12	12	12	12	12	12	Within
17. Cyber resilience	12	16	16	16	16	16	16	16	Above
18. Digital and Information	12	15	15	15	15	15	15	15	Within
19. Implementation of Health and Care (Staffing) (Scotland) Act 2019 [HCSA]	9	9	9	9	9	12	12	12	Within
20. Reduced Capital Funding	12	20	20	20	20	20	N/A	N/A	Above
21. Pandemic Risk	20	20	20	20	20	N/A	N/A	N/A	Within
22. Hospital Acquired Harm (Awaiting endorsement)	*12*	*15*	*15*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*Within*
23. Substance Related Morbidity and Mortality (Awaiting endorsement)	*15*	*20*	*20*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*Within*
24. Oral Health (Awaiting endorsement)	*16*	*20*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*Within*

- The risk level breakdown is - 12 high and 6 moderate
- Three new risks are here to seek agreement to put forward to the Board for adoption
    - Risk 22 Hospital Acquired Harm (currently high) – deep dive discussed on 13 March 2025
    - Risk 23 Substance Related Morbidity and Mortality (currently high) – deep dive circulated after 13 March 2025 meeting
    - Risk 24 Oral Health – deep dive attached for consideration (Appendix 2)

4 risks align to *Strategic Priority 1: To improve health and wellbeing.*
The Board has a Hungry appetite for risks in this domain. Three risks are within and two risks below risk appetite.

6 risks align *Strategic Priority 2: To improve the quality of health and care services.*
The Board has an Open appetite for risks in this domain. Two risks are above risk appetite and five within.

2 risks align to Strategic Priority 3: *To Improve Staff Experience and Wellbeing.* The Board has an open appetite for risks within this domain. Both are above risk appetite.

6 risks align to *Strategic Priority 4: To Deliver Value and Sustainability.*
The Board has an Open appetite for risks in this domain. Fife risks are above risk appetite and one within.

With the agreement of the new risk appetite, it is timely to give consideration as to how we can use the risk appetite to help manage our corporate risks and start to include this within our discussions.

Key Updates

Risk 1 – Population Health & Wellbeing Strategy
The PHW Strategy Annual Report is due in May 2025.

Risk 2 – Health Inequalities
The Deep Dive has been refreshed and will be brought to PH&WB for July meeting.

Risk 7 – Access to Outpatients, Diagnostics and Treatment Services
Planning for delivery of the targets for 25/26 completed with additional funding bids submitted to SG. Early indication that bids have been successful for all specialties (apart from Vascular), however formal letter of funding guarantee yet to be received. Risk – delay in start to delivery of plans could adversely affect ability to reach SG target of no patients waiting over 52 weeks by March 2026.

Risk 9 - Quality and Safety
The Organisational Learning Leadership Group (OLLG) is starting to shape the workplan for 2025/2026. A key focus of this work is the Clinical Organisational Learning Event which launched on 9th April. This event extrapolates learning of organisational significance and brings multiprofessional groups together across the NHS Fife healthcare system to share learning as a collective. Topics presented at the event will be referred from the Significant Adverse Event Panel, Clinical Governance Meetings and individuals who are eager to share learning. Each meeting will have topics under the following themes:

- Learning from celebrating success
- Learning from things that haven't gone well
- Micro learning e.g. human factors or the Infected Blood Inquiry

The content of presentations and recording of the presentation will be shared on the Organisational Learning Blink page. Topics which are not presented but are of significance will also be uploaded to this page.

Risk 10 – Primary Care Services
The Performance and Assurance Framework is now in place with regular reporting to PCGSOG. This was ratified by PCGSOG on 4 April 2025.

The risk level improved from high 16 to moderate 12 reaching its target, with the aim to maintain this level over the coming year.

Risk 13 – Delivery of a Balanced In-Year Financial Position

At the end of period 11 there is a reasonable level of confidence we will achieve the full 25M (3%). The overspend for the health board retained budget to the end of February of £17.057m includes a continuation of the underlying and current cost pressures described in the financial plan.

At the end of February, the projected overspend for health board retained is much improved when compared with the original planned residual deficit. This improvement is however limited to the health board retained budget position.

The IJB position has deteriorated further with their current forecast outturn (January position) indicating a projected deficit of £36.990m but with further additional risk of £1.650m identified in respect of GP prescribing and a particularly high cost patient requiring specialist out of area treatment.

The increasing deterioration in the IJB position will make it very difficult for the overall Board position to meet or improve on the forecast deficit reported in the financial plan in March 2024.

Scottish Government have confirmed a maximum amount of repayable brokerage will be available to NHS Fife for 2024-25 of up to £37m but have requested we continue to collaborate with partners to reduce this requirement as far as possible throughout the remainder of the financial year.

This risk will be re-set at the next round of committees to reflect the coming year 2025/26.

Risk 14 – Delivery of a Balanced In-Year Financial Position

The Board approved the Medium-Term Financial Plan 2025/26 to 2027/28 at the end of March 2025.

The plan incorporates the one-year funding settlement advised by Scottish Government on 4 December 2024. Additionally, the plan includes further funding announcements advised by Scottish Government in relation to additional New Medicines Funding and Sustainability Allocations since December 2024.

Both Acute and IJB services continue to be under significant financial and service pressure resulting from underlying deficits compounded by demand and capacity challenges. We will require to continue to work collaboratively across the health and care system to ensure the best possible use of resources and capacity, address variation and improve productivity and efficiency.

The inclusion of the sustainability payments announced by Scottish Government for 2025/26 alongside an improved underlying recurring deficit and increased savings opportunities, has significantly improved the financial position for the board leaving a residual unidentified savings gap of £9.2m to be scoped out equivalent to 0.98% of our baseline Revenue Resource Limit.

Our approach to financial recovery will be delivered by our new Re-form, Transform and Perform Framework Year 2 (RPT2). Targeting recurring savings of £28.573k in 2025/26.

Further work will continue to improve on the level of identified savings with a particular emphasis on the impact of transformation on our cost
base in the latter 2 years of the plan.

SG approval of the of our MTFF was received on the 31 March 2025.

Risk 18 – Digital & Information
A strategy completion report was presented to the NHS Fife Board in November 2024 outlining the scale of demand.

Digital and Information operate within the financial governance structure of NHS Fife and participate in the planning and governance work of FCIG, where capital allocations are agreed, following consideration of risk, to support Infrastructure lifecycle activities.

A revised Digital Framework is being created via the Digital Information Board and will be presented to governance committees for review and comment in 2025 and will outline financial pressures and workforce planning, to support the mitigation of this risk.

Work continues of service lead prioritisation of digital activities.

Risk 15 - Prioritisation and management of capital funding & Risk 20 - Reduced Capital Funding
Consideration is being given as to whether these two risks can be merged.

Risk 19 - Implementation of Health and Care (Staffing) (Scotland) Act 2019 [HCSA]
Consideration is being given as to whether this risk can now be closed.

Risk 23 – Substance Related Morbidity and Mortality

Implementation of the Medication Assisted Treatment (MAT) Standards 2021.
ADP have completed its fourth year of the programme and are able to comply with Public Health Scotland assessments to measure implementation progress across the system of care. Fife ADP and NHS Fife's progress will be published in a national report in July 2025

Implementation of the New Fife Alcohol and Drug Partnership Strategy 2024-2027.
ADP have completed their 1st year delivery plan with partners including NHS Fife. Most actions are completed, and others have continued into the second year.

Development of the New Drug Alert Process and Protocol & Communication Strategy 2024.
Completed in partnership with NHS Fife Public Health and approved by the ADP Committee. A library of alerts are in development with support from HSCP Comms. ADP are able to identify, assess and respond to new and emergent risk on a national and local level within agreed timescales.

Ensure appropriate testing and referral pathways for SH&BBV.
Completed workshop based on latest data from NESI (National Needle Exchange Survey Initiative) focussing on improvements needed to address increased crack-cocaine smoking, lower rates of Hep C testing in Fife, increased severe soft tissue infection and low foil uptake. An action plan is in development. Furthermore, NHS Fife

Addictions are developing testing protocols and refocussing workforce to increase testing rates with NHS SH&BBV support.

High Risk Pain Medication
Data has been gathered from patients with lived/living experience in NHS Fife Addictions Service and their use of HRPM to provide a clearer understanding of their risks. Data yet to be analysed and themed but likely to have a substantial impact on improvement plan for safety and reduce of risk to this patient group. NHS Fife wide consultation planned to share learning from recent Drug Related Deaths to include broader actions for prevention.

Improvement from prison/police custody to NHS Addictions Service pathways for patients liberated.
Liberation Right subgroup established within ADP structure. Over 50 people have been discussed within the first quarter. The discussions have supported people returning to Fife to register with GPs before leaving custody as well as continuing their addiction treatment and sourcing appropriate housing. Further outcomes will be developed for the 6-month evaluation. NHS Fife contributed fully to these meetings.

Details of all risks are contained within Appendix No. 1.

Next Steps
The Corporate Risk Register will continue to evolve in response to feedback from this Committee and other stakeholders, including via Internal Audit recommendations. The Register will require to adapt to reflect the current operating landscape, and our risk appetite in relation to changes in the internal and external environment including developments associated with the Reform, Transform, Perform Programme.

The Risks and Opportunities Group will seek to enhance its role in the identification and assessment of emergent risks and opportunities and make recommendations on the potential impact to the Board's Risk Appetite position. The Group will also contribute to the development of the process and content of Deep Dive Reviews.

This report provides the following Level of Assurance:

	Significant	Moderate	Limited	None
Level		x		
Descriptor	There is robust assurance that the system of control achieves, or will achieve, the purpose that it is designed to deliver. There may be an insignificant amount of residual risk or none at all.	There is sufficient assurance that controls upon which the organisation relies to manage the risk(s) are suitably designed and effectively applied. There remains a moderate amount of residual risk.	There is some assurance from the systems of control in place to manage the risk(s), but there remains a significant amount of residual risk, which requires further action to be taken.	No assurance can be taken from the information that has been provided. There remains a significant amount of residual risk

2.3.1 Quality, Patient and Value-Based Health & Care

Effective management of risks to quality and patient care will support delivery of our strategic priorities. It is expected that the application of realistic medicine principles will ensure a more co - ordinated and holistic focus on patients' needs, and the outcomes and experiences that matter to them, and their families and carers.

2.3.2 Workforce

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

2.3.3 Financial

This paper does not raise, directly, financial impacts, but these do present significant elements of risk for NHS Fife to consider and manage in pursuit of our strategic priorities.

2.3.4 Risk Assessment / Management

Management and oversight of the corporate risks continue to be maintained, with risk reporting provided regularly to the relevant groups and committees.

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 EDG. The outcome of that assessment concluded that no further action was 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

This paper reflects engagement with Executive and Non-Executive Directors, the Director of Digital & Information, the Associate Director for Risk & Professional Standards and discussions within the Risks and Opportunities Group.

2.3.8 Route to the Meeting

- Christopher McKenna Medical Director on 29 April 2025

2.4 Recommendation

This report provides the latest position in relation to the management of corporate risks. Members are asked to take a **"moderate" level of assurance** that, all actions, within the control of the organisation, are being taken to mitigate the risks as far as is possible to do so.

3 List of appendices

Appendix 1 - NHS Fife Corporate Risk Register as at 22 April 2025
Appendix 2 – Deep Dive Oral Health

Report Contact
Dr Shirley-Anne Savage
Associate Director for Risk and Professional Standards
Email shirley-anne.savage@nhs.scot

NHS Fife Corporate Risk Register as at 22/04/25

No	Strategic Priority and Risk Appetite	Risk Title and Description	Mitigation	Risk Appetite Status	Current Risk Level/ Rating	Target Risk level & rating by dd/mm/yy	Current Risk Level Trend	Risk Owner	Primary Committee
1	 HUNGRY	**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.	The strategy was approved by the NHS Fife Board in March 2023. This is in the context that the management of this specific risk will span a number of financial years. The service, workforce and financial challenges may have an impact on the scope and pace of the delivery of the ambitions within the Strategy. Reporting of progress against the strategy is through the published PHW Annual and Mid-Year Reports including public health metrics and case studies. The PHW Strategy Annual Report is due in May 2025. In 2024/25, assurance of delivery can be evidenced through the Annual Delivery Plan 2024/25, Corporate Objectives and RTP. Regular Board updates describe the progress against these plans. The transformation agenda taken forward through RTP will inform opportunities to work towards the delivery of the strategic ambitions and reshape if necessary.	Below	Mod 12	Mod 12 by 31/03/26	◄►	Chief Executive	Public Health & Wellbeing (PHWC)
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,	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.	Within	High 16	High 16 by 31/07/25	◄►	Director of Public Health	Public Health & Wellbeing (PHWC)

	HUNGRY	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.	The Population Health and Wellbeing Strategy is monitoring actions which will contribute to reducing health inequalities. Consideration of Health Inequalities within all Board and Committee papers. Leadership and partnership working to influence policies to 'undo' the causes of health inequalities in Fife. Development of Anchors strategic plan with links to addressing determinants of health inequalities. Key achievements to date: - Real Living Wage accreditation achieved - 100% of newly awarded contracts of 50K and over are with Real Living Wage accredited businesses - Eight employability programmes in place and engaging with Local Employability partnership - Baseline reporting in place to track spend on local businesses within Fife Fife Partnership are preparing to refresh their 10-year plan, with a focus on the Marmot principles. They are working to identify which interventions are most impactful in closing the health inequalities gap. This will also provide an opportunity to learn from other areas. Prevention and early intervention strategy has recently been ratified by the NHS Board. Public Health supported development of the 'Fair financial decision making' checklist to ensure that financial decisions under RTP take into account impacts on protected characteristics and inequalities.						

			A workshop to explore development of Inclusion Health Network has taken place that will seek to provide a focal point for a range of partners, including the Third sector. This network will advocate for the resolution of issues faced by inclusion health groups such as those who are homeless. Funding has been confirmed from the Child Poverty Practice Accelerator Fund to sustain the income maximisation worker to support maternity services for 2024/25. The approach will focus on support for families with children who have a potential disability or long-term condition. Subject to satisfactory progress this may be continued into 2025/26. The Deep Dive has been refreshed and will be brought to PH&WB for July meeting.						
4	 **HUNGRY**	**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 remain in place including an Executive Lead and a Board Champion. Further appointments have been made which include a lead for Clinical Sustainability and a non-exec Sustainability Champion. Regional working group and representation on the National Board is ongoing. The RTP infrastructure and change board has evolved to now include sustainability projects designed in response to the NHS Scotland Climate Change Emergency & Sustainability Strategy 2022 – 2026. Active participation in Plan 4 Fife continues. The NHS Fife Climate Emergency Report and Action Plan have been developed. These form part of the Annual Delivery	Below	Mod 12	Mod 10 by 01/10/25	◄►	Director of Property & Asset Management	Public Health & Wellbeing (PHWC)

			Plan (ADP). The Action Plan includes mechanics and timescales. Our objectives are set out and monitored through Section 10 of the ADP Work is ongoing with SG, Fife Council and East Region to include innovation in energy generation etc. We have increased our commitment to partnership working with local third sector organisations including a partnership Director appointment with FCCT (Fife Coast & Countryside Trust) and local government (Fife Council). The Board's Climate Change Annual Report was prepared for submission to PHWC in January 2024 and thereafter to Scottish Government (SG) and has been published as per the requirements of the policy DL38. Resource in the sustainability team has increased to 4 FTE's in total including an energy manager who will be key in supporting the requirements of the strategy and policy. A partnership plan for Fife Council, Fife College and University of St Andrews has progressed and was agreed by Fife Leadership Board March 2025. This set out the agreed objectives and milestones discussed in the 'addressing the climate emergency working group' and formally creates joint actions we will work on as part of the climate emergency in Fife. A corporate risk deep dive was produced in October 2024 on the risk of Environmental Management & Climate change. This was to ensure there will be						

			effective management of the risk that will allow us to meet our strategic priorities.						
6	 **OPEN**	**Whole System Capacity** There is a risk that NHS Fife may be unable able to provide safe and effective care to the population of Fife as a result of workforce capacity, significant and sustained unscheduled care and planned admission activity to the Victoria Hospital, as well as challenges in achieving timely discharge to downstream wards and provision of social care packages.	The risk descriptor has been updated. The updated wording of the risk reflects the ongoing 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. Management data from winter demonstrates re-direction via FNC and NHS 24 is having an impact in reducing demand month on month and our work to embed Discharge Without Delay (DWW) and Home First continues to provide improvements and learning. A system wide lessons learnt & planning workshop was held on 26/2/25 which identified further system wide improvements. The combination of application of our OPEL process on a daily basis and the improvement work through our Integrated Unscheduled Care and Planned Care programmes provides the operational and strategic response to the challenges posed through this risk. The System Flow Operational Group meets weekly with senior operational managers to review and plan capacity and flow across the Fife health and care system with escalation to the Integrated Unscheduled Care Board. Whole System Essential Flow Verification provides assurance that all patients identified as clinically fit or with a Planned Date of Discharge are reviewed daily. Weekly ASD Long Length of Stay (LoS) verification group to review and action	Above	High 20	High 16 by 31/03/26	◀ ▶	Director of Acute Services	Finance, Performance & Resources (F,P&RC)

			LoS. Weekend verification group reviews the number of discharges and staffing ahead of weekend.						
7	 **OPEN**	**Access to outpatient, diagnostic and treatment services** There is a risk that patient outcomes may be adversely impacted by NHS Fife's challenge in delivering the waiting times standards due to ongoing unscheduled care pressures and demand exceeding current capacity.	Planning for 2024/25 has been completed in line with planning guidance letter received on 24/01/24. The issue of the confirmed funding being 1M less than the committed staff costs has now been resolved as the Scottish Government have confirmed a further 3.4M to maintain 2023/24 activity levels. The Board has also successfully secured non-recurring funding from the 30M available nationally to support elective waiting times. The Planned Care Plan was approved by the FP&R Committee at the July meeting. This includes additional clinics, enhanced vetting and increased theatre capacity as well as funding additional medical posts (urology, neurology, gynaecology and ENT). The Integrated Planned Care Programme Board continues to oversee the productive opportunities work and this along with ongoing waiting list validation seeks to maximise available capacity. Speciality level plans in place outlining local actions to mitigate the most significant areas of risk. Focus remains on urgent and urgent suspicious of cancer patients however routine long waiting times will increase. Weekly waiting times meetings to review and action long waits. Monthly meeting to review and develop longer term plans to improve waiting times.	Above	High 20	High 16 by 31/03/26	◄►	Director of Acute Services	Finance, Performance & Resources (F,P&RC)

			Monthly meetings with Scottish Government to monitor delivery against the annual plan. The governance arrangements supporting this work continue to inform the level of risk associated with delivering against these key programmes and mitigate the level of risk over time. Discussions continue with Scottish Government around the need for additional funding to help reduce the waiting times for long waiting routine patients. Confirmation was received from Scottish Government in September that no further additional funding will be received for this financial year. December 24 Outpatient and IPDC services continue to work within trajectories however risk of cancellations during winter pressures could adversely impact performance against previously submitted plans. The anticipated Q2, Q3 and Q4 funding for Radiology with the exception of mobile imaging monies submitted against bids for 30m non-recurring funding has ceased. This will adversely affect performance in the latter part of the year particularly impacting ultrasound waiting times where there has been significant improvement in Q1. Projected 90% of patients waiting less than 6 weeks will not be sustained. Priority continues to focus on our urgent and urgent suspicion of cancer patients as well as treating patients based on clinical prioritisation, validating waiting lists and reprioritising patients where						

			indicated and reducing the number of long waiting patients. February 25 Further to planning guidance received from SG on 20th December 24, NHS Fife has submitted first draft of trajectories for 25-26. This includes RAG status against the likelihood of delivering planned care targets for TTG and OPs – no waits over 52 weeks by March 26 and for delivering standards for diagnostics and cancer. Discussions with SG are ongoing. Priority continues to focus on treating our urgent and urgent suspicion of cancer patients as well as reducing the number of long waiting patients. April 2025 Planning for delivery of the targets for 25/26 completed with additional funding bids submitted to SG. Early indication that bids have been successful for all specialties (apart from Vascular), however formal letter of funding guarantee yet to be received. Risk – delay in start to delivery of plans could adversely affect ability to reach SG target of no patients waiting over 52 weeks by March 2026.						
8	 **OPEN**	**Cancer Waiting Times (CWT)** There is a risk that patient outcomes may be adversely impacted by NHS Fife's ongoing challenge in meeting the cancer waiting times standards due to increasing patient referrals, complex cancer pathways and service capacity.	Operational risks around Pharmacy and SACT nursing capacity has been escalated. A review of the SACT Unit and nursing workforce is underway. Two ANPs and a Pathway Navigator has been recruited. There has been a Specialty Doctor recruited in Haematology and the consultant vacancy is supported by agency locums.	Within	High 15	Mod 12 by 31/03/26	◄►	Director of Acute Services	Finance, Performance & Resources (F,P&RC)

			The prostate project group is under review to incorporate learning from the Lanarkshire Model. The Nurse-led model went live in August 2023 however there has been reduced activity due to training of a replacement staff member. The Evaluation of this project currently being undertaken with an update from University of Stirling expected. Introduction of consultant lead specific to cancer services in Urology. 1 session per month, with a cancer meeting bi-monthly. There will be an increased focus on challenged cancer pathways within the speciality, focussing on the prostate pathway and MRI/TP biopsy delays. A Urology surgeon is being trained training in Prostate modality to increase RALP capacity. There will be an increased focus on renal and bladder pathways. The team are looking at the potential to carry out bladder cancer in QMH increasing capacity and reducing waiting lists. Funding for channelled endoscopes has been supported to improve waits in the head and neck pathway. Forth Valley supports mutual aid breast clinics to ensure performance is maintained. Radiology are aiming to recruit a general radiologist with a breast sub specialty. The team are collaborating with radiology to expedite hormone results to ensure timely treatment. Upper GI pathway has been challenged due to vacancies, however, final interview for specialist nurses in February 2025 with opportunities for improvement being continually sought						

			Fortnightly meetings with Scottish Government (SG) and quarterly monitoring of the Effective Cancer Management Framework is currently under review. Single Point of Contact Hub (SPOCH) continues to effectively support initiation of the Optimal Lung Cancer and support the negative qFIT pathway. To remove patients from the lung pathway in a timely manner the Hub advises patients of 'good news' albeit the service has had both sickness and vacancy challenges. Support from Health Records has helped timely appointments for patients referred urgent suspected cancer. The Cancer Framework is under review to ensure alignment with the Scottish Cancer Strategy. The Actions for 2025-26 are being agreed. 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. Cancer Waiting Times funding will be provided on a recurring basis from 2024-25. Bids have been prioritised to support improvement. A review of funding will take place for 2025-26 ADP Actions for 2025/26 have been drafted.						
9	 **OPEN**	**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	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).	Within	Moderate 12	Low 6 by 31/10/25	◀▶	Medical Director	Clinical Governance (CGC)

		the quality of care delivered to the population of Fife.	There are also effective systems & processes to ensure oversight and monitoring of national & local strategy / framework / policy /audit implementation and impact. One of the root causes of this risk is that there are “no effective system of supporting effective organisational learning”. The Organisational Learning Leadership Group (OLLG) is is starting to shape the workplan for 2025/2026. A key focus of this work is the Clinical Organisational Learning Event which launched on 9th April. This event extrapolates learning of organisational significance and brings multiprofessional groups together across the NHS Fife healthcare system to share learning as a collective. Topics presented at the event will be referred from the Significant Adverse Event Panel, Clinical Governance Meetings and individuals who are eager to share learning. Each meeting will have topics under the following themes: - Learning from celebrating success - Learning from things that haven’t gone well - Micro learning e.g. human factors or the Infected Blood Inquiry The content of presentations and recording of the presentation will be shared on the Organisational Learning Blink page. Topics which are not presented but are of significance will also be uploaded to this page. Another change which aligns to the work of the OLLG and the Adverse Events Improvement Plan is that from 1st August all significant adverse events graded as a 4 (i.e. (*“A different plan and or delivery of*						

			care, on balance of probability, would have been expected to result in a more favourable outcome, i.e. how case was managed had a direct impact on the level of harm") will now have the associated improvement plans returned to the Executive SAER panel for oversight and monitoring of improvement actions. The next phase of this work is to embed governance processes for outcomes 1-3 within divisional clinical governance structures. The intention is to redefine the risks relating to Quality and Safety beyond the process/governance focus that we currently have.						
10	 **OPEN**	**Primary Care Services** There is a risk that due to a combination increasing demand on Primary Care services, resource challenges including workforce and finance and adequate sufficient premises, service delivery may be compromised impacting on sustainability and quality of care to the population of Fife	A Primary Care Governance and Strategy Oversight Group (PCGSOG) is in place. A Primary Care Strategy was developed following a strategic needs analysis and wide stakeholder engagement. This was approved at IJB in July 2023 and is now moving to implementation. This is a 3-year strategy focused on recovery, quality and sustainability. The Annual Report for year one of delivery of the strategy was presented and approved at the PCGSOG on 16 August 2024 has now progressed to the IJB and NHS Fife Board. Of 41 actions, 25 are complete and the remaining 16 are on track as we move into year two of the plan. Year 2 plan is on track Performance and Assurance Framework now in place with regular reporting to PCGSOG. This was ratified by PCGSOG on 4 April 2025 A Primary Care Improvement Plan (PCIP) is in place; subject to regular monitoring and reporting to General	Above	Moderate 12	Mod 12 by 31/03/26	▲	Director of Health & Social Care	Public Health & Wellbeing (PHWC)

			Medical Services (GMS) Board, Quality & Communities (Q&C) Committee, IJB NHS Board and Scottish Government. In line with MOU2, pharmacotherapy and CTAC models for care continue to be developed and implemented throughout 2025/26. A General Practice Pharmacy Framework has been issued by the Directors of Pharmacy which outlines the vision to transform the pharmacy service in GP Practices. Pharmacotherapy, CTAC and In Hours Urgent Care have been accepted to HIS Primary Care Improvement Collaborative. End date recommended and endorsed by GMS implementation group - Q1 of 26/27. NHS Fife PHW Committee has suggested that a specific high level corporate risk is considered regarding access to general dentistry across Fife. This risk has been articulated and proposed to the PCGSOG and will be presented to PHWC in May 2025. Primary Care Strategic Communication Plan has been developed and approved at PCGSOG and is now in implementation phase as a key deliverable of the year two strategy. An interface group between primary and secondary care will be formally constituted by April 2025 to focus on whole system quality improvement. This will now be a deliverable in line with the ADP 25/26.						
11		**Workforce Planning and Delivery** There is a risk that the current supply of a trained workforce is insufficient to meet the anticipated whole system capacity	Continued development of the workforce elements of the Annual Delivery Plan, Population Health & Wellbeing Strategy and Strategic Framework; the development of the imminent Workforce Plan for 2025 to 2026 alongside service-based workforce plans to the RTP	Above	High 16	Mod 8 by 31/03/25	◄►	Director of Workforce	Staff Governance (SGC)

	 **OPEN**	challenges, or the aspirations set out within the Population Health & Wellbeing Strategy, which may impact on service delivery	Programme and agreed workstreams, aligned to ADP and financial planning cycles. Continued development of Service Level Workforce Plans, taking account of the 2024/2025 ADP submissions to establish the projected workforce gap between supply, demand, the financial envelope and identifying workforce and non-workforce solutions which services are progressing to mitigate workforce risks and balance service delivery. Updates now provided to each Staff Governance Committee meeting and at regular intervals to NHS Fife. Board Implementation of the Health & Social Care Workforce Strategy and Plan for 2022 to 2025 to support the Health & Social Care Strategic Plan for 2023 to 2026, the Plan for Fife and the integration agenda. HSCP Workforce Plan for 2025 to 2026 also underdevelopment for March 2025 submission. 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, e.g. Employability agenda / Modern Apprenticeships, with bespoke health focused Careers Events planned for March 2025, in conjunction with the Developing the Young Workforce Fife Board. This will showcase health career opportunities and support subject choices for the senior school phase. Repeat sessions to be run in September 2025 and on an annual basis thereafter. The new EMERGE programme in conjunction with Levenmouth Academy,						

			Fife College and NES, which commenced in August 2024 now has 6 pupils studying on the course who are interested in health-related careers, with NHS Fife work tasters held in January and February 2025, followed by work placements planned for Spring 2025. University of St Andrews MBChB (ScotCOM): Widening Participation. Following the partnership agreement in April 2024, various widening participation programmes were planned and delivered. The Summer Programme (Experience Medicine) ran for 7 weeks during the Fife Council school holiday period – July and August 2024. There were approximately 6 students per week, alongside some additional pre-med students. The events planned for September 2024 were delayed until December 2024 and were held over two sites (QMH and Cameron), on 4 and 5 December 2024, accommodating approximately 75 students across the two days. These "Carousel" events were introduced as a way to engage students at an earlier stage, with a view of moving onto the Summer Programme during their S5 year and finally into Gateway to Medicine in the equivalent of their S6 year. Planning for this to be an annual event. Gateway placements were scheduled and delivered week commencing 20th January 2025, accommodating 9 students over 4 days, with both simulation and clinical shadowing experience. A Widening Participation Lead is in the costing plan for ScotCOM to bring the various initiatives together and develop a coherent programme for future academic years.						

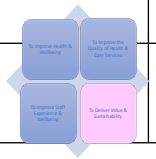
			The HSCP Anchor group is meeting quarterly and refreshed, integrated membership includes commissioning, college and community wealth building, social care, nursing, business enabling and administrative services. Public Health input and direction to support the group to develop a plan which connects to the Anchor Progression Framework within NHS Fife and community partners. Ongoing consideration of impact of planned reduction in Agenda for Change staffs' full time working week from 37.5 hours to 36 hours per week on workforce numbers and service capacity, with modelling being undertaken in line with National implementation plans. Continued consideration and modelling of impact of non-pay elements of Agenda for Change staff pay award for 2023/2024 in respect of Band 5/6 nursing review. Continued consideration of impact of non-pay elements of Agenda for Change staff pay award for 2023/2024 in respect of protected learning time (PTL) has resulted in various approaches to support implementation of PLT. 60% PDPR completion rates and 80% mandatory/core skills compliance rates are corporate priorities for 2024/25 and will continue to be priorities for 2025/26, with PDPR rates moving to 65%. NHS Fife's performance against both of these metrics was escalated to NHS Fife Board in November 2024. A short-term recovery plan (up to 31/03/2025) is in play to drive up performance, and primarily focused on all Corporate services, the quality of the data and accessible/timely line manager reporting, through a new report generated by OBILEE. Further efforts to generate momentum and						

			continually sustain performance metrics are being pursued with the HSCP, Acute and Estates & Facilities.						
12	 **OPEN**	**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 health and wellbeing opportunities are maximised, to support attraction, development and retention of staff. The Staff Health & Wellbeing Framework and Action Plan for 2022 to 2025, setting out NHS Fife's ambitions, approaches and commitments to staff health and wellbeing, are both in place in order to deliver these commitments and will be revised to take account of forthcoming IWWC in action guidance. Fife HSCP has developed a Wellbeing Action Plan 2024-25, created with colleagues from NHS Fife and other stakeholders to add value to the corporate employers' wellbeing work. Consideration and review of staff support priorities for 2022-2025 being progressed via Staff Health & Wellbeing Group and other fora, aligned to Action Plan and new IWWC actions. Current focus on stress, with the HSCP Stress Survey underway and action planning during January 2025. 1453 responses received to date. An Exit Interview Pilot is underway within HSCP using a person centred approach to obtain data on workforce movement and reasons. Mentally Healthy Workplace training continues to be delivered for all HSCP managers / supervisors. Further dates planned for 2025.	Above	High 16	Mod 8 by 31/03/25	◄►	Director of Workforce	Staff Governance (SGC)

			Work progressing on Promoting Attendance improvement actions to support reductions in staff absence and promote staff wellbeing. This includes proposals on the handling of absence management cases, with the introduction of the use of triggers and 3 stages for long term absence cases in line with the OfS Attendance Policy. Three teams that fall into high priority areas to consider implementing recommendations from a multifactorial review within HSCP Work also ongoing to triangulate absence data with post codes and other relevant data to assist any future work in this area.						
13	 **OPEN**	**Delivery of a balanced in-year financial position** There is a risk that due to the ongoing impact of the pandemic combined with the very challenging financial context both locally and nationally, the Board will not achieve its statutory financial revenue budget target in 2024/25 without further planned brokerage from Scottish Government.	Our approach to financial recovery will be delivered by our new Re-form, Transform and Perform Framework (RPT). The overall opening financial gap reduced from £54.750m to £51.350m in July 2024 as a consequence of allocation increases notified since the financial plan was approved by the NHS Fife Board in March 2024. At the end of period 11 there is a reasonable level of confidence we will achieve the full 25M 3%. , The overspend for the health board retained budget to the end of February of £17.057m includes a continuation of the underlying and current cost pressures described in the financial plan. At the end of February, the projected overspend for health board retained is much improved when compared with the original planned residual deficit. This improvement is however limited to the health board retained budget position. The IJB position has deteriorated further with their current forecast outturn (January position) indicating a projected	Above	High 25	High 25 by 31/03/25	◄►	Director of Finance & Strategy	Finance, Performance & Resources (F,P&RC)

			deficit of £36.990m but with further additional risk of £1.650m identified in respect of GP prescribing and a particularly high cost patient requiring specialist out of area treatment The increasing deterioration in the IJB position will make it very difficult for the overall Board position to meet or improve on the forecast deficit reported in the financial plan in March 2024. Scottish Government have confirmed a maximum amount of repayable brokerage will be available to NHS Fife for 2024-25 of up to £37m but have requested we continue to collaborate with partners to reduce this requirement as far as possible throughout the remainder of the financial year.						
14	 **OPEN**	**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.	Recurring and sustained delivery of our programme of work and supporting actions to achieve a target of 3% recurring savings on baseline budgets £28m in 2025/26 into future years. The Board approved the Medium-Term Financial Plan 2025/26 to 2027/28 at the end of March 2025. The plan incorporates the one-year funding settlement advised by Scottish Government on 4 December 2024. Additionally, the plan includes further funding announcements advised by Scottish Government in relation to additional New Medicines Funding and Sustainability Allocations since December 2024. Both Acute and IJB services continue to be under significant financial and service pressure resulting from underlying deficits compounded by demand and capacity	Above	High 25	High 20 by 31/03/27	◄►	Director of Finance & Strategy	Finance, Performance & Resources (F,P&RC)

			challenges. We will require to continue to work collaboratively across the health and care system to ensure the best possible use of resources and capacity, address variation and improve productivity and efficiency. The inclusion of the sustainability payments announced by Scottish Government for 2025/26 alongside an improved underlying recurring deficit and increased savings opportunities, has significantly improved the financial position for the board leaving a residual unidentified savings gap of £9.2m to be scoped out equivalent to 0.98% of our baseline Revenue Resource Limit. Our approach to financial recovery will be delivered by our new Re-form, Transform and Perform Framework Year 2 (RPT2). Targeting recurring savings of £28.573k in 2025/26. Further work will continue to improve on the level of identified savings with a particular emphasis on the impact of transformation on our cost base in the latter 2 years of the plan. SG approval of the of our MTFF was received on the 31st March 2025.						
15	 **OPEN**	**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 manage and mitigate risk and to support the developing Population Health and Wellbeing Strategy.	Ongoing governance through FCIG with capital plan being submitted through FP&R and the Board. Annual Property and Asset Management Strategy (PAMS) updates to provide strategic direction now being replaced with the Whole System Initial Agreement development over the next 2 years.	Within	Mod 12	Mod 8 (by 01/04/26 at next SG funding review)	◄►	Director of Property & Asset Management	Finance, Performance & Resources (F,P&RC)

			Rolling 5-year equipment programme and implementation of medical devices database. Implementation of medical devices database. Rolling 5-year Digital & Information programme linked to D&I strategy. Ongoing management of estate risks using the Estate Asset Management System (EAMS). Use of Business Case template to present new schemes for consideration. Future consideration/development of prioritisation investment tool. Fleet and sustainability requests will be linked to plans/strategy and presented through SBARs to Fife Capital Investment Group (FCIG).						
17	 **OPEN**	**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.	The Network Information System Directive (NISD) and now Cyber Resilience Framework Audit has concluded for 2024. The compliance rate has increased to 93%, up from 77% from the previous year. The action plan for improvement will be presented to the Information Governance and Security Steering Group for review and progress tracking. The associated and linked Risks for Cyber Resilience will be reviewed in line with the Audit report. Management actions continue to be progressed.	Above	High 16	Mod 12 by 30/09/25	◄►	Director of Digital and Information	Clinical Governance (CGC)
18		**Digital & Information**	A strategy completion report was presented to the NHS Fife Board in	Within	High 15	Mod 12 30/04/25	◄►	Director of Digital and Information	Clinical Governance (CGC)

	OPEN	There is a risk that the organisation maybe unable to sustain the financial investment necessary to deliver its D&I Strategy and as a result this will affect our ability to enable transformation across Health and Social Care and adversely impact on the availability of systems that support clinical services, in their treatment and management of patients.	November 2024 outlining the scale of demand. Digital and Information operate within the financial governance structure of NHS Fife and participate in the planning and governance work of FCIG, where capital allocations are agreed, following consideration of risk, to support Infrastructure lifecycle activities. A revised Digital Framework is being created via the Digital Information Board and will be presented to governance committees for review and comment in 2025 and will outline financial pressures and workforce planning, to support the mitigation of this risk. Work continues of service lead prioritisation of digital activities.						
19	 **OPEN**	**Implementation of Health and Care (Staffing) (Scotland) Act 2019 [HCSA]** Taking account of ongoing preparatory work, there is a risk that the current supply and availability of trained workforce nationally, will influence the level of compliance with HCSA requirements. While the consequences of not meeting full compliance have not been specified, this could result in additional Board monitoring / measures.	NHS Fife Local HCSA Reference Group, with Fife wide, multi-disciplinary and staff representation, is now well established with monthly meetings. HCSA resources continue to be shared widely within NHS Fife. Active MS Teams Channel used to share information outwith meetings. Quarterly progress returns submitted to SG February 2025. HIS engagement meeting supported assessment of reasonable assurance. Enhanced local engagement and reporting achieved via introduction of bespoke excel template, aligned to national reporting framework to capture latest activity in respect of Act requirements. Feedback continues to inform local Board wide action plan. Third quarterly high-cost agency return to 31/12/2024 submitted to SG and second quarterly internal report will be considered at January 2025 SGC and the next NHS	Below	Moderate 9	Mod 9 by 31/03/25	◄►	Director of Workforce	Staff Governance (SGC)

			Fife Board meetings. Annual report deadline is 30/04/2025. Regular updates provided to APF, EDG and SGC and Fife NHS Board. HSCP implementation group for Part 3 of the Act has been stood down since services were inspected by the Care Inspector and recorded as meeting the requirements of the Act. Representatives from Social Care services attend the Care Inspectorate national group bimonthly. Annual return for Part 3 Care Services is due to be submitted to SG by 30 June 2025. This risk on the preparations for HCSA implementation is monitored and updated via the NHS Fife HCSA Local Reference Group.						
20	 **OPEN**	**Reduced Capital Funding** There is a risk that reduced capital funding will affect our ability (scale and pace) to deliver against the priorities set out in our Population Health and Wellbeing Strategy. It may also lead to a deterioration of our asset base including our built estate, digital infrastructure, and medical equipment. There will be less opportunity to undertake change projects/programmes.	Use the capital funding we do receive wisely with requirements being prioritised in a logical manner (see Risk 15). Maintain open communication channels with Scottish Government to facilitate alignment around planning. Submit our Business Continuity & Essential Investment Infrastructure Plan to Scottish Government in January 2025.	Above	High 20	Mod 12 by 30/03/26	◄►	Director of Property & Asset Management	Finance, Performance & Resources (F,P&RC)
21	 **HUNGRY**	**Pandemic Risk** There is a risk that a novel pandemic with widely disseminated transmission and significant morbidity and	An NHS Fife Pandemic Framework Group has been established to coordinate management of this risk, including consideration and implementation of measures to reduce the pressures and	Within	High 20	High 20	◄►	Director of Public Health	Public Health & Wellbeing (PHWC)

		mortality may cause significant harm to those infected and cause widespread disruption to healthcare, supply chains, and social functioning.	negative effects a pandemic would cause locally, and to act as a source of advice to the organisation and partners. Work is underway to collate lessons from the COVID-19 response and outputs of related inquiries and implement these locally. Preparation underway to deliver large-scale population immunity and immunisation campaigns.						
22	 **OPEN**	**Hospital Acquired Harm** There is a risk that patients may come to hospital acquired harm (falls, pressure damage, hospital acquired infection, medication) resulting in adverse clinical outcomes as a result of a reduction in resource, availability of workforce and whole system pressures.	Work is underway in the following areas: • Falls Prevention • Pressure Ulcer Prevention • Hospital Acquired Infection • Medicine Incidents • Unscheduled Care Programme Board • Emergency Access • Delayed Transfer of care and Surge	Within	High 15	Mod 12 by 31/03/26	◄►	Medical Director and Nurse Director	Clinical Governance (CGC)
23	 **HUNGRY**	**Substance Related Morbidity and Mortality** There is a risk that people experiencing problem substance use may have a poor patient experience and increased morbidity and mortality due to NHS Fife being unable to provide rapid and appropriate access to all treatment and care due to lack of funding and capacity.	Implementation of the Strategy Drug Mission Priorities 2022-26. Implementation of The National Strategy for Alcohol and Drug use “Rights, Respect, Recovery” November 2018. Implementation of the Medication Assisted Treatment (MAT) Standards 2021. ADP have completed its fourth year of the programme and are able to comply with Public Health Scotland assessments to measure implementation progress across the system of care. Fife ADP and NHS Fife’s progress will be published in a national report in July 2025. Implementation of the New Fife Alcohol and Drug Partnership Strategy 2024-2027. ADP have completed their 1st year delivery plan with partners including NHS	Within	High 20	High 15 31/03/26	◄►	Director of Health & Social Care	Public Health & Wellbeing (PHWC)

			Fife. Most actions are completed, and others have continued into the second year. Development of the New Drug Alert Process and Protocol & Communication Strategy 2024. Completed in partnership with NHS Fife Public Health and approved by the ADP Committee. A library of alerts are in development with support from HSCP Comms. ADP are able to identify, assess and respond to new and emergent risk on a national and local level within agreed timescales. Ensure appropriate testing and referral pathways for SH&BBV. Completed workshop based on latest data from NESI (National Needle Exchange Survey Initiative) focussing on improvements needed to address increased crack-cocaine smoking, lower rates of Hep C testing in Fife, increased severe soft tissue infection and low foil uptake. An action plan is in development. Furthermore, NHS Fife Addictions are developing testing protocols and refocussing workforce to increase testing rates with NHS SH&BBV support. A two-year High-Risk Pain Medicines (HRPM) patient safety programme to ensure safe and appropriate prescribing of HRPMs and reduce risk of potential diversion has been delivered. This programme should be embedded into business-as-usual models and continue to implement quality improvement actions. Data gathered from patients						

			with lived/living experience in NHS Fife Addictions Service and their use of HRPM to provide a clearer understanding of their risks. Data yet to be analysed and themed but likely to have a substantial impact on improvement plan for safety and reduce of risk to this patient group. NHS Fife wide consultation planned to share learning from recent Drug Related Deaths to include broader actions for prevention. Improvement from prison/police custody to NHS Addictions Service pathways for patients liberated. Getting Liberation Right subgroup established within ADP structure. Over 50 people have been discussed within the first quarter. The discussions have supported people returning to Fife to register with GPs before leaving custody as well as continuing their addiction treatment and sourcing appropriate housing. Further outcomes will be developed for the 6-month evaluation. NHS Fife contributed fully to these meetings. Multi-agency resilience response to the potential of mass casualties due to new potent illicit substances mixed into the drug supply. A multi-agency event was held in August 2024 and a recommendation made to SG and PHS to convene a national exercise.						

Risk Movement Key

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

Corporate Risk	**Oral Health**	
Strategic Priority	To improve health and wellbeing	
Risk Appetite	**HUNGRY**	
Risk Description	**There is a risk that the population of Fife will suffer adverse effects on their dental and subsequent wider health due to the ongoing access issues and continuing de-registrations of NHS patients in general dental practices.** Context: It is important to note what is in the NHS Board's control and what is outwith our control. Unlike General Medical Services, the NHS Boards do not have a duty to, via legislation, ensure every member of the public is able to register with a NHS dental practitioner. This therefore limits the powers available to boards to influence delivery of GDS. The population are also able to choose where to access dental services and can opt to go private and are not restricted to registering in their local area. Primary care dentistry comprises of independent dental practices (independent businesses) known as General Dental Services (GDS) and the Board Managed Public Dental Service (PDS) which through the Scheme of Integration in line with Public Body Act (2014) is a delegated service with responsibility for effective operational delivery sitting within Fife's Health and Social Care Partnership (HSCP). The role of the PDS provides a 'safety net' for patients who can't access GDS and offers referral services for dental anxiety, oral surgery, special needs, paediatric dentistry and dental General Anaesthetics. Dental access is a particular challenge for Fife with approximately 30,000 de-registrations in 2024. Fife has a higher proportion of dental practices owned by Dental Body Corporates and over the past few years these businesses have experienced more challenges around recruitment and retention of staff and a number of dental practices in Fife have been mothballed. There have also been 4 DBCs mothballed in 2024. This includes 2 in Glenrothes, 1 Kinghorn and 1 in Leven.	

	Through our Public Dental Service, we ensure all unregistered patients are able to be seen within national defined timescales (as per ADP 23/24 guidance- ensure capacity for urgent dental care for unregistered/deregistered dental patients). The Covid-19 pandemic impacted severely on dental services with the Scottish Government shutting all NHS dental practices for 3 months. A slow recovery took place due to dental care relying on aerosol-generating procedures. The level of NHS dental activity has been hard to monitor as a new dental contract came into operation in November 2023. Due to access pressures antibiotic prescribing levels have not returned to pre-pre-Covid-19 levels.			
Root Cause	• Dental workforce issues regarding the recruitment and retention dentists and dental care professionals (dental nurses, dental hygienists, dental therapist, dental technicians) means there are vacancies in posts (this is an issue across the United Kingdom). Information on dentist workforce is headcount and no breakdown of whole time equivalent or percentage of time private/NHS. • Mixed economy business models and a move away from NHS dentistry towards private dentistry, in some dental practices, has resulted in reduced access to NHS dentistry in primary care. • Current dental workforce issues in primary care mean there are added pressures on our Public Dental Service (employed dental service in NHS Fife) that has potentially to impact PDS registered patients, waiting lists for referral services.			
Current Risk Level & Rating	**High**	**Likelihood - 5**	**Consequence - 4**	**Level - 20**
Target Risk Level (in year delivery)	**Moderate**	**Likelihood- 4**	**Consequence - 4**	**Level - 16**
Management Actions (current)				
Action			**Status**	**Impact on Likelihood/ Consequence**

Adapt Advice Line call options (as required) and establish an email to give up to date advice on practices open for NHS registrations. Currently receives approx 2000 calls per month. NHS dental registration look ups and inform patients to contact dental practices to access dental care. NHS Advice line keeps up to date information (monthly) on practices taking on NHS patients. Advice line phone number has an option for people to press to get email address to receive the latest information on where to get registered.	**Ontrack - ongoing**	**Very limited impact on likelihood**
Continually review numbers of patients accessing Emergency Dental Service (EDS) sessions and have 3 dentists operating per session and one standby dentist- called out 50% of the time. *Emergency Dental Services - operates 1 session each day of the weekend- managed by PDS and staffed by general dental practitioners and PDS staff.*	**On track - ongoing**	**Very limited impact on consequence**
Request weekly exceptional reporting from Dental Body Corporates to proactively plan where potential pressures in whole system.	**On track - ongoing**	**Very limited impact on consequence**
PDS 'pivot' and have dentists employed to cover urgent dental care clinics and provide 'targeted care' to prevent cycling through urgent dental care needs. *This means the PDS's own registered patients and referrals have to be 'de-prioritised' to accommodate urgent dental care needs. Clinics provided in a number of locations across Fife to improve access and reduce travel for patients.*	**On track - ongoing**	**Limited impact on Reduce consequence**
NHS Fife's and HSCP Dental Senior Management Team meet every 6 months with the Office of the Chief Dental Officer and submit monthly flash reports. *This allows key issues and challenges to be reported on/escalated to Scottish Government. It is acknowledged that there are no 'quick wins' and workforce challenges need to be addresses. Ongoing work at Scottish Government level with Ministers and the General Dental Council (GDC) (the UK dental regulatory body) to look at ways to improve the process for the recruitment of overseas dentists while maintaining patient safety.*	**In Progress- Some Challenges**	**Very limited impact on likelihood & consequence**
Ongoing data collected on NHS dental de-registrations- bulk de-registrations, privatisation- this gives accurate and timely information. *Data demonstrates ongoing bulk*	**In Progress- Some Challenges**	**Very limited impact on consequence**

de-registrations from dental practices which continues to put pressure on PDS.		
Needs assessment and strategic plan written (2024) to identify (and evidence) where Scottish Government's Scottish Dental Initiative Access (SDAI) Grants should be recommended - 3 areas suggested to Scottish government and all 3 approved.	**Completed**	
SDAI- Two practices have been approved to receive Scottish Government funds to open a multi-surgery practices in Dunfermline and Kirkcaldy. *These practices will work towards registering 1,500 NHS patients per surgery. The amount of funding doesn't require any decision from the Board or its committees. A detailed paper giving assurance is available on request.*	**In Progress - On track**	**Impact on likelihood & consequence**
Continually deliver national oral health improvement programmes and locally develop bespoke services/collaborative working to ensure inclusion health and signposting/building trust to enable engagement of services e.g. KY Cafes, gypsy traveller communities, homeless accommodation	**In Progress- On Track**	**Limited impact on consequence**
Oral Cancer Awareness Campaign:- Mouth cancer is one of the most common cancers worldwide. The incidence rate of the disease is rising and is expected to continue and can be attributed to modifiable lifestyle factors and are potentially preventable. *The PDS has established a year-long partnership with Dunfermline Athletic Football Club from August 2024, including take-home "self-check" cards displayed around the stadium concourses.*	**In Progress – On Track**	**Limited impact on consequence**
Management Actions (future)		
Action	**Status**	
VMF approval required for PDS dental nurse and reception posts to enable all clinics to operate 5 days a week and be fully staffed. Challenge to recruit to 2-3 WTE Dental Officer posts due to lack of 'supply' of dentists. *NB PDS Dental receptionist posts are Band 3 whereas EDS receptionists are Band 2 as require skills to invoice and receive money (as PDS work under GDS contract and primary care dentistry is charged (unless exempt)*	**In Progress- Some Challenges**	**Impact on consequence**

Develop and test a suite or oral health indicators as part of HSCP Performance Management Framework to measure impact of actions.	**In Progress – On track**	**Very limited impact**
Planned work with Human Resources and NHS Fife Communications on a 'dental recruitment campaign' (similar to medical campaign).	**In Progress – On track**	**Impact on likelihood and consequence**
Meeting being arranged with Chief Executive, Chair, Medical Director and Consultant in Dental Public Health with an MSP and Cabinet Secretary for Health. *Important to advise what is in/out of our control and to understand what more we can do that we are not already doing- key priority is Glenrothes area (as part of SDAI work)*	**In Progress – On track**	**Very limited impact on consequence**
Use the recent National Dental Inspection Programme (NDIP) data to target resources. The aim is to expand components of Childsmile, such as the supervised toothbrushing programmes to include more school years to help reduce inequalities *(as part of the Scottish Government's commitment to reduce inequalities)*	**In Progress – On track**	**Limited impact on consequence**

Action Status Key
Completed
In Progress - On track
In Progress- Some Challenges
In Progress- Significant Challenges
Not started

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**15 May 2025**
Title:	**Risk Management Key Performance Indicators 2024/25**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
Report Author:	**Dr Shirley-Anne Savage, Associate Director for Risk and Professional Standards, NHS Fife**

Executive Summary:

This report provides:

- a summary detail on the number of risks currently held on the Datix Risk Register and the number of risks opened and closed for the period 01/05/24 to 30/04/25
- an assessment of compliance against the KPIs

The committee are asked to take a moderate level of assurance from the update provided.

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Annual Delivery Plan
- Emerging issue
- Local policy
- NHS Board / IJB Strategy or Direction / Plan for Fife
- NHS Fife Board Strategic Priorities
    - To Improve Quality of Health & Care Services

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Audit and Risk Committee and by extension the Board, require assurance that systems are in place to review and monitor the adequacy and effectiveness of our risk management arrangements.

2.2 Background

Key Performance Indicators (KPIs) are recognised as a tool to support this activity. This report provides an update on performance against a set of risk management KPIs.

It is recognised that the KPIs will continue to be refined in response to feedback from this Committee and the wider organisation, and that future iterations of this report will reflect such developments.

2.3 Assessment

Appendix 1 provides:

- summary detail on the number of risks currently held on the Datix Risk Register and the number of risks opened and closed for the period 01/05/24 to 30/04/25 and
- an assessment of compliance against the KPIs

The data show the dynamic nature of the risk register, with fluctuations from month to month; it is recognised that the reasons for this are multi-factorial. The data show a relatively stable picture with room for improvement across all areas of required compliance.

As part of its workplan, the ROG will continue to consider how to further develop the operational management of risk, including working with services to drill down into the risk data to better understand the organisation's risk profile, and the quantum of risks. This will include reviews of risk type, location, ownership and related assessments, and the identification of trends or areas that may require further interrogation and / or escalation and oversight. Importantly, this activity will consider the extent to which the risk profile reflects the current operating landscape and operational challenges.

This report provides the following Level of Assurance:

	Significant	Moderate	Limited	None
Level		x		
Descriptor	There is robust assurance that the system of control achieves, or will achieve, the purpose that it is designed to deliver. There may be an insignificant amount of residual risk or none at all.	There is sufficient assurance that controls upon which the organisation relies to manage the risk(s) are suitably designed and effectively applied. There remains a moderate amount of residual risk.	There is some assurance from the systems of control in place to manage the risk(s), but there remains a significant amount of residual risk, which requires further action to be taken.	No assurance can be taken from the information that has been provided. There remains a significant amount of residual risk

2.3.1 Quality, Patient and Value-Based Health & Care

Effective risk management is a key component to ensure patient safety by contributing to improving the reliability and safety of our health care systems and processes.

2.3.2 Workforce

Effective management of risk is key to ensuring staff work in a safe environment and will support delivery of our strategic priorities, to support staff health and wellbeing.

2.3.3 Financial

This paper does not raise, directly, financial impacts, but these do present significant elements of risk for NHS Fife to consider and manage in pursuit of our strategic priorities.

2.3.4 Risk Assessment / Management

The arrangements for managing risk affect patients, staff and others in contact with the Board's services. Healthcare provision is complex and involves a degree of inherent and new risks. Risks must therefore, be properly managed.

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

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

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

This paper is informed mainly by communications with the ROG.

2.3.8 Route to the Meeting

- Chris McKenna, Medical Director on 2 May 2025
- Alistair Graham, Director of Digital and Information on 2 May 2025

2.4 Recommendation

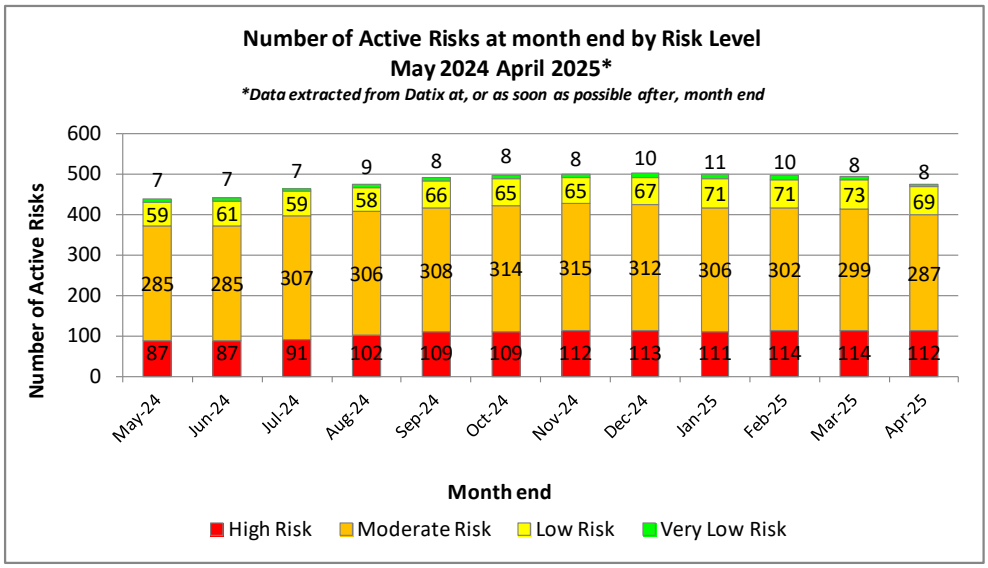
- Members are asked to take a **"moderate" level of assurance from** the update provided, noting that the ROG will continue to refine the associated KPIs

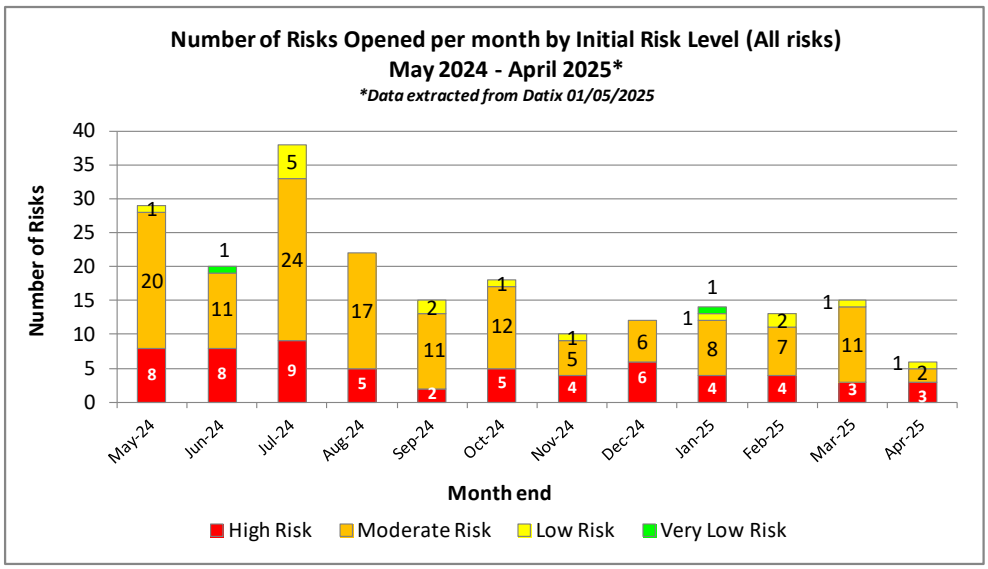
3 List of appendices

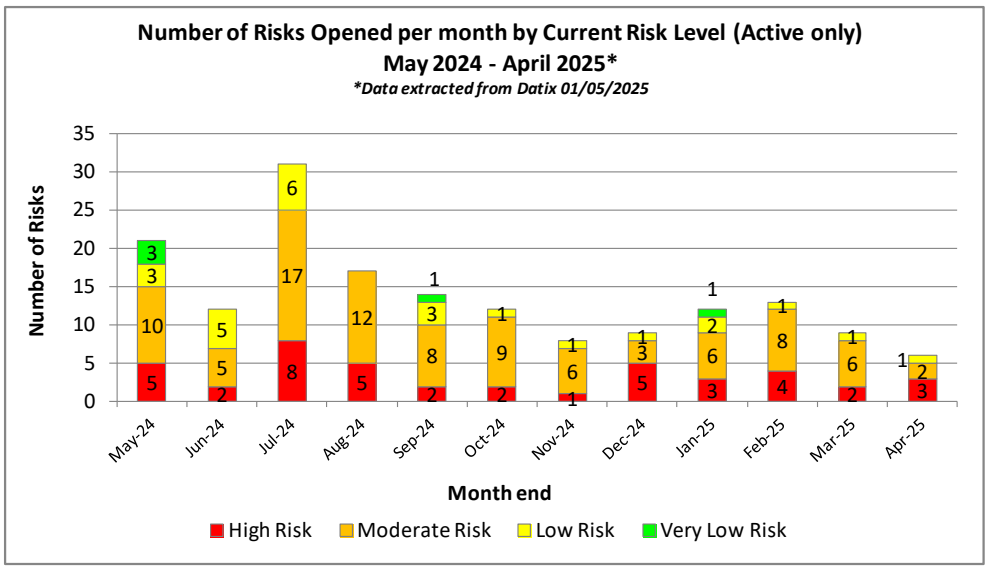
- Appendix No. 1, Risk Management Key Performance Indicator Report 1 May 2024 – 30 April 2054 to the Audit & Risk Committee, on 15 May 2025

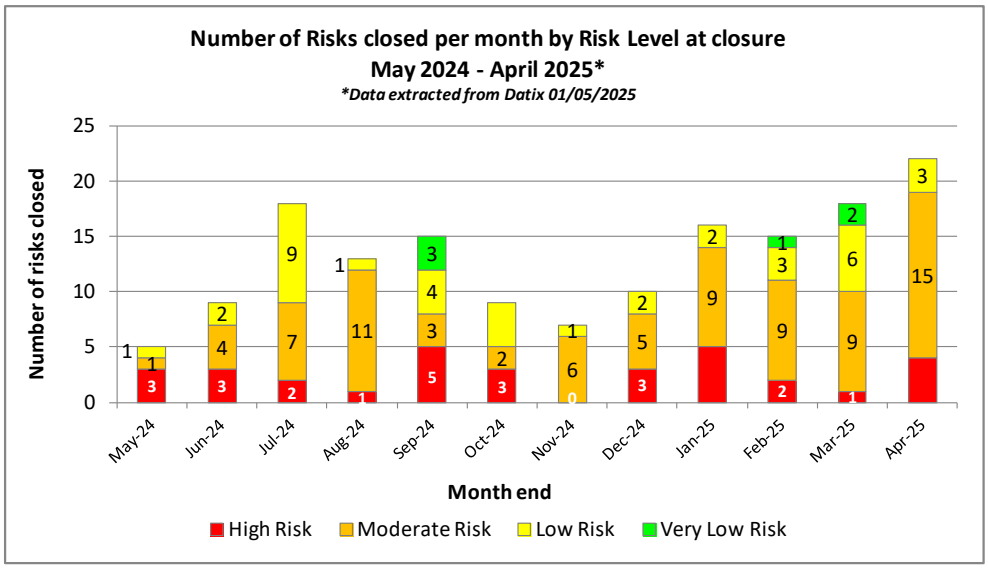
Report Contact: Dr Shirley-Anne Savage, Associate Director for Risk and Professional Standard Email shirley-anne.savage@nhs.scot

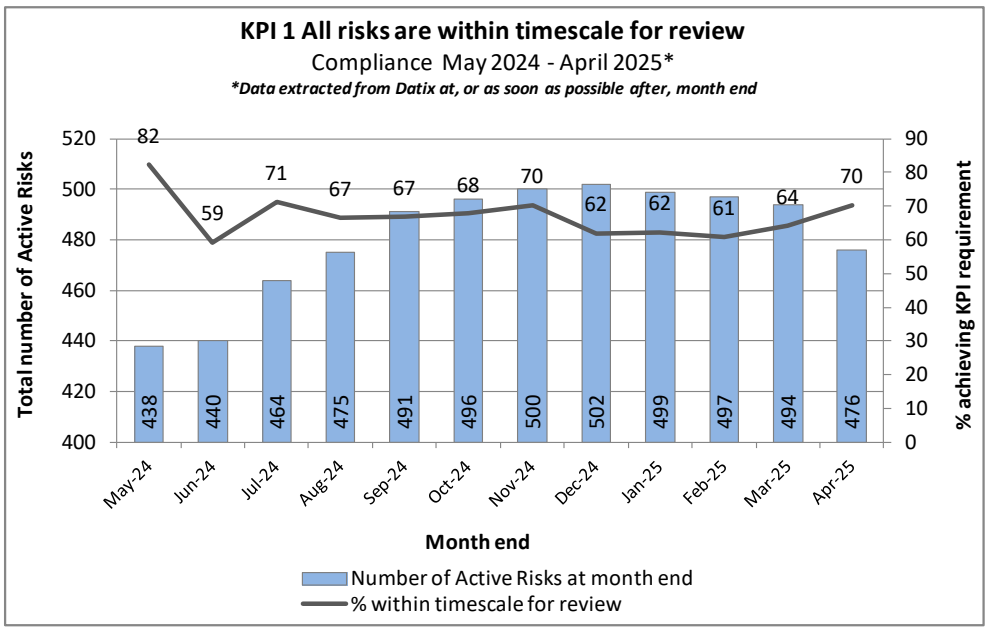
Risk KPI information May 2024 to April 2025

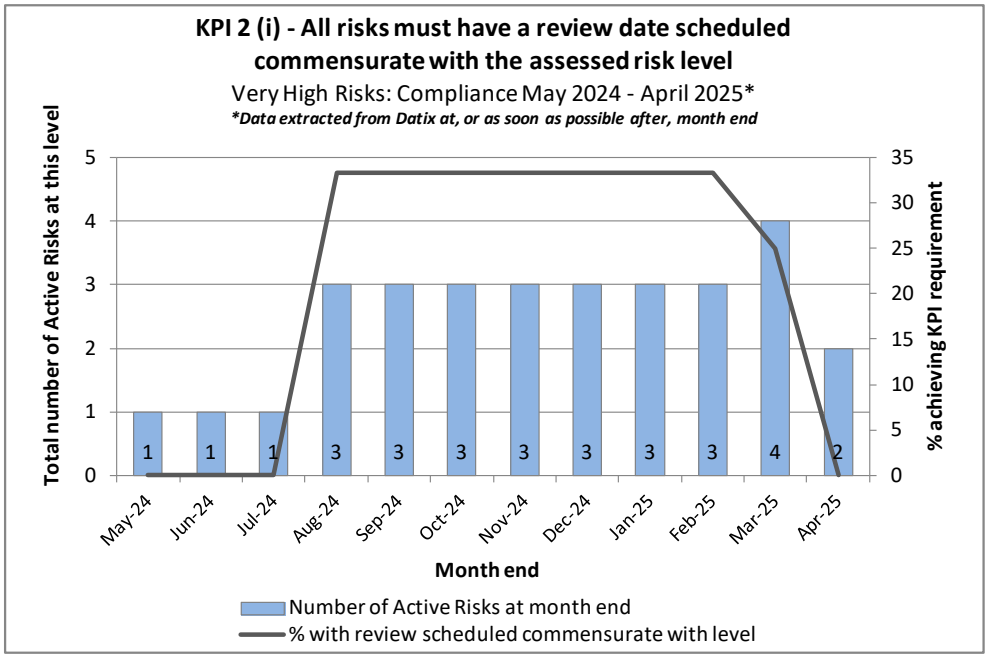


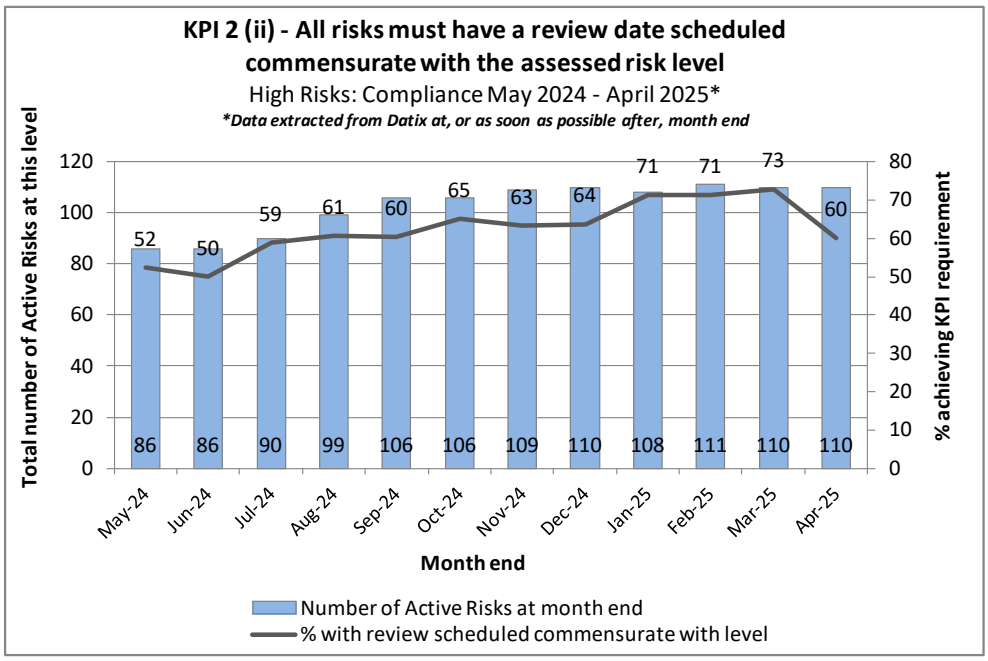


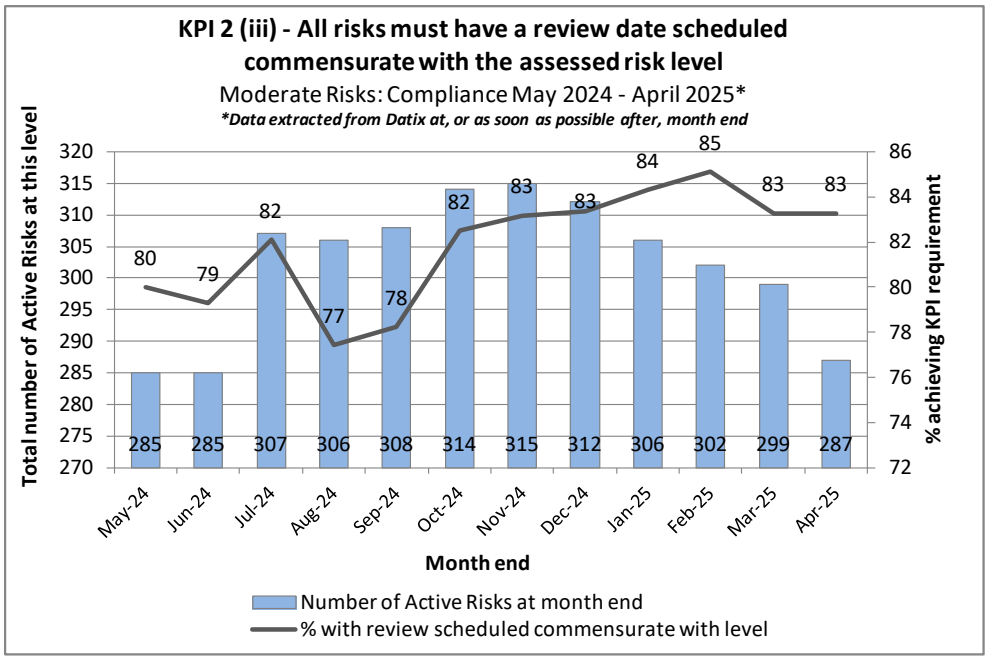


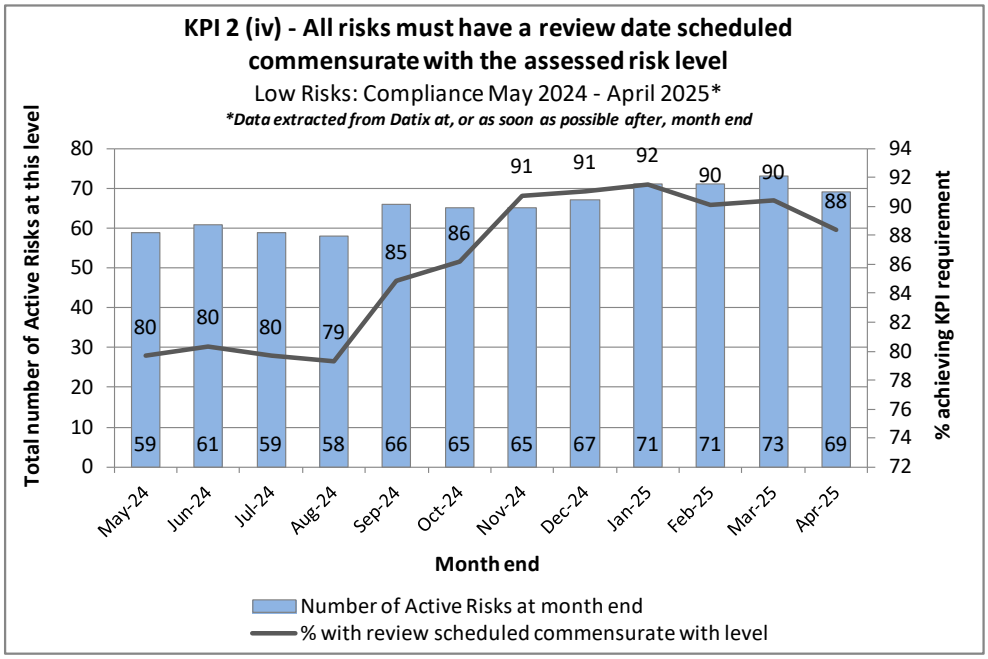

Number of Risks closed per month by Risk Level at closure
May 2024 - April 2025*
*Data extracted from Datix 01/05/2025
Number of risks closed
Month end
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25
Apr-25
High Risk
Moderate Risk
Low Risk
Very Low Risk

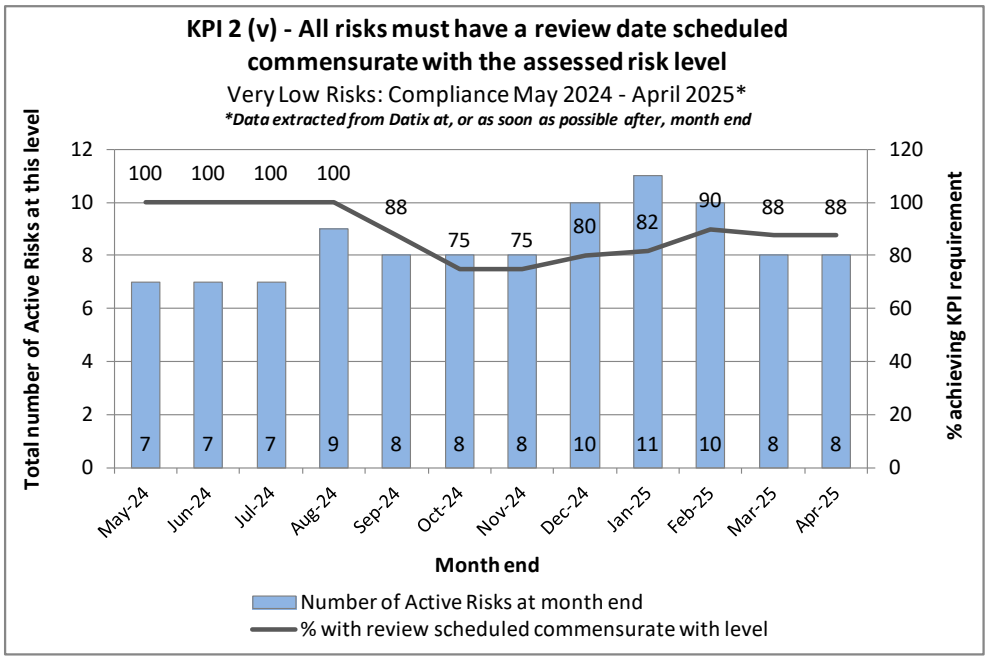

KPI 1 All risks are within timescale for review
Compliance May 2024 - April 2025*
*Data extracted from Datix at, or as soon as possible after, month end
Total number of Active Risks
% achieving KPI requirement
Month end
Number of Active Risks at month end
% within timescale for review


KPI 2 (i) - All risks must have a review date scheduled commensurate with the assessed risk level
Very High Risks: Compliance May 2024 - April 2025*
*Data extracted from Datix at, or as soon as possible after, month end
Total number of Active Risks at this level
% achieving KPI requirement
Month end
Number of Active Risks at month end
% with review scheduled commensurate with level

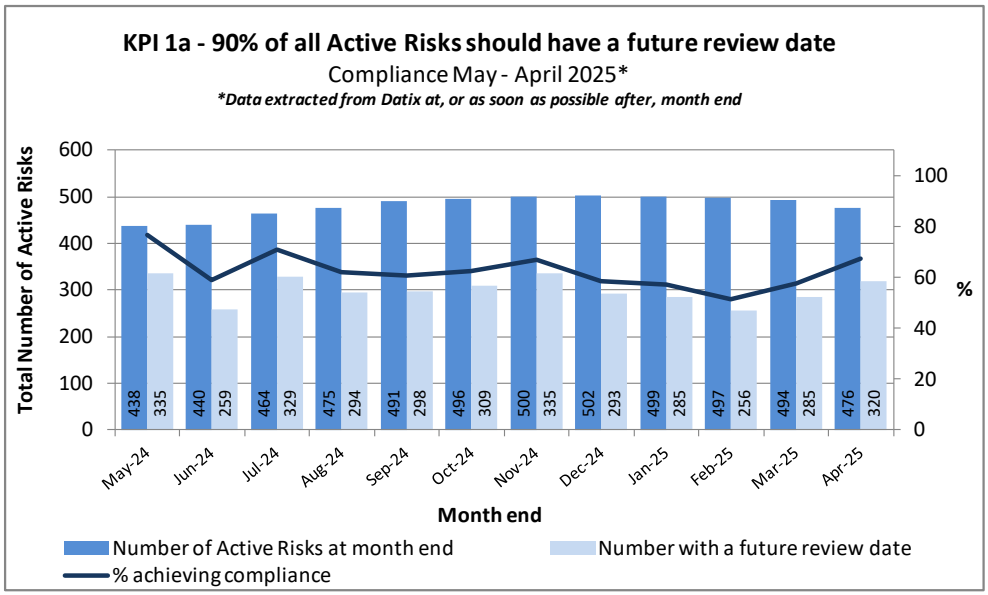

KPI 2 (ii) - All risks must have a review date scheduled commensurate with the assessed risk level
High Risks: Compliance May 2024 - April 2025*
*Data extracted from Datix at, or as soon as possible after, month end
Total number of Active Risks at this level
% achieving KPI requirement
May-24 Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25
86 86 90 99 106 106 109 110 108 111 110 110
52 50 59 61 60 65 63 64 71 71 73 60
Month end
Number of Active Risks at month end
% with review scheduled commensurate with level

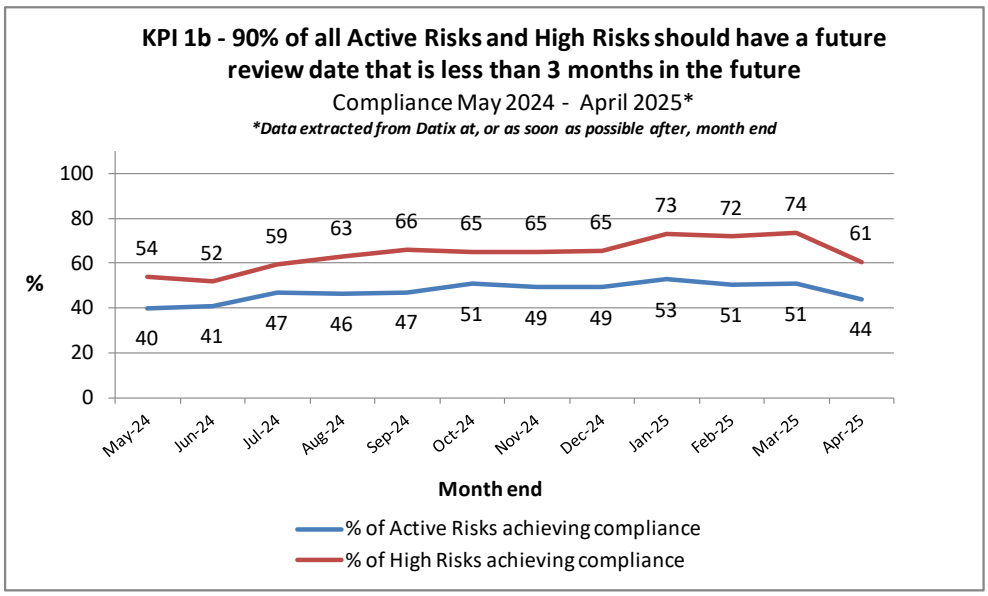

KPI 2 (iii) - All risks must have a review date scheduled commensurate with the assessed risk level
Moderate Risks: Compliance May 2024 - April 2025*
*Data extracted from Datix at, or as soon as possible after, month end
Total number of Active Risks at this level
% achieving KPI requirement
May-24 Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25
285 285 307 306 308 314 315 312 306 302 299 287
80 79 82 77 78 82 83 83 84 85 83 83
Month end
Number of Active Risks at month end
% with review scheduled commensurate with level

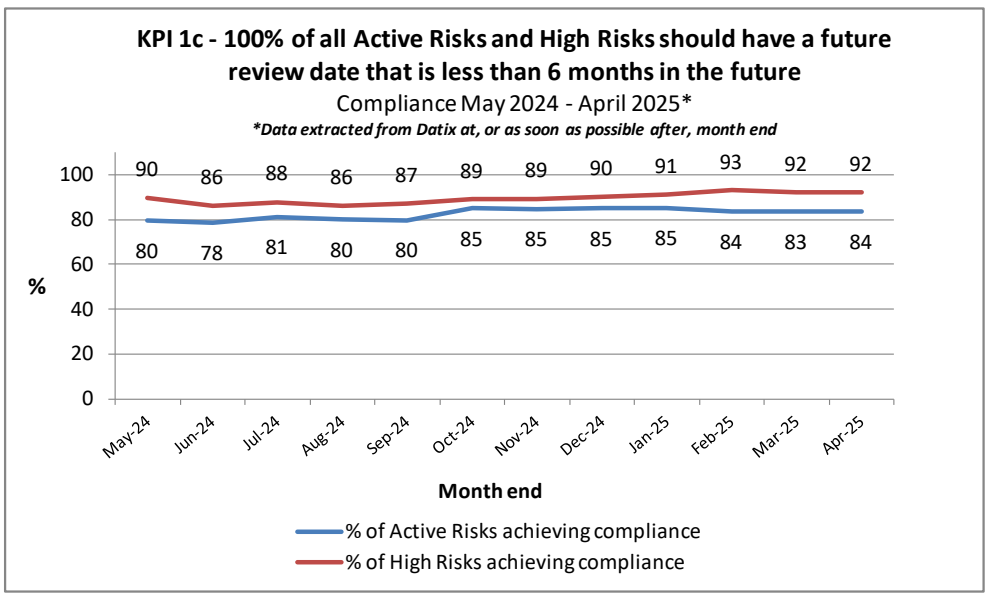

KPI 2 (iv) - All risks must have a review date scheduled commensurate with the assessed risk level
Low Risks: Compliance May 2024 - April 2025*
*Data extracted from Datix at, or as soon as possible after, month end
Total number of Active Risks at this level
% achieving KPI requirement
May-24 Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25
59 61 59 58 66 65 65 67 71 71 73 69
80 80 80 79 85 86 91 91 92 90 90 88
Month end
Number of Active Risks at month end
% with review scheduled commensurate with level

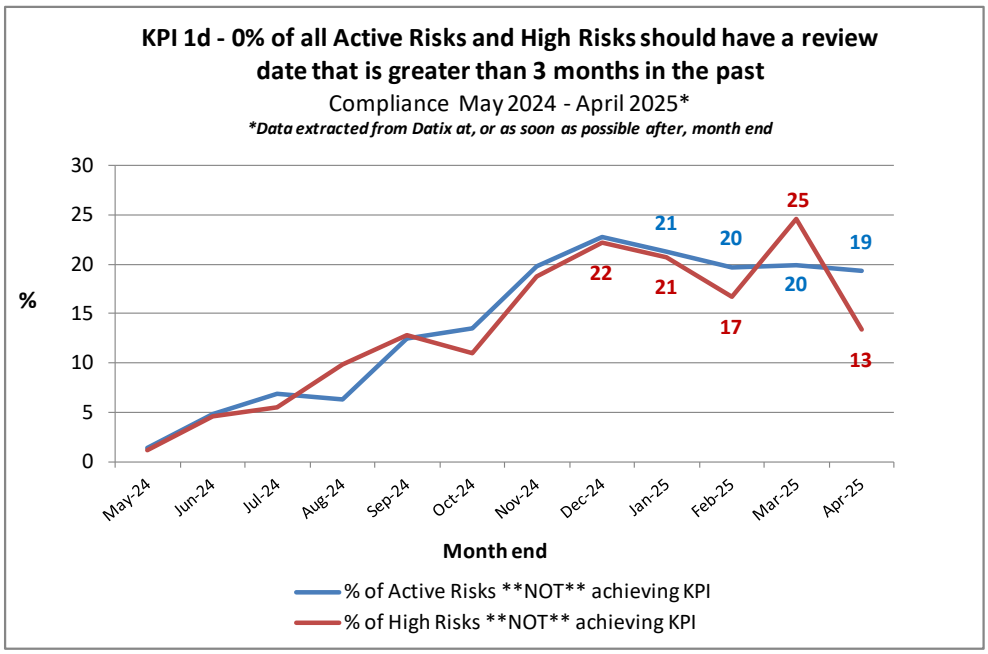

KPI 2 (v) - All risks must have a review date scheduled commensurate with the assessed risk level
Very Low Risks: Compliance May 2024 - April 2025*
*Data extracted from Datix at, or as soon as possible after, month end
Total number of Active Risks at this level
% achieving KPI requirement
Month end
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25
Apr-25
100 100 100 100 88 75 75 80 82 90 88 88
7 7 7 9 8 8 8 10 11 10 8 8
Number of Active Risks at month end
% with review scheduled commensurate with level

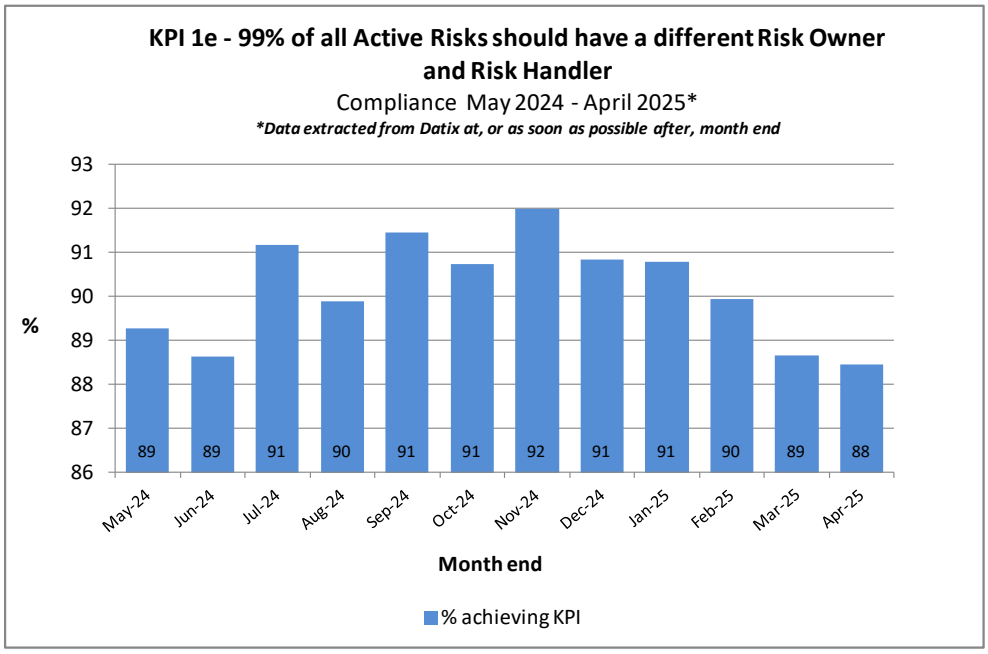
NEW

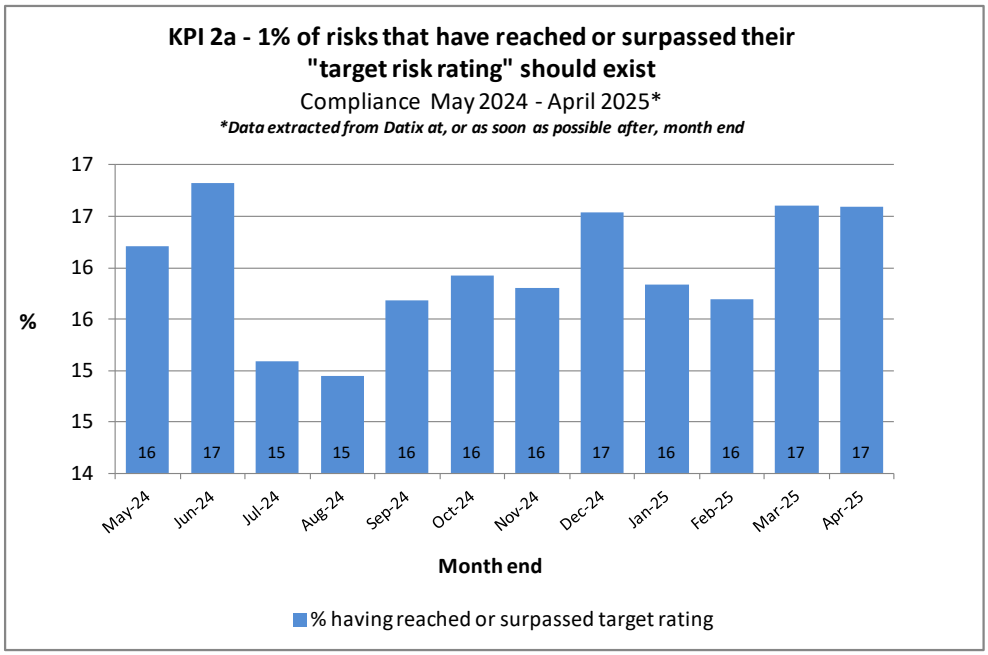

KPI 1a - 90% of all Active Risks should have a future review date
Compliance May - April 2025*
*Data extracted from Datix at, or as soon as possible after, month end
Total Number of Active Risks
%
Month end
Number of Active Risks at month end
Number with a future review date
% achieving compliance

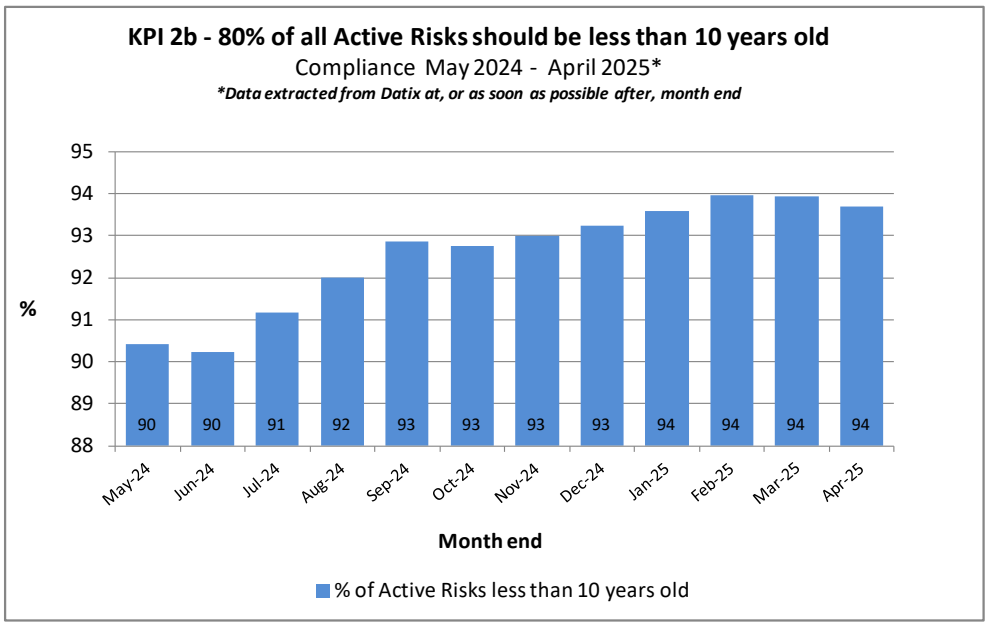

KPI 1b - 90% of all Active Risks and High Risks should have a future review date that is less than 3 months in the future
Compliance May 2024 - April 2025*
*Data extracted from Datix at, or as soon as possible after, month end
%
Month end
% of Active Risks achieving compliance
% of High Risks achieving compliance


KPI 1c - 100% of all Active Risks and High Risks should have a future review date that is less than 6 months in the future
Compliance May 2024 - April 2025*
*Data extracted from Datix at, or as soon as possible after, month end
%
Month end
% of Active Risks achieving compliance
% of High Risks achieving compliance


KPI 1d - 0% of all Active Risks and High Risks should have a review date that is greater than 3 months in the past
Compliance May 2024 - April 2025*
*Data extracted from Datix at, or as soon as possible after, month end
%
30
25
20
15
10
5
0
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25
Apr-25
21
20
19
22
21
20
25
17
13
Month end
% of Active Risks **NOT** achieving KPI
% of High Risks **NOT** achieving KPI


KPI 1e - 99% of all Active Risks should have a different Risk Owner and Risk Handler
Compliance May 2024 - April 2025*
*Data extracted from Datix at, or as soon as possible after, month end
%
93
92
91
90
89
88
87
86
89
89
91
90
91
91
92
91
91
90
89
88
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25
Apr-25
Month end
% achieving KPI


KPI 2a - 1% of risks that have reached or surpassed their "target risk rating" should exist
Compliance May 2024 - April 2025*
*Data extracted from Datix at, or as soon as possible after, month end
%
17
17
16
16
15
15
14
16
17
15
15
16
16
16
17
16
16
17
17
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25
Apr-25
Month end
% having reached or surpassed target rating


KPI 2b - 80% of all Active Risks should be less than 10 years old
Compliance May 2024 - April 2025*
*Data extracted from Datix at, or as soon as possible after, month end
%
95
94
93
92
91
90
89
88
90
90
91
92
93
93
93
93
94
94
94
94
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25
Apr-25
Month end
% of Active Risks less than 10 years old

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**15 May 2025**
Title:	**Risks & Opportunities Group Annual Assurance Statement 2024/25**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
Report Author:	**Dr Shirley-Anne Savage, Associate Director for Risk and Professional Standards**

Executive Summary:

- This paper provides the Annual Statement of Assurance for the Risks and Opportunities Group including the outcome of a self-assessment exercise.
- The Annual Statement of Assurance and the self-assessment are presented to provide assurance that the requirements of the Group are being fulfilled.
- This report provides a moderate level of assurance.

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Local policy
- NHS Fife Board Strategic Priorities
  - To Improve Quality of Health & Care Services
  - To Deliver Value and Sustainability
  - To Improve Health & Wellbeing
  - To Improve Staff Experience and Wellbeing

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This paper provides ARC with the Annual Statement of Assurance for the Risks and Opportunities Group including the outcome of a self-assessment exercise.

2.2 Background

The Annual Statement of Assurance and the self-assessment are presented to provide assurance that the requirements of the Group are being fulfilled. The self-assessment also gave members an opportunity to reflect and consider ways to improve the Group's effectiveness. Combined, these processes seek to provide assurance that any potential improvements and developments will be identified and appropriately actioned.

2.3 Assessment

Statement of Assurance

The Statement summarises the business covered by the Risks and Opportunities Group during 2024/2025 and is provided at Appendix 1.

Self-Assessment questionnaire (completed by members and attendees)

The self-assessment comprised several effectiveness-related questions, where a scaled 'Strongly Agree/Strongly Disagree' response to each question was sought. Textual comments were also invited, for respondents to provide direct feedback. Results are provided in Section 9 Self-Assessment within the Assurance Statement (Appendix 1).

The ARC are asked to take a moderate level of assurance.

This report provides the following Level of Assurance:

	Significant	Moderate	Limited	None
Level		x		
Descriptor	There is robust assurance that the system of control achieves, or will achieve, the purpose that it is designed to deliver. There may be an insignificant amount of residual risk or none at all.	There is sufficient assurance that controls upon which the organisation relies to manage the risk(s) are suitably designed and effectively applied. There remains a moderate amount of residual risk.	There is some assurance from the systems of control in place to manage the risk(s), but there remains a significant amount of residual risk, which requires further action to be taken.	No assurance can be taken from the information that has been provided. There remains a significant amount of residual risk

2.3.1 Quality, Patient and Value-Based Health & Care

Elevating the profile of risk management in NHS Fife will further support delivery of our strategic priorities through improved operational governance and better alignment with the Population Health and Wellbeing Strategy and associated work streams.

2.3.2 Workforce

Effective management of workforce risks will support staff health and wellbeing, and the quality of health and care services.

2.3.3 Financial

This paper does not raise, directly, financial impacts, but these do present significant elements of risk for NHS Fife to consider and manage in pursuit of our strategic priorities.

2.3.4 Risk Assessment / Management

The self-assessment offers assurance that the Group has reflected on its performance during 2024/2025 and is committed to taking the necessary improvement actions.

2.3.5 Equality and Human Rights, including children's rights, health inequalities and Anchor Institution ambitions

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

2.3.6 Climate Emergency & Sustainability Impact

This paper does not raise, issues relating to climate emergency and sustainability

2.3.7 Communication, involvement, engagement and consultation

This paper reflects the input of the Risks and Opportunities Group.

2.3.8 Route to the Meeting

ELT – 24 April 2025

2.4 Recommendation

This paper is provided to members for:

- **Assurance** – This report provides a "moderate" level of assurance

3 List of appendices

The following appendices are included with this report:

- Appendix No. 1, Annual Statement of Assurance for the Risks and Opportunities Group

Report Contact
Dr Shirley-Anne Savage
Associate Director for Risk and Professional Standards
Email shirley-anne.savage@nhs.scot

DRAFT ANNUAL STATEMENT OF ASSURANCE FOR NHS FIFE RISKS AND OPPORTUNITIES GROUP 2024/25

1. Purpose

1.1 To provide the NHS Fife Audit and Risk Committee and the Executive Directors' Group with the assurance that the NHS Fife Risks and Opportunities Group has fulfilled its purpose and remit during 2024/2025.

1.2 The Risks and Opportunities Group has been delegated the responsibility by the Executive Directors' Group (EDG) to progress the activities described below, which largely reflect the Group's Terms of Reference, 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 in relation to delivery of the NHS Fife Population Health and Wellbeing Strategy and escalating to the EDG as appropriate
- Assessing risks, opportunities, issues and events that arise and responding accordingly, making appropriate recommendations on potential impact upon the Board's Risk Appetite position
- 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, supporting the sharing of best practice amongst teams and senior leaders.

1.3 This assurance statement summarises the business covered during 2024/2025.

2. Membership

2.1 During the financial year to 31 March 2025, membership of the ROG comprised:

Member	Designation
Lynn Barker	Director of Nursing, Fife Health & Social Care Partnership (HSCP)
Gemma Couser	Associate Director of Quality & Clinical Governance, NHS Fife
Vicki Bennett	Staff side Co Chair, HSCP Local Partnership Forum (LPF)
Pauline Cumming	Risk Manager, NHS Fife (Retired in May 2024)
Fiona Forrest	Acting Director of Pharmacy, NHS Fife
Susan Fraser	Associate Director of Planning & Performance, NHS Fife

Alistair Graham (Deputy Chair)	Director, Digital & Information, NHS Fife
Kirsty MacGregor	Director of Communications, NHS Fife
Gillian MacIntosh	Head of Corporate Governance & Board Secretary, NHS Fife
Dr Iain MacLeod	Deputy Medical Director, Acute Services Division, NHS Fife
Dr Rishma Maini	Consultant, Public Health, NHS Fife
Maxine Michie	Deputy Director of Finance, NHS Fife
Belinda Morgan	General Manager, Medical Directorate, Acute Services Division, NHS Fife
Frances Quirk	Assistant Research, Knowledge & Information Director, NHS Fife
Jimmy Ramsay	Estates Manager, Compliance, NHS Fife
Nicola Robertson	Director of Nursing, Corporate, NHS Fife
Shirley-Anne Savage (Chair)	Associate Director for Risk and Professional Standards, NHS Fife
Audrey Valente	Chief Financial Officer, Fife Council
Amanda Wong	Director of Allied Health Professions, NHS Fife
Rhona Waugh	Head of Workforce Planning & Staff Wellbeing, NHS Fife
Mairi McKinley	Head of Practice & Professional Development, NHS Fife
Attendee	**Designation**
Barry Hudson	Regional Audit Manager
Avril Sweeney	Risk Compliance Manager, Fife HSCP

2.2 The ROG may invite other colleagues to attend meetings to contribute to particular topics as required. Attendees and deputies are recorded in the individual notes of each meeting and in the attendance schedule set out at Appendix 1.

3. Meetings

3.1 The Group met on 5 occasions during the financial year to 31 March 2025, on the undernoted dates: The 4 June meeting was cancelled due to the number of apologies.

- 2 April 2024
- 6 August 2024
- 8 October 2024
- 3 December 2024
- 4 February 2025

4. Business

4.1 For the period under review, to support delivery of its annual work plan, the agenda considered the Corporate Risk Register and Operational Risk at alternate meetings.

Standing Agenda Items

4.2 **Risk Appetite**
After two Board development sessions in 2024 the Board's Risk Appetite was approved by the Board and set in November 2024. As described above it was considered as part of the update to the Risk Management Framework.

It is recognised that risk appetite is not static and must be reviewed and adjusted to reflect changes in the internal and external environment that may affect our risk profile or strategy. To this end, the ROG will facilitate a review of the risk appetite annually with a refresh every two years.

4.3 **Risk Management Framework**

The finalised Risk Management Framework, incorporating the new risk appetite statement, was presented to the Audit & Risk Committee on 12 December 2024 and approved by the Fife NHS Board in January 2025. At the time of writing, work on a Delivery Plan for 2025/26 to support implementation is currently underway. The Delivery Plan will be agreed through the ROG before going forward to EDG and the Audit and Risk Committee.

4.4 **Corporate Risk Register and Deep Dives**

The Group received frequent updates on the corporate risks aligned to each of the Board's governance committees. Members took the opportunity to reflect on feedback as the corporate risks have developed over time through presentation and consideration by the committees, particularly in relation to the usefulness and format of deep dive reviews.

Corporate Risk Deep Dive reviews continue to form an important component of our risk assurance arrangements and provide a focus for in-depth discussion and scrutiny.

A key characteristic of a risk deep dive review is that it should be carried out at specific points during the life cycle of a risk. Criteria for undertaking a deep dive review have been agreed and include the creation of a new corporate risk, materially deteriorating risks, or the proposed de-escalation / closure of a corporate risk.

Deep dives presented and considered at the ROG meeting this year were:

- Substance related morbidity and mortality
- Hospital acquired Harm
- Access to general dentistry

Tis initiated some very useful discussion, and the ROG members were able to provide very helpful comment and suggestions on each of the deep dives in order that they were ready for presentation to the committees.

To enhance the assurance that can be taken from deep dives, the ROG must focus on the Internal Audit recommendations:

- an assessment as to the impact of management actions on the target score;
- a focus on controls, with explicit assurance and conclusion on their effectiveness;
- an assessment of the proportionality of proposed actions; and
- external and internal factors associated with risks and their potential influence

4.5 **Assurance Levels**

We continue to use the four-level assurance model, and this continues to add consistency to our reporting. The use of the assurance levels continues to evolve, as we seek to enhance the evidence to substantiate the level of assurance being offered.

Reports to the governance committees include a statement on the latest position in relation to the management of risks linked to the respective committees, the proposed 'level' of assurance that members can take from the report, and detail on mitigating actions.

5. Performance

5.1 Key Performance Indicators (KPIs)

The Group agreed a set of KPIs associated with operational risk which demonstrate active risk management. These include:

- 90% of all Active Risks should have a future review date
- 90% of all Active and High Risks should have a future review date that is less than 3 months in the future
- 100% of all Active and High Risks should have a future review date that is less than 6 months in the future
- 0% of all Active and High Risks should have a review date that is greater than 3 months in the past
- 1% of risks that have reached or surpassed their "target risk rating" should exist
- 80% of all Active Risks should be less than 10 years old

KPI reports have been discussed at the ROG meeting and presented where appropriate to the Audit and Risk Committee meeting. A review is underway to determine how best to present the KPI data and act upon the results on an ongoing basis.

6. Horizon Scanning

The ROG continues to consider opportunities, particularly in relation to delivery of the NHS Fife Population Health and Wellbeing Strategy. The part of the group's role has taken longer to embed, and a renewed focus is required for 2025/26.

7. Governance

At each meeting the ROG reviews progress against the Workplan, considers issues for escalation and receives reports on any other relevant business.

The ROG has reported on its work to the Audit and Risk Committee in May, September and in March 2025.

8. Developments and Emerging Business

8.1 Review of the Risk Assessment Matrix

The matrix used in NHS Fife is based on the NHS Scotland matrix which was originally developed in 2008.

The ROG had identified the need to further promote the matrix locally as a tool to support risk assessment and decision making. The group also discussed the need to update the matrix to ensure descriptors are current and comprehensive in scope and terminology.

At the same time similar considerations were taking place across other Scottish NHS Boards and a short life working group was set up through Healthcare Improvement Scotland (HIS) to review the national matrix and expand and modernise the content. A matrix has been developed and distributed and will allow NHS Fife to reflect and adapt the current NHS Fife matrix.

8.2 Risk Description

The ROG has recognised the importance of ensuring that risks are clearly and succinctly described and reflect the current organisational challenges. Descriptions should express the risk, the cause, and the consequences.

During 2024/25 there have been some description changes to risks within the Corporate Risk Register and a plan to review others during 2025/26.

Currently the Risk Management Team is undertaking work on operational risk registers and assisting the operational teams with risk descriptions and risk management.

8.3 **Development of a Risk Summary Dashboard**

It is recognised that the Datix system provides a well-used management tool for the individual management of risk, as well as recording of incidents, complaints, claims, safety alerts and business continuity data.

The Risk Summary Dashboard supports risk owners and handlers to move through activities detailed within the Operational Guidance document. Work will continue promoting this tool as we work with the operational divisions on their operational risk registers.

8.4 **Procurement of a New Risk Management System**

Work is underway to assess the suitability of the systems available to NHS Fife for future management of risk, recording of incidents, complaints, claims, safety alerts and business continuity. This involves evaluation of our current DATIX system against the new Inphase system and DATIX Cloud. The ROG will be integral in assisting with the evaluation of the different systems. In the interim DATIX web system will be in place till March 2026.

9. Self-Assessment

9.1 The Group has undertaken a self-assessment of its own effectiveness, using a questionnaire considered and approved by the Group's Chair and Deputy Chair.

Seven members or regular attendees of the Group completed the questionnaire and provided the following key feedback:

In relation to membership and dynamics, the majority of respondents indicated that the Group was provided with sufficient membership, authority and resource to perform its role effectively and independently, and that there is effective scrutiny and challenge from the Group, including on matters that are critical or sensitive. Responses indicate the Group's agenda is well managed and ensures that all topics within its terms of reference are appropriately covered. There was a strong indication that members are able to express their opinions openly and constructively.

There was agreement that the Group's membership is appropriate and that the group provides an appropriate level of scrutiny and is provided with assurance to ensure the corporate risks are being managed to an acceptable level.

Areas on which there were mixed opinions indicating the need for further consideration and discussion include:

- whether members were clear about their role and how their participation can best contribute to the group's overall effectiveness
- whether members have a sufficient knowledge of the issues within their remit to identify areas of concern

- members' confidence that the delegation of responsibilities from the Executive Directors Group is operating effectively as part of the overall governance.

There were some suggestions that will be focussed on over the coming year:

- Review the membership particularly from areas that are not regularly sending a representative
- Provide greater clarity of ownership and responsibility for implementing action
- Continue to build on the opportunity agenda and alignment with the strategic planning process
- Training and development opportunities for members

10. Conclusion

10.1 As Chair and Deputy Chair of the Group during financial year 2024-2025, we are satisfied that the approach, the frequency of meetings, the scope of the business undertaken and the range of attendees at meetings of the Group has allowed us to fulfil our remit. As a result of the work undertaken during the year, we can confirm that adequate and effective governance arrangements were in place in the areas under our remit during the year.

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

10.3 We commend the commitment and enthusiasm of fellow members of the Group and all attendees. We thank all staff who have prepared reports and participated in meetings.

Signed: Date: dd /mm /2025
Signed: Date: dd /mm /2025

On behalf of the NHS Fife Risks and Opportunities Group

Appendix 1

NHS Fife Risks & Opportunities Group Attendance Record

1st April 2024 to 31st March 2025

Member	Designation	2nd Apr 2024	4th June 2024 - cancelled	6th Aug 2024	8th Oct 2024	3th Dec 2024	4th Feb 2025
Lynn Barker (LB)	Director of Nursing, Health & Social Care Partnership (HSCP)	x		x	✓	x	
Vicki Bennett (VB)	Staff side Co Chair HSCP Local Partnership Forum (LPF)			x	✓	✓	
Gemma Couser (GC)	Associate Director of Quality & Clinical Governance	✓		✓	✓	✓	
Pauline Cumming (PC)	Risk Manager	✓					
Fiona Forrest (FF)	Director of Pharmacy	x		✓	✓	✓	
Susan Fraser (SF)	Associate Director of Planning and Performance	✓		x	x	✓	
Alistair Graham (AG) (Chair)	Director, Digital & Information (D&I)	✓		x	✓	✓	
Kirsty MacGregor (KM)	Associate Director of Communications	✓		✓	✓	x	
Gillian MacIntosh (GM)	Head of Corporate Governance & Board Secretary	✓		x	✓	✓	
Mairi McKinley (MMcK)	Senior Practitioner - Practice & Professional Development			✓	✓	x	
Dr Iain MacLeod (IM)	Deputy Medical Director	x		x	✓	✓	
Dr Rishma Maini (RM)	Consultant, Public Health	x		✓	✓	x	
Maxine Michie (MM)	Deputy Director of Finance	✓		x	✓	✓	
Belinda Morgan (BM)	General Manager, Emergency Care Directorate, Acute Services Division	✓		x	✓	x	
Frances Quirk (FQ)	Assistant Research, Knowledge & Information (RIK) Director	x		✓	✓	x	
Jimmy Ramsay (JR)	Estates Manager, Compliance	x		x	x	x	
Nicola Robertson (NR)	Director of Nursing, Corporate	✓		x	x	✓	
Shirley-Anne Savage (SAS)	Associate Director for Risk & Professional Standards	✓		✓	✓	✓	
Audrey Valente (AV)	Chief Financial Officer, Fife Council	x		x	x	x	
Rhona Waugh	Head of Workforce Planning & Staff Wellbeing	✓		✓	✓	✓	
Amanda Wong (AW)	Director of Allied Health Professions	x		x	✓	x	
In attendance							
Kirsty Chater	Business Manager, Fife Health & Social Care Partnership	x					
Barry Hudson (BH)	Regional Audit Manager	x		x	✓	x	
Avril Sweeney (AS)	Risk Compliance Manager	x					

✓ attended
x did not attend

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**15 May 2025**
Title:	**Draft Audit & Risk Committee Annual Statement of Assurance 2024/25**
Responsible Executive:	**Susan Dunsmuir, Director of Finance**
Report Author:	**Gillian MacIntosh, Board Secretary**

Executive Summary:

- All formal Committees of the NHS Board are required to provide an Annual Statement of Assurance to the NHS Board, detailing the work undertaken during the year and identifying any internal control weaknesses that might be considered for disclosure within the Governance Statement of the Annual Accounts.
- The draft statement is enclosed as an appendix, and this contains a textual account of the Committee's business during the financial year, to evidence to the Board that the Committee has delivered fully on its remit and delegated powers.
- Members are asked to take a "significant" level of assurance that the Committee has delivered on its remit during the 2024/25 reporting year and advise of any changes to the draft report text, prior to onward submission to the Audit & Risk Committee and thence the Board.

1 Purpose

This is presented for:

- Approval

This report relates to a:

- Legal requirement
- Local policy

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

- Effective

2 Report summary

2.1 Situation

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

2.2 Background

Each Committee must consider its proposed Annual Statement at the first Committee meeting of the new financial year. The current draft takes account of initial comments received from Committee Chair in post in the 2024/25 reporting year.

The drafts of the Board's other committees' assurance statements have been reviewed in the production of this report and these will be included on the next meeting's agenda, once approved at this present May cycle of Committee meetings.

2.3 Assessment

In addition to recording practical details such as membership and rates of attendance, the format of the report includes a more reflective and detailed section (Section 4) on agenda business covered in the course of 2024/25, with a view to improving the level of assurance given to the NHS Board.

This report provides the following Level of Assurance:

	Significant	Moderate	Limited	None
Level	x			
Descriptor	There is robust assurance that the system of control achieves, or will achieve, the purpose that it is designed to deliver. There may be an insignificant amount of residual risk or none at all.	There is sufficient assurance that controls upon which the organisation relies to manage the risk(s) are suitably designed and effectively applied. There remains a moderate amount of residual risk.	There is some assurance from the systems of control in place to manage the risk(s), but there remains a significant amount of residual risk, which requires further action to be taken.	No assurance can be taken from the information that has been provided. There remains a significant amount of residual risk

A significant level of assurance is suggested, given the Committee has considered all relevant items of business delegated to it during 2024/25, escalating directly to the Board any matters of concern. No matters for disclosure in the Governance Statement of the Annual Accounts have been identified.

2.3.1 Quality/ Patient Care

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

2.3.2 Workforce

N/A.

2.3.3 Financial

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

2.3.4 Risk Assessment/Management

Details on the Committee's discussions on its oversight of the Board's risk management processes are detailed within the report.

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

This paper does not relate to the planning and development of specific health services, nor any decisions that would significantly affect groups of people. Consequently, an EQIA is not required. Whilst the Committee has no equality-related matters within its remit, detail on the Board Committees' work in this area will be contained in the other Committee Statements of Assurance to be considered at the Committee's next meeting.

2.3.6 Climate Emergency & Sustainability Impact

No direct impact via this report.

2.3.7 Communication, involvement, engagement and consultation

N/A.

2.3.8 Route to the Meeting

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

2.4 Recommendation

The paper is provided for:

- **Assurance & approval** – subject to members' comments regarding any amendments necessary

3. List of Appendices

Appendix 1 – Annual Statement of Assurance for the Audit & Risk Committee for 2024/2025

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

ANNUAL STATEMENT OF ASSURANCE
FOR THE AUDIT & RISK COMMITTEE 2024/25

1. Purpose of Committee

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

1.2 The duties of the Audit & Risk Committee are in accordance with the principles and best practice outlined in the Scottish Government Audit & Assurance Committee Handbook, dated February 2023.

2. Membership of Committee

2.1 During the financial year to 31 March 2025, membership of the Audit & Risk Committee comprised:

Alastair Grant	Chair / Non-Executive Member
Cllr Graeme Downie	Non-Executive Stakeholder Member, Fife Council (to July 2024)
Anne Haston	Non-Executive Member
Aileen Lawrie	Non-Executive Stakeholder Member, Area Clinical Forum (to February 2025)
Cllr Mary Lockhart	Non-Executive Stakeholder Member, Fife Council (from January 2025)
Kirstie MacDonald	Non-Executive Member (Whistleblowing Champion) (to December 2024)
Nicola Robertson	Non-Executive Stakeholder Member, Area Clinical Forum (from March 2025)

2.2 The Committee may choose to invite individuals to attend the Committee meetings for the consideration of particular agenda items, but the Chief Executive, Director of Finance & Strategy (the Executive lead for risk during 2024-25), Head of Financial Services & Procurement, Associate Director of Risk & Professional Standards, Board Secretary, Chief Internal Auditor, senior Internal Audit colleagues and statutory External Auditor are normally in routine attendance at Committee meetings. Other attendees, deputies and guests are recorded in the individual minutes of each Committee meeting.

3. Meetings

3.1 The Committee met on five occasions during the year to 31 March 2025, on the undernoted dates:

- 16 May 2024
- 20 June 2024 (approval of Annual Accounts)
- 12 September 2024
- 12 December 2024
- 13 March 2025

3.2 The attendance schedule is attached at Appendix 1.

4. Business

4.1 The range of business covered at meetings held throughout the year, as further detailed below, demonstrates that the full range of matters identified in the Audit & Risk Committee's remit is being addressed. In line with its Constitution and Terms of Reference, reviewed annually (the last occasion in May 2025), the Committee has considered standing agenda items concerned with the undernoted aspects:

- Internal Control frameworks and arrangements;
- Internal & External Audit planning and reporting;
- Corporate Governance, including the Board's implementation of and compliance with the NHS Scotland *Blueprint for Good Governance*;
- Regular updates to the NHS Fife Code of Corporate Governance, including within the Standing Financial Instructions and Scheme of Delegation;
- Scrutiny of the Board's Annual Statutory Financial Statements, including the meaningfulness of the accompanying Governance Statement;
- Risk Management arrangements and reporting, including progress with revising the risk management framework, Board's risk appetite and review of the effectiveness of the Corporate Risk Register; and
- other relevant matters arising during the year.

4.2 The Audit & Risk Committee's first meeting of the 2024/25 reporting year took place in May 2024, where a number of papers related to preparations for the approval of the 2023/24 statutory accounts process were considered. The Committee scrutinised a timeline for the Board's annual accounts preparation, for members' awareness around key deadlines to be met, noting that the full set of annual accounts had been submitted to the External Auditors at that date and review was proceeding to schedule. The draft Governance Statement was reviewed, including the background to a disclosure to be made relating to an Information Governance & Security breach, and comments given prior to its final consideration as part of the July 2024 annual accounts meeting. An initial draft of the Risk Management Annual Report for 2023/24 was considered by members, with a number of comments made on the draft content and reflection on the newly introduced levels of assurance, supported also by consideration of the Risk Management Key Performance Indicators for 2023/24 (a final version was subsequently approved in September 2024, following completion of the risk appetite refresh work). An update on internal audit progress against delivery of the 2023/24 Internal Audit Plan was also discussed, with members noting the final outstanding areas of work as conclusion of the year-end process approached and arrangements made to address capacity challenges due to recent staff turnover.

4.3 The meeting in June 2024 scrutinised in full the governance-related year-end documentation, auditor reports and statutory financial statements for 2023/24. This included the Board's annual accounts, internal and external audit annual reports, plus the Patients' Private Funds and Service Auditor Reports on Third Party Services provided on behalf of NHS Fife by NHS National Services Scotland (NSS) and NHS Ayrshire & Arran. Each of the auditor reports gave an unqualified opinion. The Annual Internal Audit Report for 2023/24 concluded that there were adequate and effective internal controls in place and that the 2023/24 Internal Audit Plan has been delivered in line with Public Sector Internal Audit Standards. In reference to External Audit, the annual audit report from Azets on 2023/24 summarised their audit of the annual financial statements, as well as their comment on financial sustainability, governance and best value (a follow-up report on how these recommendations have been addressed in year was also considered by members in March 2025). The Committee took significant assurance from these reports as part of the portfolio of evidence provided in support of its evaluation of the internal environment and the approval of the Governance Statement. The Committee was pleased to endorse to the Board the formal signing of the 2023/24 annual accounts and the Board approved the 2023/24 financial statements at their meeting on 25 June 2024.

4.4 In relation to the year-end position, the late notification of an unexpected deterioration in the Integration Joint Board (IJB) financial position impacted negatively on the level of brokerage NHS Fife had to request from Scottish Government. As discussed in detail at the June 2024 meeting, it was agreed that an independent review was required for the Committee to take adequate assurance around the IJB internal systems of financial control, due to members' concerns that the IJB position had comprised the Board's financial arrangements. Further scrutiny was thought necessary to ensure that effective systems and processes were in place within the IJB. The Lessons Learned review reported formally to the Committee in December 2024. A root cause analysis was undertaken, supported by independent scrutiny, to provide an understanding of the reasons why there was significant movement between the financial projection and the actual expenditure incurred at year-end. The review identified a number of improvement actions that will further strengthen the controls that are already in place. Assurance was also provided that there is regular reporting to the IJB Finance, Performance & Scrutiny Committee and the IJB full Board, and that the frequency of meetings between the Directors of Finance, from both the IJB and NHS Fife, has been increased to consider the in-year position as it develops.

4.5 Drafts of the Internal Audit Strategic Plan for 2024-27 and the Operational Internal Audit Annual Plan for 2023/24 were considered at the Committee's September 2024 meeting, noting alignment to the strategic planning process, risk management developments and implementation of the Board's new Population Health & Wellbeing Strategy. A stand-alone review of the Year One performance of the Board's new Re-form, Perform, Transform (RTP) programme of work has been commissioned, this being NHS Fife's initiative to make the changes needed to maintain patient safety and quality of care, in line with the Board's values, while managing current financial challenges.

4.6 In relation generally to internal audit, members have reviewed and discussed in detail at meetings report summaries from the internal auditors covering a range of service areas and have considered management's progress in completing audit actions raised, through regular follow-up reporting. The interim evaluation of the internal control framework supplied at the mid-year point (December 2024) gave useful reference to any potential issues to be addressed before year-end. The largely positive findings gave a reasonable level of assurance to members. A further discussion on available resource within the Internal Audit team took place in December 2024, noting that two audit reviews (Supplementary Staffing and Digital & Information Strategy) would be deferred in consequence to 2025/26 (the Committee being assured with the risk-based approach taken to determine priority of resource), and welcoming the intention for a full-strength audit team to be in place from early 2025.

4.7 In relation to internal audit follow-up work, review dates have been considered for actions that have remained open longer than one year, and extensions were routinely reviewed to consider how likely it is that actions will be implemented by the revised implementation date. To provide greater assurance to the Committee, Internal Audit reports were agreed to be initially considered by the Executive Directors' Group, Chief Executive, Director of Finance and individual audit colleagues to help with oversight over outstanding action points. The Audit Follow up Protocol has been updated during the year to ensure this remains effective.

4.8 At the Committee's March 2025 meeting, the Committee considered a briefing on the introduction of the Global International Accounting Standards, applicable across public sector organisations from 1 April 2025. To ensure Internal Audit's compliance with the new Standards, an improvement plan has been developed for implementation over 2025/26. The Plan will also encompass recommendations from the recently undertaken External Quality Assessment of the internal audit service, to bring both strands of improvement work into the one plan. The Committee's Terms of Reference review has also incorporated the new Global International Account Standards guidance in its recent refresh.

4.9 The Committee has approved the planning memorandum for the 2024/25 statutory accounts cycle, as also for the Patients' Private Funds from the respective External Auditor. Members have noted the approval by the Board of Trustees of the planning memorandum for the audit of Endowment Funds held by Fife Health Charity. Regular updates on the current 2024/25 accounts approval timeline have been reported to the Committee, with input from both the internal and external auditor, noting the intention to seek Board approval for the annual accounts in late June 2025, meeting the relevant Scottish Government deadlines.

4.10 A summary self-assessment against the various requirements of the NHS Scotland *Blueprint for Good Governance* was carried out by Board members in late 2023, following which an action plan was approved by the full NHS Fife Board in March 2024. This is being monitored to completion by the Committee. Updates on progress with delivering the action plan has been given to meetings in September 2024 and March 2025, with two actions currently open, both of which are tied to national timeframes / work. The Committee will continue to monitor both to closure.

4.11 The Committee has also considered national reviews undertaken by Audit Scotland, including the findings of their report 'NHS in Scotland 2024 – Finance & Performance' at the December 2024 meeting, with consideration of its recommendations locally. Noting that the report's conclusions set out that Boards should be setting a balanced financial position over the next three years, identifying realistic recurring savings targets and reducing reliance on non-recurring savings by considering fundamental changes to service delivery, further discussion has subsequently taken place at Board Development Sessions on the proposed approach in Fife. The Committee also considers the content of Audit Scotland Technical Bulletins on a regular basis, noting the areas therein of relevance to public sector bodies and health boards specifically.

4.12 In year, an update to the Standing Financial Instructions was made in May 2024, to amend levels of authorisation for financial spend and authorisation of orders, as part of the Board's Grip & Control processes. The Committee was pleased to approve the changes for immediate effect, to support the annual Code of Corporate Governance review undertaken each May.

4.13 For assurance purposes, the Audit & Risk Committee has considered the annual assurance statements of each of the governance committees of the Board, namely: the Clinical Governance Committee; the Finance, Performance & Resources Committee; the Public Health & Wellbeing Committee; the Remuneration Committee; and the Staff Governance Committee. These detail the activity of each committee during the year, the business they have considered in discharging their respective remits and an outline of what assurance the Board can take on key matters delegated to them. No significant issues were identified from these reports for disclosure in the financial statements, as per the related content of the 2024/25 Governance Statement.

4.14 Appropriate assurance has been provided that each Committee has fulfilled their key remit areas on behalf of the Board during the reporting year. The Clinical Governance Committee report has provided due reflection on the assurance that can be taken around matters of clinical quality and safety, information security & governance, digital & information, resilience and Health & Safety. The Finance, Performance & Resources Committee has closely monitored the position in relation to the Board's year-end position, financial targets and delivery progress thereon, and has also considered key performance targets around waiting times and delivery of clinical services. The Public Health & Wellbeing Committee has responsibility for oversight of the Board's immunisation delivery programme and delegated community-based services such as children's mental health services, plus scrutiny of progression of the Board's organisational Population Health & Wellbeing

Strategy and related work around health inequalities. The Staff Governance Committee has received regular updates on recruitment to support key programmes and staff development activities, in addition to ongoing detail on staff well-being initiatives and work underway to reduce sickness absence and improve mandatory training and appraisal compliance. The Remuneration Committee has completed its usual business of Executive cohort performance appraisal and objective setting. Further detail on all these areas can be found within the individual Committee reports mentioned above. In addition to the Committee reports, the individual Executive Directors' Assurance letters have provided helpful detail on the internal control mechanisms and mitigation of risks within individual portfolios and Directorates.

4.15 In reference to the Fife Integration Joint Board, due to its own year-end accounts approval timeline, it is not possible for the NHS Fife Board to receive a final version of an assurance statement from the IJB prior to the Board's approval of its own statutory financial accounts in June 2025. The Committee has, however, taken assurance from a formal letter received from the Chief Officer of the Fife Integration Joint Board providing assurance on the adequacy of the governance and internal control environment of that body. As part of the usual information-sharing exercise, the Committee will consider the final IJB Internal Audit report at its forthcoming meeting in September 2025.

4.16 During the year, members of the Committee engaged in a number of training opportunities, covering best practice arrangements for Audit & Risk Committees. In April 2025, to support the onboarding of a new Committee Chair and new members, a session was held outlining the key functions of internal and external audit, with discussion also of the remit of the Committee. A training session with the Internal and External Auditors was held in May 2025 outlining the year-end processes each undertake as part of the review of the financial statements, responsibilities of the Audit & Risk Committee in reference to scrutiny of these, and details on the systems of internal control, in preparation for the review and scrutiny of the annual accounts, prior to the Committee's formal consideration of the 2024/25 financial statements. The presentation slides were usefully adapted to be used as a helpful checklist by members, when the accounts are tabled for formal approval in June 2025.

4.17 Progress with fraud cases and counter fraud initiatives were discussed by the Committee in private session on a regular basis throughout the year. The Committee received quarterly fraud updates, on relevant cases and investigations; initiatives undertaken to identify and address fraud; and the work carried out by Practitioner & Counter Fraud Services in relation to detecting, deterring, disabling and dealing with fraud in the NHS. These reports also detail the counter fraud training delivered to staff, including the roll-out of the NHS Fraud Awareness module. This has provided the Committee with the assurance that the risk of fraud is being proactively managed across NHS Fife. In May 2024, the Committee took reasonable assurance from the Counter Fraud Standards Assessment report for 2023/24, noting the anticipated position that NHS Fife did not assess itself as fully meeting all the Standards by the end of 2023/24, with three remaining partially met, and that the aim is for all the Standards to be met fully by the end of the three-year partnership agreement, which is line with other NHS Boards. The Committee were assured from the Fraud Annual Action Plan for 2024/25, which was developed between all NHS Scotland Health Boards and Counter Fraud Services, and in addition has been tailored locally to support the delivery of the Counter Fraud Standards. This was considered by members at the September 2024 meeting. Additionally, the bi-annual match checking via the National Fraud Initiative has been undertaken in the reporting year, with work underway to review higher risk matches and follow up internally as might be required.

4.18 Regular reporting on losses and special payments is factored into the Committee's workplan on a quarterly basis, to help support the annual accounts reconciliation process generally and, in support of Counter Fraud Standards, to increase the Committee's oversight. Work in-year has been undertaken to relate this audit reporting to ongoing work

around organisational learning, with the clinical learning from legal claims now being reviewed by the Organisational Learning Group with reporting onward to the Clinical Governance Committee. The Committee is also provided with regular updates on the application of any Procurement Waivers of Competitive Tender to provide assurance that the process is being correctly applied and therefore the risk to the Board of non-compliance is effectively managed.

4.19 Minutes of Committee meetings have been approved by the Committee and presented to Fife NHS Board. The Board also receives an Assurance Report at each meeting from the Chair, highlighting any key issues discussed by the Committee at its preceding meeting. The Committee maintains a rolling action log to record and manage actions agreed from each meeting, and reviews progress against deadline dates at subsequent meetings. The format of the action log has been enhanced, to provide greater clarity on priority actions and their due dates. A rolling update on the workplan is presented to each meeting, for members to gain assurance that reports are being delivered on a timely basis and according to the overall schedule. A final version of the workplan for 2025/26 was approved at the Committee's March 2025 meeting.

5. Best Value

5.1 Since 2013/14 the Board has been required to provide overt assurance on Best Value. A revised Best Value Framework was considered and agreed by the NHS Board in January 2018. Appendix 2 provides evidence of where and when the Committee considered the relevant characteristics during 2024/25.

6. Risk Management

6.1 All NHS Boards are subject to the requirements of the Scottish Public Finance Manual (SPFM) and must operate a risk management strategy in accordance with the relevant guidance issued by Scottish Ministers. The general principles for a successful risk management strategy are set out in the SPFM. In year, the Board has, via the Committee, approved a new Risk Management Strategy Framework, ensuring a streamline approach, updated to reflect key processes and controls in the Board's management of risk.

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

6.3 In line with the Board's agreed risk management arrangements, the Audit & Risk Committee has considered risk through a range of reports and scrutiny, including review of the 19 risks within the Corporate Risk Register. During 2024/25, the high-level risks identified as having the potential to impact on the delivery of NHS Fife's strategic priorities, and related operational high-level risks, were reported bi-monthly through the Corporate Risk Register to the governance committees, and subsequently to the Audit & Risk Committee and the Board.

6.4 The corporate risks collectively outline the organisational risks associated with the delivery of the Board's Population Health & Wellbeing Strategy. It is recognised that all risks on the corporate risk register are impacted by and are aligned to the Strategy. All corporate risks are reviewed regularly and reported bi-monthly to the governance committees and twice a year to the Board. During Financial Year 2024/25, developments of note in relation to corporate risks include the following:

<u>Risks Closed</u>

Optimal Clinical Outcomes: Following consideration of an updated deep dive review at the Clinical Governance Committee's meeting in March 2024, there was further discussion through the Risks and Opportunities Group on whether it was appropriate to close the risk and develop a revised risk or risks. Following this, and further discussion at the Clinical Governance Oversight Group, the recommendation was made to the Executive Directors' Group in September 2024 to close the risk and reframe a new risk.

Offsite area Sterilisation and Disinfection Unit Service: This risk was removed from the Corporate Risk Register in November 2024 and moved onto an operational risk register held by Acute Services and the Director of Property & Asset Management.

Risks Opened

Pandemic Preparedness / Biological Threats: A report and an initial deep dive review were progressed through the Public Health Assurance Committee and the Executive Directors' Group in March / April 2024. This review was agreed at the May 2024 Board and the risk now sits under the Director of Public Health and the Board's Public Health & Wellbeing Committee.

Capital Funding - Service Sustainability: The creation of a new risk in this area was approved by the Executive Directors' Group in May 2024 and this has now been included on the Corporate Risk Register, aligned to Finance, Performance & Resources Committee.

Potential Risks

A number of new potential corporate risks have been discussed for adoption:

Hospital Acquired Harm: Hospital Acquired Harm is a new risk intended to replace the closed Optimal Clinical Outcomes Risk. A draft deep dive was presented for consideration to the Clinical Governance Committee in March 2025.

Substance Related Morbidity and Mortality: Following a direction by the Public Health & Wellbeing Committee, a deep dive was assigned to a small team to ascertain the need for a specific NHS Fife risk with regards to deaths from drugs use. This aims to identify aspects of strategy, policy and delivery within the Board where there is a relevance pertaining to the prevention of drug-related deaths and to recommend actions that reduce the likelihood and consequence. The deep dive has progressed through the Risks & Opportunities Group, the Public Health Assurance Committee and the Public Health & Wellbeing Committee.

Access to General Dentistry: The Board's Public Health & Wellbeing Committee has suggested that a specific high-level corporate risk be considered regarding access to general dentistry across Fife. This risk has recently been created, is under review by the Primary Care Governance & Strategy Oversight Group and will be considered by the Public Health & Wellbeing Committee in May 2025.

6.5 Operationally, the Risks & Opportunities Group supports and embeds an effective risk management framework and culture across the organisation. The Group meet bi-monthly to support the continued development of an effective and consistent approach to the management of operational risk, as well as the ongoing consideration of enhancements to the Corporate risk management approach. The Group has reviewed and updated its Terms of Reference, with the most recent iteration approved in August 2024. At each meeting the Risks & Opportunities Group reviews progress against its Annual Workplan, considers issues for escalation, and receives reports on any other relevant business. The Risks & Opportunities Group has reported on its work to the Audit & Risk Committee in September 2024 and in March 2025, via a detailed progress report. An Annual Assurance Statement from the Risk & Opportunities Group was also considered by Audit & Risk in May 2025.

6.6 During 2024/25, the Group's work has included:

- Supporting the development and updates of the Risk Management Framework;
- Continuing to inform and support the developments and improvements in relation to the Corporate Risk Register, recommendations on changes or additions to the corporate risks and the broader organisational risk profile, assurance levels and deep dive reviews;
- Contributing to the development of a Risk Summary Dashboard and guidance to support and enhance our operational risk management approach and maintain alignment to the principles outlined within the Risk Management Framework;
- Reviewing the Risk Assessment Matrix and considering the need for updates to descriptors and terminology, taking account of similar work nationally;
- Considered the development of meaningful Key Performance Indicators that could be implemented to demonstrate active risk management.

6.7 The Group has undertaken a self-assessment of its own effectiveness, which has been considered at its meeting in April 2025 and thereafter reported to the Audit & Risk Committee in May 2025. The assessment covers elements including membership and group dynamics, role clarity and expectations, effectiveness of the scrutiny and challenge function, management of the agenda and impact of the Group in terms of outputs, as well as suggested actions to further improve the Group's effectiveness in respect of delivering its remit.

6.8 The Board began reassessing its risk appetite at a dedicated Development Session held in April 2024 and this has been completed in year, following a second Board Development Session in June 2024. This provided opportunity to discuss and reflect on the Board's appetite and consider the changes required in terms of both the risk appetite descriptors, and the levels of risk the Board is prepared to tolerate in the pursuit of its strategic priorities, especially delivery of the Population Health & Wellbeing Strategy. This was particularly relevant as the Board responded and adapted to the challenging financial outlook with new Re-form, Transform, Perform Framework. The new risk appetite statement was agreed by the Board at its meeting in November 2024, with a supporting paper considered by the Committee in December 2024..

7. Self-Assessment

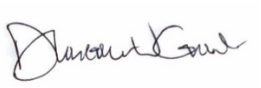
7.1 The Committee has undertaken a self-assessment of its own effectiveness, utilising a revised questionnaire considered and approved by the Committee Chair. Attendees were also invited to participate in this exercise, which was carried out via an easily accessible online portal. A report summarising the findings of the survey was considered and approved by the Committee at its March 2025 meeting, and action points are being taken forward at both Committee and Board level.

8. Conclusion

8.1 As Chair of the Audit & Risk Committee during financial year 2024/25, I am satisfied that the integrated approach, the frequency of meetings, the breadth of the business undertaken and the range of attendees at meetings of the Committee has allowed us to fulfil our remit as detailed in the Code of Corporate Governance. As a result of the work undertaken during the year, I can confirm that adequate and effective governance arrangements were in place throughout NHS Fife during the year. Audit & Risk Committee members conclude that they have given due consideration to the effectiveness of the systems of internal control in NHS Fife, have carried out their role and discharged their responsibilities on behalf of the Board in respect of the Committee's remit as described in the Standing Orders.

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

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

Signed:  Date:

Alastair Grant, Chair
On behalf of the Audit & Risk Committee

Appendix 1 – Attendance Schedule
Appendix 2 – Best Value

APPENDIX 1

AUDIT & RISK COMMITTEE - ATTENDANCE RECORD
1 April 2024 – 31 March 2025

	16.05.24	20.06.24	12.09.24	12.12.24	13.03.25
Members					
A Grant, Non-Executive Member **(Chair)**	✓	✓	✓	✓	✓
Cllr G Downie, Stakeholder Member, Fife Council	x	✓			
A Haston, Non-Executive Member	✓	✓	✓	✓	✓
A Lawrie, Area Clinical Forum Representative	✓	✓	x	✓	
Cllr M Lockhart, Stakeholder Member, Fife Council					✓
K Macdonald, Non-Executive Member	✓	✓	✓		
N Robertson, Area Clinical Forum Representative					x
In attendance					
K Booth, Head of Financial Services	✓	✓	✓	✓	✓
A Brown, Principal Auditor	✓	x	✓		x
C Brown, Head of Public Sector Audit (UK), Azets	✓	✓	x	✓	✓
P Cumming, Risk Manager	x				
S Dunsmuir, Incoming Director of Finance					✓ observing
B Hudson, Regional Audit Manager	✓	✓	x	✓	✓
A Ferguson, Senior Audit Manager, Azets		✓		✓	✓
P Kilpatrick, Board Chair		✓ observing			✓ part
J Lyall, Chief Internal Auditor	✓	✓	✓	✓	✓
G MacIntosh, Head of Corporate Governance & Board Secretary	✓	✓	✓	✓	✓
C MacKenzie, Senior, Azets				✓	✓
M McGurk, Director of Finance & Strategy **(Exec Lead)**	✓	✓	x	✓ part	x
M Michie, Deputy Director of Finance			✓ deputising	✓ deputising	✓ deputising
A Mitchell, Thomson Cooper		✓			
C Potter, Chief Executive	✓	✓	✓	x	✓ part
SA Savage, Associate Director of Quality & Clinical Governance	✓	✓	✓	x	x
A Valente, Chief Financial Officer, HSCP				✓ deputising	

	16.05.24	20.06.24	12.09.24	12.12.24	13.03.25
A Wood, Non-Executive Member					observing

APPENDIX 2

BEST VALUE FRAMEWORK

Vision and Leadership

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

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

GOVERNANCE AND ACCOUNTABILITY

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

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

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

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

USE OF RESOURCES

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

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

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

PERFORMANCE MANAGEMENT

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

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

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

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

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

CROSS-CUTTING THEME – SUSTAINABILITY

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

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

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

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

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

CROSS-CUTTING THEME – EQUALITY

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

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

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

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE:
NHS Fife meets the requirements of equality legislation.	Evidence of equality considerations in Board's decision-making structure	**BOARD** **COMMITTEES**	Ongoing	Annual Assurance Statement from the Equality & Human Rights Steering Group EQIA completion for strategic projects and reports
The Board and senior managers understand the diversity of their customers and stakeholders.	Equality Impact Assessments are reported to the Board and Committees as required and identify the diverse range of stakeholders.	**BOARD** **COMMITTEES**	Ongoing	EQIA section on SBAR Community Engagement Policy approved in-year
NHS Fife's policies, functions and service planning overtly consider the different current and future needs and access requirements of groups within the community.	In accordance with the Equality and Impact Assessment Policy, Impact Assessments consider the current and future needs and access requirements of the groups within the community.	**BOARD** **COMMITTEES**	Ongoing	Population Health & Wellbeing Strategy has specific EQIA associated with its ambitions EQIA section on SBARs Equality & Diversity Board Champion appointed in-year

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE:
Wherever relevant, NHS Fife collects information and data on the impact of policies, services and functions on different equality groups to help inform future decisions.	In accordance with the Equality and Impact Assessment Policy, Impact Assessments will collect this information to inform future decisions.	**BOARD** **COMMITTEES**	Ongoing	EQIA section on SBARs Regular reporting to Public Health & Wellbeing Committee and Staff Governance Committee on equality-related issues

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**15 May 2025**
Title:	**Annual Review of Committee's Terms of Reference**
Responsible Executive:	**Susan Dunsmuir, Director of Finance**
Report Author:	**Gillian MacIntosh, Board Secretary**

Executive Summary:

- The Committee's Terms of Reference is presented for endorsement, before onward submission to the NHS Fife Board for approval.
- The review is carried out on annual basis, as part of the overall annual governance process, and reflected in the annual update to the NHS Fife Code of Corporate Governance (the subject of a separate agenda item), submitted to the Board in May.
- Proposed changes are tracked within the enclosed document, for visibility.

1. Purpose

This report is presented for:

- Approval

This report relates to:

- Local policy

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

- Effective

2 Report summary

2.1 Situation

All Committees are required to regularly review their Terms of Reference, and this is normally done in March of each year. Any changes are then reflected in the annual update to the NHS Fife Code of Corporate Governance, which is reviewed in full by the Audit & Risk Committee and then formally approved by the Board thereafter. In the current year, the Audit & Risk Committee's formal review was delayed until May, to allow appropriate reflection within the remit of the new Global International Audit Standards and to capture any further revisions from the Committee's Development Session held in April to consider the Committee's core purpose and areas of focus.

2.2 Background

The current Terms of Reference for the Committee were last reviewed in March 2024, as per the above cycle.

2.3 Assessment

An updated draft of the Committee's Terms of Reference is attached for members' consideration, with suggested changes tracked for ease. These changes are also detailed in a subsequent agenda item on the broader Code of Corporate Governance. Following the Committee's approval, the final version of the Code of Corporate Governance, reflecting all committee remit changes, will be presented to the NHS Board for approval.

This report provides the following Level of Assurance:

	Significant	Moderate	Limited	None
Level	x			
Descriptor	There is robust assurance that the system of control achieves, or will achieve, the purpose that it is designed to deliver. There may be an insignificant amount of residual risk or none at all.	There is sufficient assurance that controls upon which the organisation relies to manage the risk(s) are suitably designed and effectively applied. There remains a moderate amount of residual risk.	There is some assurance from the systems of control in place to manage the risk(s), but there remains a significant amount of residual risk, which requires further action to be taken.	No assurance can be taken from the information that has been provided. There remains a significant amount of residual risk

A significant level of assurance is proposed, noting that the Terms of Reference have received significant review, both by members and Internal Audit, to ensure these remain current and fit-for-purpose.

2.3.1 Quality, Patient and Value-Based Health & Care

N/A

2.3.2 Workforce

N/A

2.3.3 Financial

N/A

2.3.4 Risk Assessment / Management

The regular review and update of Committee Terms of Reference will ensure appropriate governance across all areas and that effective assurances are provided to the Board.

2.3.5 Equality and Human Rights, including children's rights, health inequalities and Anchor Institution ambitions

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

is not required. There are no specific equality-related matters delegated to the Audit & Risk Committee, though reflection of the wider system of internal control and legislative compliance falls under the Audit & Risk Committee's remit. This is exercised in the main through the Committee seeking assurance from other Board committees at year-end, via review of Annual Assurance Statements.

2.3.6 Climate Emergency & Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

N/A

2.3.8 Route to the Meeting

This paper has been considered initially by the internal auditors, Committee Chair, Lead Executive Director and Head of Financial Services & Procurement.

2.4 Recommendation

This paper is provided to members for:

- **Discussion** - consider the attached remit, advise of any proposed changes and **endorse** a final version for further consideration by the Board.

3 List of appendices

The following appendices are included with this report:

- Appendix 1 – Audit & Risk Committee's Terms of Reference

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

AUDIT AND RISK COMMITTEE
CONSTITUTION AND TERMS OF REFERENCE

Date of Board Approval: ~~28 May 2024~~ TBC

1. PURPOSE

1.1 To provide the Board with assurance that the activities of Fife NHS Board are within the law and regulations governing the NHS in Scotland and that an effective system of internal control is maintained. The duties of the Audit and Risk Committee shall be in accordance with the Scottish Government Audit & Assurance Handbook, dated ~~April 2018~~February 2023.

2. COMPOSITION

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

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

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

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

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

- Chief Executive
- Director of Finance ~~& Strategy (who is also Executive Lead for Risk Management)~~
- Medical Director (who is the Executive Lead for Risk Management)
- Chief Internal Auditor
- Regional Internal Audit Manager and/or Principal Internal Auditor
- Statutory External Auditor
- Head of Financial Services & Procurement
- ~~Risk Manager~~Associate Director of Risk & Professional Standards
- Board Secretary

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

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

3. QUORUM

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

4. MEETINGS

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

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

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

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

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

5. REMIT

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

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

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

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

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

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

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

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

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

Internal Control and Corporate Governance

5.3 To evaluate the framework of internal control and ~~corporate~~ integrated governance system~~comprising the following components~~, as ~~recommended by~~described in the NHS Scotland Blueprint for Good Governance.~~Turnbull Report~~:

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

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

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

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

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

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

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

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

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

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

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

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

Internal Audit

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

5.10 To monitor audit progress and review governance, management and reporting arrangements to obtain assurance that the internal audit service is fulfilling its mandate, including review of audit reports.

5.11 To monitor the management action taken in response to the audit recommendations in line with the Audit Follow Up Protocol.

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

5.13 To approve the Internal Audit Strategy and Charter, including the Internal Audit Mandate, and:-

- To champion and demonstrate support for Internal Audit
- To collaborate with senior management to provide the internal audit function with sufficient resources to fulfil the Mandate and achieve the plan
- To assist with setting audit priorities and approve the internal audit functions performance objectives, at least annually

5.14 To approve the Internal Audit Reporting Protocol and Audit Follow Up Protocol.

5.15 To approve the Fife Integration Joint Board Internal Audit Output Sharing Protocol, and review and approve arrangements for the internal audit external assessment.

5.16 To review the operational effectiveness of Internal Audit by considering the results of the internal audit function's quality assurance and improvement programme, reviewing the five-yearly external quality assessment or self-assessment with independent validation, and through ongoing consideration of the audit standards, resources, staffing, technical competency and performance measures.

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

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

External Audit

5.19 To note the appointment of the Statutory Auditor and to approve the appointment and remuneration of the External Auditors for the NHS Fife Annual Accounts and the NHS Fife Patients' Funds Accounts.

5.20 To consider all statutory audit material, in particular:

- Audit Reports;
- Audit Strategies & Plans;
- Annual Reports;
- Management Letters.

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

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

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

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

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

Risk Management

5.25 The Committee has no executive authority, and has no role in the executive decision-making in relation to the management of risk, although it may draw attention to strengths and weaknesses in control and make suggestion for how such weaknesses might be dealt with. The Committee is charged with ensuring that there is an appropriate publicised Risk Management Framework with all roles identified and fulfilled. The Committee shall seek specific assurance that:

- There is an effective risk management system in place to identify, assess, mitigate, ~~and~~ monitor and review risks at all levels of the organisation;
- There is appropriate ownership of risk in the organisation, and that there is an effective culture of risk management;
- The Board has clearly defined its risk appetite (i.e. the level of risk that the Board is prepared to accept, tolerate, or treat at any time), and that the executive's approach to risk management is consistent with that appetite;
- A robust and effective Corporate Risk Register is in place.

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

- Receive and review a quarterly report summarising any significant changes to the Board's Corporate Risk Register, and what plans are in place to mitigate them;
- Assess whether the Corporate Risk Register is an appropriate reflection of the key risks to the Board and enables the identification of gaps in control and assurance, so as to advise the Board;
- Consider the impact of changes to the risk register on the assurance needs of the Board and the Accountable Officer, and communicate any issues when required;
- Receive an annual report on risk management, confirming whether or not there have been adequate and effective risk management arrangements throughout the year, and highlighting any material areas of risk;
- The Committee shall seek assurance on the overall system of risk management for all risks and risks pertinent to its core functions.

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

Standing Orders and Standing Financial Instructions

5.27 To review annually the Standing Orders and associated appendices of Fife NHS Board within the Code of Corporate Governance and advise the Board of any amendments required.

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

Annual Accounts

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

5.30 To review the draft Annual Report and Performance Review of Fife NHS Board within the Annual Accounts.

5.31 To review annually (and recommend Board approval of any changes in) the accounting policies of Fife NHS Board.

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

Other Matters

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

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

5.35 The Committee shall review regular reports on Fraud and potential Frauds as presented by the Fraud Liaison Officer (FLO), in addition to the Board's response and action to counter the threat posed by fraud.

5.36 The Chairperson of the Committee will submit an Annual Report of the work of the Committee to the Board following consideration by the Audit and Risk Committee annually, to give assurance that the Committee has delivered against its Terms of Reference.

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

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

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

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

6. AUTHORITY

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

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

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

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

7. REPORTING ARRANGEMENTS

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

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

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**15 May 2025**
Title:	**Annual Review of Code of Corporate Governance**
Responsible Executive:	**Ben Hannan, Director of Planning & Transformation**
Report Author:	**Gillian MacIntosh, Board Secretary**

Executive Summary:

- The Audit & Risk Committee (and thence the Board) review annually any changes to the Code of Corporate Governance, to ensure this key documents remains current.
- Changes are clearly tracked within the document linked below for visibility. These are of a minor nature and are limited only to updates to Committee remits, as discussed at the March cycle of meetings, and a number of minor changes to the Standards of Business Conduct for staff related to the handling of gift vouchers.
- The Committee is invited to endorse the changes made, recommending the amendments to the Board for subsequent approval, and also take assurance from the review exercise successfully completed for 2025/26.

1. Purpose

This is presented for:

- Approval
- Assurance

This report relates to a:

- Local policy

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

- Effective

2. Report Summary

2.1 Situation

The Fife NHS Board Code of Corporate Governance is an all-encompassing suite of documents setting out the Board's Standing Orders, Committee Terms of Reference, Scheme of Delegation, Standing Financial Instructions, Code of Conduct for Board

Members and Standards of Business Conduct for Staff. It is therefore important that it remains current and correct.

2.2 Background

An annual review of the Code of Corporate Governance is normally undertaken each spring, to coincide with the new financial year, with this completed as scheduled previously in 2024.

2.3 Assessment

The updated version of the Code has been made available to members online for review (https://www.nhsfife.org/media/tzvjxw5y/code-of-corporate-governance-master-may-25.pdf), to help manage the amount of pages with the paper pack. The version accessible at the above link reflects the following updates clearly tracked within:

- minor tracked changes to each Standing Committee's remit, as discussed and agreed by each Committee following their Terms of Reference review at their March cycle of meetings; (pp.17-44); and
- a number of minor changes to the Standards of Business Conduct for Staff, relative to treatment of any gift vouchers so gifted to staff, to clarify procedures following a number of instances that have raised handling issues during the last year (pp.118-121).

There have been no changes made to the Board's Standing Orders, Standing Financial Instructions, Scheme of Delegation and Code of Conduct for Board Members. Both the Standing Orders and Code of Conduct for Board members follow a national template, where the content of each is prescribed.

This report provides the following Level of Assurance:

	Significant	Moderate	Limited	None
Level	X			
Descriptor	There is robust assurance that the system of control achieves, or will achieve, the purpose that it is designed to deliver. There may be an insignificant amount of residual risk or none at all.	There is sufficient assurance that controls upon which the organisation relies to manage the risk(s) are suitably designed and effectively applied. There remains a moderate amount of residual risk.	There is some assurance from the systems of control in place to manage the risk(s), but there remains a significant amount of residual risk, which requires further action to be taken.	No assurance can be taken from the information that has been provided. There remains a significant amount of residual risk

A significant level of assurance is suggested, reflecting the completion of each Committee's remit review and compliance with national model guidance in regards to Standing Orders and Members' Code of Conduct.

2.3.1 Quality/ Patient Care

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

2.3.2 Workforce

N/A.

2.3.3 Financial

Ensuring appropriate scrutiny of NHS Fife's governance documents, and ensuring these remain up to date, is a core part of the Committee's remit.

2.3.4 Risk Assessment/Management

The identification and management of risk is an important factor in Board Committees providing appropriate assurance to the NHS Board. The Committee Terms of Reference contained with the Code outline the delegated responsibilities in this area from the Board to its key standing committees.

2.3.5 Equality and Human Rights, including children's rights, health inequalities and Anchor Institution ambitions

This paper does not relate to the planning and development of specific health services, nor any decisions that would significantly affect groups of people. Consequently, an EQIA is not required. The Board Committee remits detail where equality-related issues are covered in each respective Committee's area of responsibility.

2.3.6 Climate Emergency & Sustainability Impact

No direct impact via this annual updating exercise.

2.3.7 Communication, involvement, engagement and consultation

N/A.

2.3.8 Route to the Meeting

This paper has not been considered by any previous group, though its content reflects comments received from colleagues within the Finance Directorate and Fife Health Charity in relation to the changes proposed in the Standards of Business Conduct for Staff. In relation the latter, the Director of Finance & Strategy has approved the proposed text. Each of the Committees' Terms of Reference have been reviewed at their meetings held in March 2025.

2.4 Recommendation

The paper is provided for:

- **Recommending approval to the Board of the updated Code** – subject to members' comments regarding any further amendments necessary.

3 List of appendices

- Appendix 1 – Revised Code of Corporate Governance

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

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**15 May 2025**
Title:	**Draft Governance Statement**
Responsible Executive:	**Susan Dunsmuir, Director of Finance**
Report Author:	**Gillian MacIntosh, Board Secretary**

Executive Summary:

- This paper provides for the Committee's review the first draft of the Governance Statement, which is a key component of the Annual Accounts document.
- A fundamental part of the Chief Executive role as Accountable Office is to manage and control all the available resources used in the organisation. The Governance Statement is a key feature of the annual accounts and provides commentary on how these duties have been carried out in the course of the year, including aspects of corporate governance and risk management.
- Members are asked to discuss the initial draft of the document and advise of any areas that need further review, in advance of the final version coming to the Committee in June with the Annual Financial Statements.

1 Purpose

This is presented for:

- Discussion

This report relates to a:

- Government policy/directive
- Legal requirement

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

- Effective

2 Report summary

2.1 Situation

As Accountable Officers, Chief Executives are responsible for maintaining sound systems of internal control. Chief Executives must prepare a Governance Statement

that complies with guidance in the Scottish Public Finance Manual (SPFM), which is accurate, complete and fairly reports the known facts.

2.2 Background

For 2024/25, there have been no substantial changes made to the Governance Statement format or guidance, as set out within the NHS Scotland Annual Accounts Manual. However, there are a number of areas which merit consideration in the Governance Statement for 2024/25. These include:

- detail on the achievements of the 'Re-form, Transform, Perform' portfolio of work successfully delivered during the year;
- and review of the second year of the Board's Population Health & Wellbeing Strategy.

A placeholder has been included to anticipate a section on the IJB financial position, to be populated in the next version. There also remains two sections (identified by highlighted text) where final information is awaited at the time of writing, with these to be finalised shortly.

There are no disclosures anticipated within the Governance Statement at the time of writing.

2.3 Assessment

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

As part of the overall governance and assurance processes of the Board, both the Chief Internal Auditor and the Board's External Auditor (currently Azets) are required to provide an annual report within the dimensions of their respective remits. In providing the Internal Audit Annual report, the Chief Internal Auditor specifically reviews the Governance Statement for:

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

This report provides the following Level of Assurance:

	Significant	Moderate	Limited	None
Level		x		
Descriptor	There is robust assurance that the system of control achieves, or will achieve, the purpose	There is sufficient assurance that controls upon which the organisation relies to manage the risk(s)	There is some assurance from the systems of control in place to manage the risk(s), but there	No assurance can be taken from the information that has been provided. There remains a significant

	that it is designed to deliver. There may be an insignificant amount of residual risk or none at all.	are suitably designed and effectively applied. There remains a moderate amount of residual risk.	remains a significant amount of residual risk, which requires further action to be taken.	amount of residual risk

A moderate level of assurance is suggested, reflecting the fact that finalisation of a few sections are required at the time of submissions. Feedback from members and attendees is also sought on the current draft.

2.3.1 Quality / Patient Care

Good governance is a central pillar in enhancing quality standards and improving patient care.

2.3.2 Workforce

The Draft Governance Statement reflects the control environment supporting staff governance.

2.3.3 Financial

The Draft Governance Statement reflects the control environment supporting financial governance and is a central part of the annual accounts document.

2.3.4 Risk Assessment/Management

Details on developments in-year on the Board's risk management processes are detailed within the report.

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

Although not included in the Corporate Governance section of the front-end narrative, the Performance Report of the Annual Accounts provides detail on equality-related initiatives undertaken during the year. There is explicit reference to the ongoing employment tribunal and the commitment to take forward learning from this in relation to finalising the Board's Equality Outcomes Plan.

2.3.6 Climate Emergency & Sustainability Impact

Relevant section included in the broader accounts narrative front-end.

2.3.7 Communication, involvement, engagement and consultation

Appropriate communication, involvement, engagement and consultation within the organisation and with key external stakeholders (such as the auditors and Scottish Government colleagues) was conducted in the preparation of the paper.

2.3.8 Route to the Meeting

The Audit & Risk Committee is the first group to whom the draft Governance Statement has been made available.

2.4 Recommendation

The paper is provided for **discussion**. The Committee is invited to review the draft Governance Statement as attached and provide any comments on its content as required. A further version will come back to the Committee for formal approval with the annual financial statements.

3 List of appendices

The following appendices are included with this report:

- Appendix 1 – Draft Governance Statement (submitted in draft to Internal Audit)

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

Corporate Governance Report

Directors' Report

Date of Issue

Financial statements were approved by the Board and authorised for issue by the Accountable Officer on 24 June 2025.

Appointment of Auditors

The Public Finance and Accountability (Scotland) Act 2000 places personal responsibility on the Auditor General for Scotland to decide who is to undertake the audit of each health body in Scotland. The Auditor General has appointed Chris Brown, Regional Managing Partner, Azets, to undertake the audit of Fife Health Board. The general duties of the auditors of health bodies, including their statutory duties, are set out in the Code of Audit Practice issued by Audit Scotland, and approved by the Auditor General.

Board Membership

Under the terms of the Scottish Health Plan, the NHS Fife Board is a board of governance whose membership will be conditioned by the functions of the Board. Members of the NHS Board are selected on the basis of their position or the particular expertise, which enables them to contribute to the decision-making process at a strategic level.

The NHS Fife Board has collective responsibility for the performance of the local NHS system as a whole, and reflects a partnership approach, which is essential to improving health and health care. NHS Board members are also Trustees of the Fife Health Board endowment funds held by the Fife Health Charity. The members of the NHS Fife Board who served during the year from 1 April 2024 to 31 March 2025 were as follows:

Non-Executive Members

Patricia Kilpatrick	Chairperson
Alistair Morris	Vice Chairperson
Jo Bennett	Non-Executive Member (from 01.06.2024)
Sinead Braiden	Non-Executive Member
Alastair Grant	Non-Executive Member
Colin Grieve	Non-Executive Member
Anne Haston	Non-Executive Member
Dr John Kemp	Non-Executive Member
Kirstie MacDonald	Whistleblowing Champion & Non-Executive Member (to 31.12.2024)
Arlene Wood	Non-Executive Member
Lynne Parsons	Stakeholder Member, Employee Director (Co-Chair, Area Partnership Forum)
Aileen Lawrie	Stakeholder Member (Chairperson, Area Clinical Forum) (to 28.02.2024)
Nicola Robertson	Stakeholder Member (Chairperson, Area Clinical Forum) (from 01.03.2025)
Councillor Graham Downie	Stakeholder Member (Fife Councillor) (to 05.07.2024)
Councillor Mary Lockhart	Stakeholder Member (Fife Councillor) (from 01.11.2024)

Executive Members

Carol Potter	Chief Executive
Janette Keenan	Director of Nursing
Margo McGurk	Director of Finance & Strategy / Deputy Chief Executive
Dr Chris McKenna	Medical Director
Dr Joy Tomlinson	Director of Public Health

Statement of Board Members' Responsibilities

Under the National Health Service (Scotland) Act 1978, the Health Board is required to prepare accounts in accordance with the directions of Scottish Ministers, which require that those accounts give a true and fair view of the state of affairs of the Health Board as at 31 March 2025 and of its operating costs for the year then ended. In preparing these accounts the Directors are required to:

- Apply on a consistent basis the accounting policies and standards approved for the NHS Scotland by Scottish Ministers.

- Make judgements and estimates that are reasonable and prudent.

- State where applicable accounting standards as set out in the Financial Reporting Manual have not been followed where the effect of the departure is material.

- Prepare the accounts on the going concern basis unless it is inappropriate to presume that the Board will continue to operate.

The Health Board members are responsible for ensuring that proper accounting records are maintained, which disclose with reasonable accuracy at any time the financial position of the Board and enable them to ensure that the accounts comply with the National Health Service (Scotland) Act 1978 and the requirements of the Scottish Ministers. They are also responsible for safeguarding the assets of the Board and hence taking reasonable steps for the prevention of fraud and other irregularities.

The NHS Board members confirm they have discharged the above responsibilities during the financial year and in preparing the accounts.

Board Members and Senior Managers' Interests

Details of any interests of Board members, senior managers and other senior staff in contracts, or potential contractors, with the NHS Board, as required by IAS 24, are disclosed in Note 24.

A register of interests, which includes details of company directorships or other significant interests held by Board members that may conflict with their management responsibilities, is available by contacting the Corporate Governance Support Officer, Corporate Governance & Board Administration, Queen Margaret Hospital, Whitefield Road, Dunfermline KY12 0SU or via fife.boardadministration@nhs.scot. A copy is also published online at the following link: www.nhsfife.org/about-us/nhs-fife-board/register-of-board-interests/.

Directors' third-party indemnity provisions

Individual members of the NHS Board or the NHS Board as a group are covered by the NHS Board's Clinical Negligence and other Risks Indemnity Scheme (CNORIS) in respect of potential claims against them.

Remuneration for non-audit work

No non-audit work has been carried out by Azets or the Fife Health Charity auditors, Thomson Cooper, during 2024/25.

Value of Land

During the year the Board has had 100% of land revalued by the Valuation Office Agency, who have confirmed that the Board's Statement of Financial Position values do not significantly differ from market values.

Public Services (Scotland) Act 2010

Sections 31 and 32 of the Public Services Reform (Scotland) Act 2010 imposed duties on the Scottish Government and listed public bodies to publish information on expenditure and certain other matters as soon as is reasonably practicable after the end of each financial year.

NHS Fife publishes the required information on the NHS Fife website at the following link: www.nhsfife.org/about-us/guide-to-information-available-through-the-model-publication-scheme/finance-guide-to-information/.

Information Governance and Security Incidents reported to the Information Commissioner's Office

There was one outstanding personal data-related incident / data protection breach from Financial Year 2022/23 concluded in this reporting year. The Information Commissioner's Office (ICO) issued a Reprimand to the Board for an incident that occurred in February 2023, in which an unauthorised person gained access to a ward at St Andrews Community Hospital. An update on all actions undertaken by the Board in response to the

Reprimand was submitted to the ICO in June 2024 and confirmation was subsequently received from the ICO that the case was closed.

There were three outstanding incidents from Financial Year 2023/24, originally reported in August and September 2023, that also concluded in 2024/25. In all three cases, the ICO has confirmed that no action in either of the incidents is necessary.

For Financial Year 2024/25, there was a total of 14 incidents (an increase on the 12 last year) reported to the competent authorities, the ICO and/or the Scottish Government. Three incidents were reported to the Scottish Government only, as they fell under Network & Information Systems reporting obligations. There was one incident, reported January 2025, which, after investigation, was subsequently found not to meet the threshold for reporting (which the ICO has confirmed). There have been seven breaches reported between January 2025 and March 2025 and, at the time of writing, we await a response from the ICO regarding four of these. The ICO have confirmed they are taking no further action on all other incidents.

Disclosure of Information to Auditors

The Directors who have held office at the date of approval of this Directors' Report confirm that, so far as they are each aware, there is no relevant audit information of which the Board's auditors are unaware; and each Director has taken all the steps that they ought reasonably to have taken as a Director to make themselves aware of any relevant audit information and to establish that the Board's auditors are aware of that information.

Statement of the Chief Executive's Responsibilities as the Accountable Officer of the Health Board

Under Section 15 of the Public Finance and Accountability (Scotland) Act, 2000, The Principal Accountable Officer (PAO) of the Scottish Government has appointed me as Accountable Officer of Fife Health Board.

This designation carries with it the responsibility for:

- the propriety and regularity of financial transactions under my control;
- the economical, efficient, and effective use of resources placed at the Board's disposal; and
- safeguarding the assets of the Board.

In preparing the Accounts I am required to comply with the requirements of the Government's Financial Reporting Manual and in particular to:

- observe the accounts direction issued by the Scottish Ministers including the relevant accounting and disclosure requirements and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the Government's Financial Reporting Manual have been followed and disclose and explain any material departures; and
- prepare the accounts on a going concern basis.

I confirm that the Annual Report and Accounts as a whole are fair, balanced, and reasonable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced, and understandable.

I am responsible for ensuring proper records are maintained and that the Accounts are prepared under the principles and in the format directed by Scottish Ministers.

To the best of my knowledge and belief, I have properly discharged my responsibilities as accountable officer as intimated in the Departmental Accountable Officer's letter to me of 31 January 2020.

Governance Statement

Scope of Responsibility

As Accountable Officer, I am responsible for maintaining an adequate and effective system of internal control that supports compliance with the organisation's policies and promotes achievement of the organisation's aims and objectives, including those set by Scottish Ministers. I am also responsible for safeguarding the public funds and assets assigned to the organisation. These financial statements consolidate the Health Board's Endowment fund, the Fife Health Charity. This statement includes any relevant disclosure in respect of these Endowment funds.

Purpose of Internal Control

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

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

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

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

Governance Framework

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

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

The Board meets every two months to progress its business and holds a Development Session in intervening months to discuss topical and strategic issues for NHS Fife. The Code of Corporate Governance, which is revised on an annual basis, identifies Committees and Sub-Committees that report to the Board to help it fulfil its duties. These include the following governance Committees:

- Clinical Governance;
- Audit & Risk;
- Staff Governance;
- Remuneration;
- Finance, Performance & Resources; and
- Public Health & Wellbeing

Clinical Governance Committee

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

Membership:
- Six Non-Executive or Stakeholder Members of the Board
- Chief Executive
- Medical Director
- Director of Nursing
- Director of Public Health
- A Staff Side Representative of NHS Fife Area Partnership Forum
- One Representative from the NHS Fife Area Clinical Forum

Chair:
Arlene Wood, Non-Executive Board Member

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

Audit & Risk Committee

Principal Function:
To provide the Board with the assurance that the activities of Fife Health Board are within the law and regulations governing the NHS in Scotland and that an effective system of internal control is maintained. The duties of the Audit & Risk Committee are in accordance with the Scottish Government Audit & Assurance Committee Handbook, dated February 2023, and associated Treasury guidance on assurance mapping.

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

Chair:
Alastair Grant, Non-Executive Board Member

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

Staff Governance Committee

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

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

Chair:
Colin Grieve, Non-Executive Board Member

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

Remuneration Committee

Principal Function:
To consider and agree performance objectives and performance appraisals for staff in the Executive cohort, to oversee performance arrangements for designated senior managers, and to direct the appointment process for the Chief Executive and Executive Members of the Board.

Membership:
- Fife NHS Board Chairperson
- Two Non-Executive Members of the Board
- Employee Director

Chair:
Patricia Kilpatrick, Chairperson

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

Finance, Performance & Resources Committee

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

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

Chair:
Alistair Morris, Non-Executive Board Member

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

Public Health & Wellbeing Committee

Principal Function:
To assure Fife NHS Board that NHS Fife is fully engaged in supporting wider population health and wellbeing for the local population, including overseeing the implementation of the population health and wellbeing actions defined in the Board's strategic plans and ensuring effective contribution to population health and wellbeing related activities.

Membership:
- Four Non-Executive Members of the Board
- Employee Director
- Chief Executive
- Director of Finance & Strategy
- Director of Nursing
- Director of Public Health
- Medical Director

Chair:
Patricia Kilpatrick, Chairperson (from 31.06.2024)
John Kemp (from 01.07.2024)

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

Other Governance Arrangements

The conduct and proceedings of the NHS Board are set out in the Board's Standing Orders. These specify the matters which are solely reserved for the NHS Board to determine, the matters which are delegated under the scheme of delegation and the matters which are remitted to a Standing Committee of the NHS Board. In April 2020, the Board adopted the new national Model Standing Orders for NHS Boards, created to support the implementation of the NHS Blueprint for Good Governance, and to improve consistency across NHS Boards using this 'Once for Scotland' approach. There have been no amendments to the Standing Orders in 2024/25.

An updated Code of Conduct for Members of Fife NHS Board (www.nhsfife.org/about-us/nhs-fife-board/code-of-conduct-for-board-members/) was formally adopted in 2022, based on model guidance created for NHS Scotland and approved by the Standards Commission for Scotland. Board members have received national briefings on the revised Code's requirements and regular updates from the Standards Commission on related guidance, and updates have been made to the Board's internal Gifts & Hospitality and Registering and Declaration of Interests processes to capture the required information under the Code. Both the Standing Orders, Code of Conduct for Members and Scheme of Delegation are contained within the Board's Code of Corporate Governance, which also includes the Standing Financial Instructions. These documents are the focus of the NHS Board's annual review of governance arrangements. The annual review also covers updating the remits of the NHS Board's Standing Committees and a self-assessment of each Committee's effectiveness, along with a review of the Board's Financial Operating Procedures.

All committees of the Board are required to provide an Annual Statement of Assurance to the Audit & Risk Committee and Board, describing their membership, attendance, frequency of meetings, business addressed, outcomes and extent of assurances provided. Each Statement also provides detail on risk management arrangements and an assessment of how Best Value principles have been addressed and seek to demonstrate

how each Committee have fully fulfilled their roles and remit during the reporting year. The format and content of these reports have been revised in the current year, taking on board past feedback, and a template for the respective sub-committees / groups that formally report into a Standing Committee has been followed to ensure consistency. Further guidance has also been provided to governance colleagues in the Fife Integration Joint Board in order to improve the content of assurances from their committees to the NHS Board.

All NHS Board Executive Directors undertake a review of development needs as part of the annual performance management and development process. Access to external and national programmes in line with development plans and career objectives is also available. During 2024/25, the Executive Directors continued their programme of team coaching to further develop strong collaborative leadership and to establish an approach to model and enact ways of working and behaviours that are integral to the vision of NHS Fife.

During the year, the Board has received updates on progress in delivery of the action plan created to help support the implementation of the second edition of the Blueprint for Good Governance. The content of the action plan was informed by a self-assessment exercise involving all Board members and routine attendees, measuring the Board's current operations against the Blueprint functions. The survey exercise was subsequently followed by a dedicated in-person Board development session held in February 2024, facilitated by Board Development colleagues from NHS Education for Scotland, to agree the Board's actions, collating these in the format of an improvement plan.

The self-assessment exercise and resulting action plan is a key element of implementing the arrangements of the NHS Scotland Blueprint for Good Governance and the survey and plan format are provided to Boards by Scottish Government as part of a Once for Scotland approach common across all Health Boards. The second edition of the Blueprint builds on the original guidance issued by Scottish Government in 2019 and sets out the methodology for assessing the effectiveness of the healthcare governance system against the principles of good governance. The aim is for Boards to develop a programme of activity to drive continuous improvement in the delivery of good governance. In seeking to map the Board's arrangements for governance against the standards given in the national Blueprint, detailed consideration has been given as to whether the right systems are in place to provide appropriate levels of assurance and to identify areas where improvements can be made.

Updates on completion of the Board's action plan has been given to the Audit & Risk Committee and the Board, in both September 2024 and March 2025, with the most recent update paper available online at www.nhsfife.org/media/j05mxdjb/blueprint-action-plan-0325.pdf. A series of actions have been completed during the year,, including renewal of the Board's risk appetite statement, finalising a stakeholder engagement strategy, increasing the benchmarking information available to the Board, and facilitating more opportunities for Board members to engage with staff and stakeholder groups. Monitoring the delivery of the two remaining actions, both of which are linked to national processes, will continue over the next 2024/25 reporting year, with external reporting to Scottish Government on progress thereon.

To support the Board-level governance review, each year every Board committee also undertakes a detailed self-assessment exercise, via the format of an online questionnaire surveying both members and attendees for their feedback. The regular review of Board committee effectiveness is an important tool in identifying areas where improvements can made, such as in enhancing training opportunities, and is a central part of the internal year-end assurance process.

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

Non-Executive Directors have a supported orientation to the organisation, as well as a series of site visits and briefing sessions aligned to their committee appointments. An enhanced induction programme has been established to support new members and a dedicated Induction Pack (available at www.nhsfife.org/about-us/nhs-fife-board/board-members-induction-pack/) is updated on a rolling basis. This programme, developed originally by NHS Fife, has been used to create national guidance issued to all Boards across Scotland, as an example of best practice. Opportunities for ongoing member support also exist at a national level via the NHS Scotland Board Development website and related resources, and discussions around individual member development and uptake of training opportunities are a key part of the annual appraisal process of each member by the Chair.

To ensure that the NHS Board complies with relevant legislation, regulations, guidance and policies, a distribution process is in place to ensure that all Circulars and communications received from the Scottish Government Health and Social Care Directorate (SGHSCD) are directed to Senior Managers who are held

responsible for implementation. A process to monitor compliance with regulations and procedures laid down by Scottish Ministers and the SGHSCD is in place.

In accordance with the principles of Best Value, the Board aims to foster a culture of continuous improvement. The Board Committees support the Board in delivering best value through the relevant focus within their Terms of Reference and the annual workplans, with reporting thereon in each annual assurance statement. Directors and Managers are encouraged to review, identify and improve the efficient and effective use of resources.

NHS Fife has implemented the National Whistleblowing Standards, introduced to all Boards from 1 April 2021. A dedicated Whistleblowing Champion took up position on the Board as a full Non-Executive Member in April 2021. At the time of writing, this post is out to recruitment, following the postholder's resignation in December 2024. The Board's Staff Governance Committee has undertaken review of the National Whistleblowing Standards and have overseen their adoption locally, including the cycle of regular reporting on the number of cases raised under the Standards and also any anonymous concerns raised. A refreshed approach, realigning the responsibilities for implementation of the Standards to within the Corporate Governance function, took effect in 2024/25. The Board is committed to achieving the highest possible standards of service and the highest possible ethical standards in public life in all of its practices. To achieve these ends, it encourages staff to use internal mechanisms for reporting any fraud, malpractice or illegal acts or omissions by its staff. The Board wishes to create a working environment which encourages staff to contribute their views on all aspects of patient care and patient services. All staff have a duty to protect the reputation of the service they work within. The Board does not tolerate any harassment or victimisation of staff using this policy, and treats this as a serious disciplinary offence, managed under the NHS Scotland Conduct Policy.

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

The Board is committed to working in partnership with staff, other public sector organisations and the third sector. NHS Fife strives to consult all of its key stakeholders. We do this in a variety of ways. How we inform, engage and consult with patients and the public in transforming services is an important part of how we plan for the future. To fulfil our responsibilities for public involvement, we routinely communicate with, and involve, the people and communities we serve, to engage with them on our plans and performance. During 2024/25, the Executive Team has been augmented by a new Director-level post with a remit for Communications & Engagement, and the Board has appointed from within the Non-Executive cohort a Community Engagement Champion.

An Integrated Performance & Quality Report (IPQR) was presented to each Clinical Governance Committee, Finance, Performance & Resources Committee, Staff Governance Committee, Public Health & Wellbeing Committee and Board meeting. This provides detailed monitoring information on a range of measures covering financial and clinical delivery, with additions in the year to include delegated services such as mental health. The enduring impact of the pandemic on performance against key metrics has been significant and the Board notes the challenges faced in recovering the position, particularly in relation to reducing waiting times and the number of referrals. The NHS Board also considers at each meeting the most up-to-date information available in relation to the financial position. At the time of writing, there is a review underway of the IPQR's content and format, to improve reporting data and to ensure it remains relevant and clear to Board members.

Any reports resulting from external regulatory inspections of, or visits to, NHS Fife healthcare sites are considered in detail at the Board's Clinical Governance Committee. A Safe Delivery of Care (Acute) unannounced follow-up inspection was undertaken by Healthcare Improvement Scotland (HIS) in the Victoria Hospital between 3 and 5 December 2024. The report on the inspection was published on 13 March 2025 (available online at www.healthcareimprovementscotland.scot/publications/victoria-hospital-safe-delivery-of-care-inspection-march-2025/). HIS had originally carried out an unannounced inspection at Victoria Hospital from 31 July to 2 August 2023, where concerns were raised in relation to patient safety and maintenance of the hospital environment. The inspection resulted in four areas of good practice, two recommendations and nine requirements to be addressed. The purpose of the follow-up inspection in December 2024 was to assess the progress that has been made in delivery of the NHS Fife improvement action plan. The follow-up inspection resulted in nine areas of good practice, one recommendation and 12 requirements being identified. The report states that the inspectors were assured that progress has been made with all requirements from the earlier inspection, with matters related to maintenance of the healthcare environment being met or partially met. The inspectors noted an open and supportive culture amongst staff, with senior hospital managers sufficiently visible and demonstrating good oversight of both clinical and wider system pressures. Despite the visit taking place during the winter period, when the hospital was under considerable pressure, it was noted that the areas

inspected were calm and well led, with hospital teams working together to provide compassionate care. An improvement plan has been developed to meet the requirements identified in the report. These include improvement required around patient dignity, hand hygiene, patient documentation, fire training compliance, safe storage of cleaning products and safe management of waste. A full report and update on the implementation of the improvement plan is scheduled to be considered by the Clinical Governance Committee in May 2025.

A Safe Delivery of Care, Mental Health Inspection, of Queen Margaret Hospital, Wards 1, 2 and 4, was carried out on 18 and 19 February 2025. A draft report will be sent to NHS Fife Board on 14 May 2025 for factual accuracy and the final report will be published on 12 June 2025. This, plus an update on the implementation of the linked improvement plan, will be presented to the Clinical Governance Committee in July 2025. [Section to be updated on report's publication]

The Mental Welfare Commission (MWC) visit people in hospital, in their own home or in a care home, in secure accommodation, or in any other setting where they are receiving care and treatment. About a quarter of visits are unannounced. The MWC produces reports on all visits to people using services, so that services can learn from them and improve the care and treatment they provide. The MWC regularly visit mental health and learning disability services. The MWC does this through local visits - to people who are being treated or cared for in local services, such as a particular hospital ward, a local care home, local supported accommodation, or a prison. A report is produced after each of these visits and recommendations made for change when necessary. Local visit reports are published on the MWC website at www.mwcscot.org.uk/visits-investigations/local-visit-reports. The MWC made seven announced and two unannounced visits to Fife during 2024/25, to services being delivered at Lynebank, Stratheden and Queen Margaret Hospital. All visit reports are reviewed by the Clinical Governance Oversight Group, with a route of escalation to the Clinical Governance Committee.

During 2024/25 the Board, as the Corporate Trustee for the Fife Health Charity, kept under review the overall governance for charitable funds, including the approach to the management and oversight of funds.

Integration Joint Board (IJB)

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

Minutes of the IJB's Quality & Communities Committee are considered at the Clinical Governance Committee of the NHS Board and an annual assurance statement is also provided from the IJB's Chief Internal Auditor and the IJB's Quality & Communities Committee to support the assurance process. The Integrated Performance & Quality Report encompasses all aspects of delegated services.

The approach adopted for health and social care within Fife is the 'fully delegated' model, with the IJB responsible for governance and assurance of all operational activities for its delegated functions. During 2024/25 the NHS Board and supporting governance committees maintained an overarching assurance role in relation to both clinical and financial governance, and therefore oversight of the adequacy and effectiveness of controls for delegated functions. The operational and governance framework of the IJB continues to be developed, to ensure clarity and consistency of approach.

A revised Fife Integration Scheme, following joint review by the partners, received formal sign-off by the Scottish Government on 8 March 2022 and is next due for review in 2027. The format of the reviewed Scheme continues to follow the Model Integration Scheme introduced across Scotland. The Fife version clearly details:

- Information on the role of the Chief Officer in respect of operational direction and accountability to the IJB, in addition to their role overseeing clinical and care governance.
- Clarity around the responsibilities and accountabilities of NHS Fife and Fife Council for clinical and care governance and the professional roles held by the Executive Nurse Director, the Executive Medical Director, and the Chief Social Work Officer.
- Confirmation that the IJB will ensure mechanisms to discharge its statutory responsibilities for the delivery of integrated health and social care services, health and wellbeing outcomes, the quality aspects of integrated functions for strategic planning and public involvement and delivery, monitoring and reporting on integration thought Localities, Directions, and its Annual Performance Report.
- Details on the financial basis upon which the parties share the cost of overspends or underspends incurred by the IJB.

Review of Adequacy and Effectiveness

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

- Discussions with Executive Directors and senior managers who are responsible for developing, implementing and maintaining internal controls across their areas.
- Annual Statements of Assurance from each Director.
- Reports from other inspection bodies.
- The work of the internal auditors, who submit regular reports to the Audit & Risk Committee, which include their independent and objective opinion on the effectiveness of risk management, control and governance processes, together with recommendations for improvement.
- The work of the external auditors, which includes their independent and objective opinion on the audit of the annual report and accounts, their review of key financial systems and consideration of the four key audit dimensions in their Annual Report.
- The completion of self-assessment questionnaires considering the Board's own performance and that of its Committees.
- The range of topics covered at Board Development Sessions, to develop the knowledge, awareness and engagement of both Executive and Non-Executive Board members on strategic matters.
- The effectiveness of the Board's agreed approach to Risk Management.
- The work of the other assurance Committees and groups supporting the Board: Staff Governance Committee, Remuneration Committee, Finance, Performance & Resources Committee, Public Health & Wellbeing Committee, and the Clinical Governance Committee (which also embraces Information Governance & Security).

The Annual Internal Audit Report 2024/25 was provided to the Audit & Risk Committee concluding that the Board has adequate and effective controls in place, and that the 2024/25 internal audit plan has been delivered in line with public sector internal audit standards.

The Board took assurance during 2024/25 from the Service Audit reports provided by the third-party service providers. T*he Service Audit report in relation to the NSI Financial Ledger services was provided unqualified. Whilst the Service Audit reports for both the IT Services and the Practitioner and Counter Fraud Services were provided with minor qualifications, conformation was nevertheless provided that neither of these was an adverse opinion. In addition, a Type 1 Service Audit was also provided with regards to the Payroll Services, which, following the TUPE transfer in February 2023, is now carried out externally from NHS Fife*. [Section to be updated once reports received in May].

Data Quality

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

Assurance on the information included in reports also comes from the overall approach to the management of information (overseen by the Information Governance & Security Steering Group) and validation processes and assurances on the quality of information provided from internal audit and other scrutiny bodies. I can confirm that that there were no significant control weaknesses or issues reported at the year-end which the Information Governance & Security Steering Group considered should be disclosed in the Governance Statement, as they may have impacted financially or otherwise in the year or thereafter.

Risk Management

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

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

NHS Fife is committed to maintaining and fully embracing an effective organisational risk culture. All of the key areas within the organisation maintain a risk register. The risk registers are held in Datix, the Risk Management

Information System. The Risk Management team provide training and support in response to the needs of individuals and teams.

During 2024/25 several initiatives have been implemented to improve the effectiveness of the risk management framework within NHS Fife, which are described below.

Risk Appetite

There was recognition that the risk appetite required to be reviewed, with the Board's previous risk appetite being set in July 2022. A dedicated Board Development Session on risk appetite was held in April 2024, followed by a second in June 2024. This provided opportunity to discuss and reflect on the Board's appetite and consider the changes required in terms of both the risk appetite descriptors, and the levels of risk the Board is prepared to tolerate in the pursuit of its strategic priorities, especially delivery of the Population Health & Wellbeing Strategy. This was particularly relevant as the Board responded and adapted to the challenging financial outlook with new Re-form, Transform, Perform Framework. The new risk appetite statement was agreed by the Board at its meeting in November 2024.

Risk Management Framework

The finalised Risk Management Framework, incorporating the new risk appetite statement, was presented to the Audit & Risk Committee in December 2024 and approved by the Fife NHS Board in January 2025. At the time of writing, work on a Delivery Plan for 2025/26 to support implementation is currently underway.

Corporate Risk Register

The corporate risks collectively outline the organisational risks associated with the delivery of the Board's Population Health & Wellbeing Strategy. It is recognised that all risks on the corporate risk register are impacted by and are aligned to the Strategy. All corporate risks are reviewed regularly and reported bi-monthly to the governance committees and twice a year to the Board.

During Financial Year 2024/25, developments of note in relation to corporate risks include the following:

Risks Closed

Optimal Clinical Outcomes: Following consideration of an updated deep dive review at the Clinical Governance Committee's meeting in March 2024, there was further discussion through the Risks and Opportunities Group on whether it was appropriate to close the risk and develop a revised risk or risks. Following this, and further discussion at the Clinical Governance Oversight Group, the recommendation was made to the Executive Directors' Group in September 2024 to close the risk and reframe a new risk.

Offsite area Sterilisation and Disinfection Unit Service: This risk was removed from the Corporate Risk Register in November 2024 and moved onto an operational risk register held by Acute Services and the Director of Property & Asset Management.

Risks Opened

Pandemic Preparedness / Biological Threats: A report and an initial deep dive review were progressed through the Public Health Assurance Committee and the Executive Directors' Group in March / April 2024. This review was agreed at the May 2024 Board and the risk now sits under the Director of Public Health and the Board's Public Health & Wellbeing Committee.

Capital Funding - Service Sustainability: The creation of a new risk in this area was approved by the Executive Directors' Group in May 2024 and this has now been included on the Corporate Risk Register, aligned to Finance, Performance & Resources Committee.

Potential Risks

A number of new potential corporate risks have been discussed for adoption:

Hospital Acquired Harm: Hospital Acquired Harm is a new risk intended to replace the closed Optimal Clinical Outcomes Risk. A draft deep dive was presented for consideration to the Clinical Governance Committee in March 2025.

Substance Related Morbidity and Mortality: Following a direction by the Public Health & Wellbeing Committee, a deep dive was assigned to a small team to ascertain the need for a specific NHS Fife risk with regards to deaths from drugs use. This aims to identify aspects of strategy, policy and delivery within the Board where there is a relevance pertaining to the prevention of drug-related deaths and to recommend actions that reduce the likelihood and consequence. The deep dive has progressed through the Risks & Opportunities Group, the Public Health Assurance Committee and the Public Health & Wellbeing Committee.

Access to General Dentistry: The Board's Public Health & Wellbeing Committee has suggested that a specific high-level corporate risk be considered regarding access to general dentistry across Fife. This risk has recently been created, is under review by the Primary Care Governance & Strategy Oversight Group and will be considered by the Public Health & Wellbeing Committee in May 2025.

The table below shows the risk score for each of the corporate risks from April to December 2024 against the target score and against the current risk appetite. Of the 20 open risks (including Substance related Morbidity and Mortality and Hospital Acquired Harm), there are still a significant number above risk appetite (2 are below risk appetite, 8 within risk appetite and 10 above risk appetite).

Risk Title	Target Score	Current Score	Dec 2024	Oct 2024	Aug 2024	June 2024	April 2024	Risk Appetite
1. Population Health & Wellbeing Strategy	12	12	12	12	12	12	12	Below
2. Health Inequalities	16	16	20	20	20	20	20	Within
4. Policy obligations in relation to environmental management and climate change	10	12	12	12	12	12	12	Below
5. Optimal Clinical Outcomes	10	N/A	N/A	15	15	15	15	Within
6. Whole System Capacity	16	20	20	20	20	20	20	Above
7. Access to outpatients, diagnostic and treatment services	16	20	20	20	20	20	20	Above
8. Cancer Waiting Times	12	15	15	15	15	15	15	Within
9. Quality & Safety	6	12	12	12	12	12	12	Within
10. Primary Care Services	12	16	16	16	16	16	16	Above
11. Workforce Planning and Delivery	8	16	16	16	16	16	16	Above
12. Staff Health and Wellbeing	8	16	16	16	16	16	16	Above
13. Delivery of a balanced in year financial position	25	25	25	25	25	25	16	Above
14. Delivery of recurring financial balance over the medium-term	20	25	25	25	25	25	16	Above
15. Prioritisation and management of capital funding	8	12	12	12	12	12	12	Within
16. Off-site area sterilisation and disinfection unit service	6	N/A	N/A	12	12	12	12	Within
17. Cyber resilience	12	16	16	16	16	16	16	Above
18. Digital and Information	12	15	15	15	15	15	15	Above
19. Implementation of Health and Care (Staffing) (Scotland) Act 2019 [HCSA]	9	9	9	9	12	12	12	Within
20. Reduced Capital Funding	12	20	20	20	20	N/A	N/A	Above
21. Pandemic Risk	20	20	20	20	N/A	N/A	N/A	Within
22. Hospital Acquired Harm	12	15	N/A	N/A	N/A	N/A	N/A	Within
23. Substance Related Morbidity and Mortality	15	20	N/A	N/A	N/A	N/A	N/A	Within

Strategic Risk Profile

The Strategic Risk Profile, as a dashboard set in the context of the Board's risk appetite, continues to be reported in the monthly Board Integrated Performance & Quality Report.

The full Profile is part of the introductory Corporate Risk Summary section. Extracts related to specific strategic priorities are contained within the Assessment section against the following areas of performance - clinical governance; operational; finance; staff governance; and public health and wellbeing. A section on the corporate risks is also now included in the introduction to the Annual Delivery Plan.

Assurance Levels

We continue to use the four-levels of assurance model, and this continues to add consistency to our reporting. The use of the assurance levels continues to evolve, as we seek to enhance the evidence to substantiate the level of assurance being offered.

Reports to the governance committees include a statement on the latest position in relation to the management of risks linked to the respective committees, the proposed 'level' of assurance that members can take from the report, and detail on mitigating actions.

Deep Dive Reviews

Corporate Risk Deep Dive reviews continue to form an important component of our risk assurance arrangements and provide a focus for in-depth discussion and scrutiny.

A key characteristic of a risk deep dive review is that it should be carried out at specific points during the life cycle of a risk. Criteria for undertaking a deep dive review have been agreed and include the creation of a new corporate risk, materially deteriorating risks, or the proposed de-escalation / closure of a corporate risk.

The requirement for a deep dive continues to be determined through routes including the Executive Directors' Group and the Risks & Opportunities Group.

Risks & Opportunities Group

The Risks & Opportunities Group was established in September 2022 and supports and embeds an effective risk management framework and culture across the organisation. The Group meet bi-monthly to support the continued development of an effective and consistent approach to the management of operational risk, as well as the ongoing consideration of enhancements to the Corporate risk management approach.

The Group has reviewed and updated its Terms of Reference, with the most recent iteration approved in August 2024. At each meeting the Risks & Opportunities Group reviews progress against its Annual Workplan, considers issues for escalation, and receives reports on any other relevant business. The Risks & Opportunities Group has reported on its work to the Audit & Risk Committee in September 2024 and in March 2025.

During 2024/25, the Group's work has included:

- Supporting the development and updates of the Risk Management Framework;
- Continuing to inform and support the developments and improvements in relation to the Corporate Risk Register, recommendations on changes or additions to the corporate risks and the broader organisational risk profile, assurance levels and deep dive reviews;
- Contributing to the development of a Risk Summary Dashboard and guidance to support and enhance our operational risk management approach and maintain alignment to the principles outlined within the Risk Management Framework;
- Reviewing the Risk Assessment Matrix and considering the need for updates to descriptors and terminology, taking account of similar work nationally;
- Considered the development of meaningful Key Performance Indicators that could be implemented to demonstrate active risk management.

The Group has undertaken a self-assessment of its own effectiveness, which has been considered at its meeting in April 2025 and thereafter reported to the Audit & Risk Committee in May 2025. The assessment covers elements including membership and group dynamics, role clarity and expectations, effectiveness of the scrutiny and challenge function, management of the agenda and impact of the Group in terms of outputs, as well as suggested actions to further improve the Group's effectiveness in respect of delivering its remit.

The Risks & Opportunities Group has developed a workplan for 2025/26 that will drive efforts to further develop a positive and proactive approach to risk management across the organisation.

The risk profile is currently being managed effectively with a new risk appetite defined. Further work is required during 2025/26 to effectively use the risk appetite in the ongoing management of the corporate risks.

During 2024/25 the Director of Finance & Strategy has been Executive Lead for Risk Management and reported on all of the above to the Audit & Risk Committee. For 2025/26, the Executive Lead for risk will be the Medical Director.

Population Health & Wellbeing Strategy – Year Two

The NHS Fife Population Health & Wellbeing Strategy 2023-28 (www.nhsfife.org/strategy/) was published in March 2023. Since publication, two mid-year reports and one annual report have been produced to evidence progress of the ambitions within the Strategy.

The latest report, the Strategy Mid-Year Report 2024-2025 (www.nhsfife.org/media/of0bb2qm/population-health-and-wellbeing-strategy-mid-year-report-2024-2025.pdf), describes how we have developed the Re-form, Transform, Perform Framework, which addresses our financial challenges whilst continuing to ensure our services are meeting the needs of the population of Fife. The Framework is firmly rooted in the ambitions laid out in our NHS Fife Population Health & Wellbeing Strategy.

Updates on the work are structured around NHS Fife's 2024-25 Corporate Objectives. In turn these are aligned to the four strategic priorities outlined in our strategy, these being:

- Strategic Priority 1: *improve health and wellbeing*
- Strategic Priority 2: *improve the quality of health and care services*
- Strategic Priority 3: *improve staff experience and wellbeing*
- Strategic Priority 4: *deliver value and sustainability*

For each corporate update, context was provided, where necessary, explaining how the corporate objective builds on work already undertaken; an update on what has been achieved in April to September 2024; and what was planned in the latter half of the financial year (October 2024 to March 2025).

Two case studies were included, which show how services are being redesigned in practice. The first described the impact of the Rapid Cancer Diagnostic Service. The second outlines how admissions to hospital for our most frail patients have reduced through collaborative working across the admissions team and the Hospital at Home Service.

The breadth and range of work described in recent reports is a testament to the continued efforts and support all the staff employed by NHS Fife, who have demonstrated their ongoing commitment to the ambitions set out in our Population Health & Wellbeing Strategy.

'Re-form, Transform, Perform' Framework

In March 2024, the Board approved its new Re-form, Transform, Perform (RTP) Framework. The Board's Population Health & Wellbeing Strategy remains the foundation of strategic intent and priorities for NHS Fife through to 2028, whilst the RTP serves as a tactical plan to deliver these strategic aims, supported by our annual planning mechanisms. The Framework sets out our intention to implement a renewed strategic approach to creating the right conditions for us to evolve our services, empower our staff and to ensure a more sustainable future for NHS Fife, whilst meeting our statutory responsibility to contain spend within our allocated resources.

RTP is prioritising four primary workstreams: Medicines; Service Design and Delivery; Infrastructure; and Workforce, each under Executive leadership. These workstreams are designed to be agile and fluid, enhancing delivery without altering individual roles or accountabilities. Initial savings are allocated to these streams, enabling focused delivery, rapid progress and effective monitoring, all under Executive oversight to align with strategic goals. Combined, these activities seek to deliver the required level of financial savings, to deliver a sustainable and recurring balanced financial position, whilst fostering new and innovative ways of addressing the healthcare challenges facing our local population.

Delivering Value and Sustainability is one of the Board's strategic priorities and our financial improvement plan is being delivered through RTP, working collaboratively across the system. Financial performance against the 3% savings schemes identified in our financial plan at the end of December is described below.

At the end of the financial year, we are reporting a reasonable level of success against our planned trajectories. The 2024/25 financial plan required cost improvements of £25m to be delivered through the RTP programmes. At the end of the year, the delivery of this target exceeded the agreed plan with £26.592m savings achieved by the end of quarter 4, of which £18.405m is assessed as being delivered on a recurring basis.

Performance against the in-year savings plan agreed for 2024/25 represents the highest level recurring savings delivered by the Board in the last 5 years, in total and on a recurring basis. The intention is to build on this momentum, pace and commitment to deliver during the next financial planning period. It is recognised, however, that the level of cost reduction required to balance will be dependent on the pace and delivery of our broader transformation aims.

IJB Financial Position

IJB position [Section to be included once year-end figures are known]

Disclosures

During the 2024/25 financial year, no significant control weaknesses or issues have arisen in the expected standards for good governance, risk management and control.

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**15 May 2025**
Title:	**Losses and Special Payments Quarter 4 2024/25**
Responsible Executive:	**Susan Dunsmuir, Director of Finance**
Report Author:	**Kevin Booth, Head of Financial Services & Procurement**

Executive Summary:

- The Boards Losses and Special Payments have decreased by £519,846 in quarter 4 (£506,463) in comparison to quarter 3 (£1,026,309) 2024/25.
- There has been an increased spend in relation to both Debtors write offs and payments in relation to vehicle damage in the quarter, and these have been dually reported back to the relevant departments.
- At the year end a total of £1,941,063 has been recorded for losses and special payments which is significantly below the £4,120,062 reported in the Annual Accounts in 2023/24.
- At the year end, analysis across the high-level categories of spend illustrates that the Clinical Compensation payments are below average in the last six years. Whilst Non-Clinical compensation payments are slightly below average. Losses and special payments excluding both of these categories of compensation payments are above average after eliminating any exceptional items.

1 Purpose

This is presented 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 4 (01/01/25 – 31/03/25).

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 Head of Financial Services & Procurement 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 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 1 summarises the Boards losses and special payments for the period 01/01/25 – 31/03/25. 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 265 losses and special payments in the quarter which was comparable to the number reported in quarter 3 (268) of 2024/25. The total cost reported however has decreased in the quarter to £506,463, from the £1,026,309 reported in quarter 3. This decrease was predominantly as a result of the decrease in value of the clinical compensation payments (£307,346 down from £921,044). Whilst there was an increased spend of £96,182 against non-clinical compensation payments made in the quarter in comparison to the £63,088 recorded in quarter 3. The total of losses and special payments out with clinical and non-clinical compensation payments was £102,935 which was an increase in comparison to quarter 3 (£42,177). This increase can be attributed to the year-end debtor's review reported in quarter 4.

The Treasury team carried out their quarterly analytical review to provide additional assurance and the following items were noted:

1 – With reference to section 3 (Equipment losses), there was Desktop computer noted missing and assumed stolen (£681) from a ward in VHK. This was dually reported to Police Scotland.

2 – In section 5 (Payroll losses), there were payroll overpayments following the Year End Debtors review written off totalling £40,202. This brought the total for the full year to £67,419. These losses continue to be dually shared with the Financial Management Team for escalation with the Workforce Directorate.

3 – In section 6 (Buildings and Fixtures losses), there were 16 claims for vandalism totalling £6,980, predominantly as a result of patients at Stratheden and Whytemans Brae.

4 – In section 15 (Claims abandoned), there was £1,818 and £664 paid out in relation to patient's hardship funds for taxi transfers and bus transfers respectively from A&E. Whilst there were three insurance excess payments totalling £600 for car lease drivers paid out. Lastly there was a further £47,311 written off in relation to Other Debtors following the Year End review, off which the majority (£39,970) related to overseas patients.

5 – In section 20 (Equipment damage) there were 2 reports of damage to NHS IT equipment totalling £869 which required replacement.

6 – With regards to clinical compensation payments (Section 23), there were a total of 12 cases settled in the quarter to a value of £307,346. Whilst a further 11 cases for a value of £96,182 were settled in relation to non-clinical compensation payments (Section 24).

7 – In section 28 (compensation to patients and staff for financial loss) there were 6 claims totalling £1,983 for the loss or damage to clothing and personal effects.

8 – In section 30 (payments in relation to vehicle accidents) there were 4 payments totalling £605 relating to NHS Fleet vehicles and a further 4 payments totalling £1,217 relating to Enterprise pool cars. These costs have been dually escalated to the NHSF Transport and Fleet Manager for further discussion following the recent increased trend of these losses.

The above findings will be carried into the quarter 1 (2025/26) review to assist with the identification of any developing trends which may materially affect the Boards expected position moving forward.

At the year end, the spend on Losses and Special payments totals £1,941,063 from 951 reports. By comparison there was a total cost of £4,120,062 from 749 reports recorded in the 2023/24 Annual Accounts.

The attached charts (see appendix 2) are presented to provide additional assurance over the trajectory of the high-level categories at the year-end in comparison to previous years. The clinical compensation payments have averaged £3.52m over the six-year period and the spend in 2024/25 is significantly below this average. The non-clinical compensation payments have averaged £218k over the six-year period and the 2024/25 spend is just below this level. The losses out with the clinical and non-clinical compensation payments have averaged £252k across the six years and the 2024/25 spend remains below this level. It should be noted that there were significant one-off items in both 2022/23 (£71K) and 2023/24 (£949K) which if excluded show a more consistent average cost across the period of £82k, and the 2024/25 spend significantly exceeds this.

This report provides the following Level of Assurance:

	Significant	Moderate	Limited	None
Level	x			
Descriptor	There is robust assurance that the system of control achieves, or will	There is sufficient assurance that controls upon which the organisation relies	There is some assurance from the systems of control in place to manage the	No assurance can be taken from the information that has been provided. There

	achieve, the purpose that it is designed to deliver. There may be an insignificant amount of residual risk or none at all.	to manage the risk(s) are suitably designed and effectively applied. There remains a moderate amount of residual risk.	risk(s), but there remains a significant amount of residual risk, which requires further action to be taken.	remains a significant amount of residual risk

2.3.1 Quality, Patient and Value-Based Health & Care

The losses and special payments require to be tightly controlled as they can have a material impact on the Boards financial position and ability to maintain budgets to ensure/enhance Patient Care.

2.3.2 Workforce

The procedural guidance for Managers to ensure the appropriate treatment for any losses or special payments is detailed in the Financial Operating Procedures.

2.3.3 Financial

The losses and special payments are included within the Boards Annual Accounts, are subject to external audit and are submitted to the Scottish Government for oversight at the year end.

2.3.4 Risk Assessment/Management

The types and levels of the Board's losses and special payments are monitored to manage any potential reoccurrence and future exposure to the Board where possible.

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

The Board's process for the treatment of its losses and special payments are detailed within the Financial Operating Procedures to ensure they are applied consistently and providing equity of treatment.

2.3.6 Climate Emergency and Sustainability Impact

There is no direct impact on the Climate Emergency and Sustainability objectives.

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 31 December 2024.

2.4 Recommendation

- **Assurance** – The committee is provided with a “significant” level of assurance.

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Summary of Losses and Special Payments 01/01/25 – 31/03/25
- Appendix No 2, Annual spend graphs for comparison

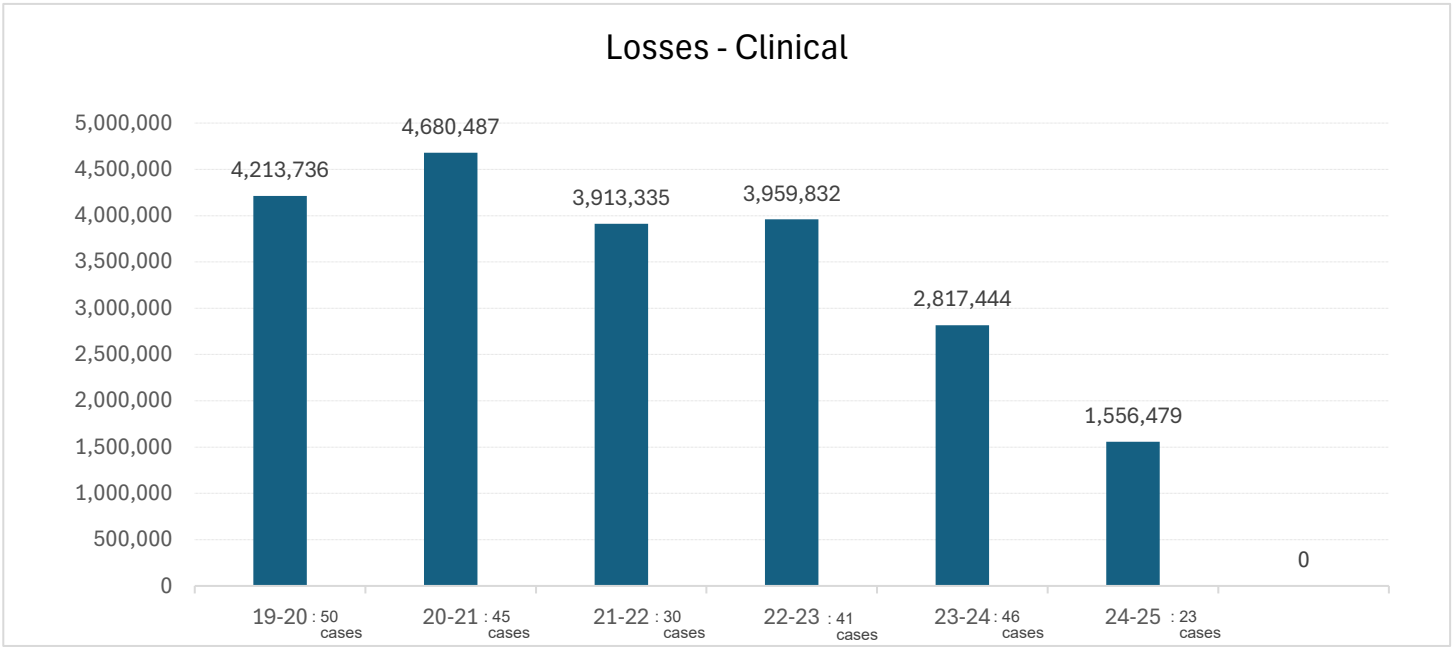
Report Contact
Kevin Booth
Head of Financial Services & Procurement
Email kevin.booth@nhs.scot

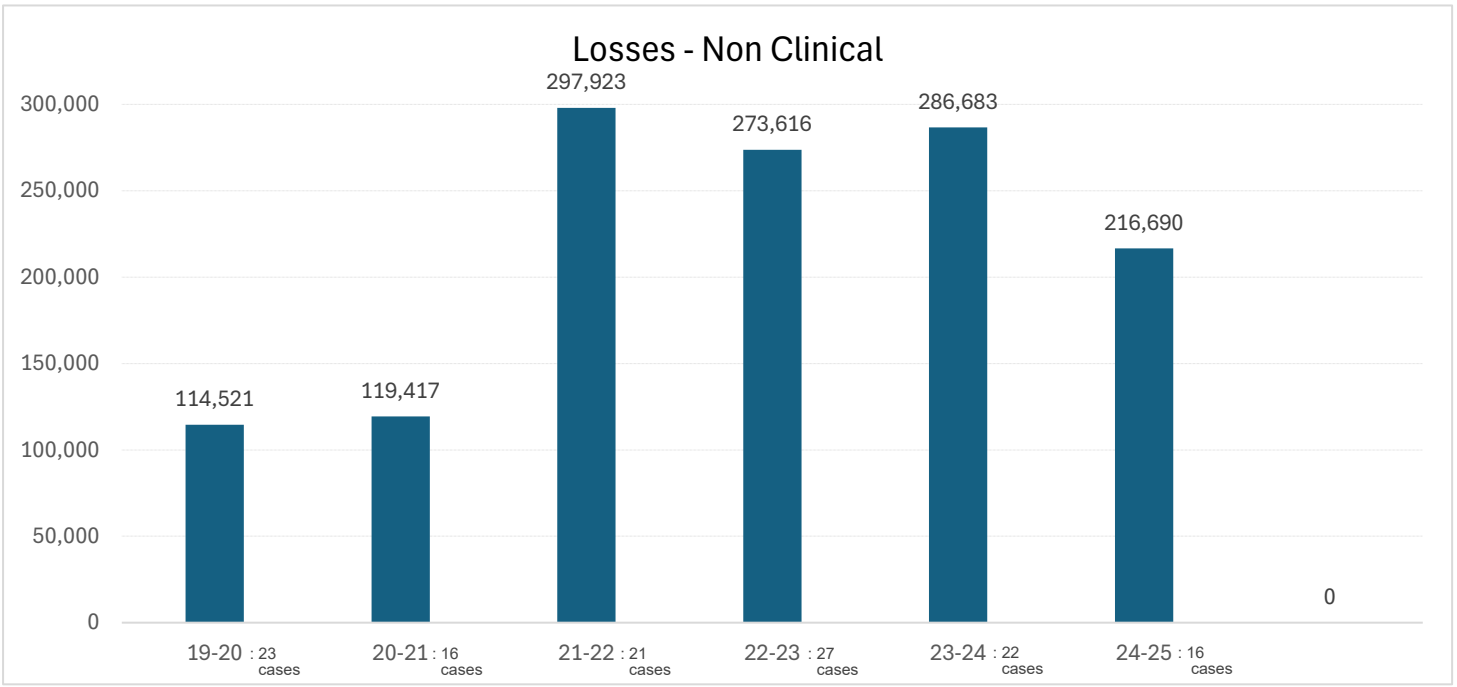
FIFE HEALTH BOARD

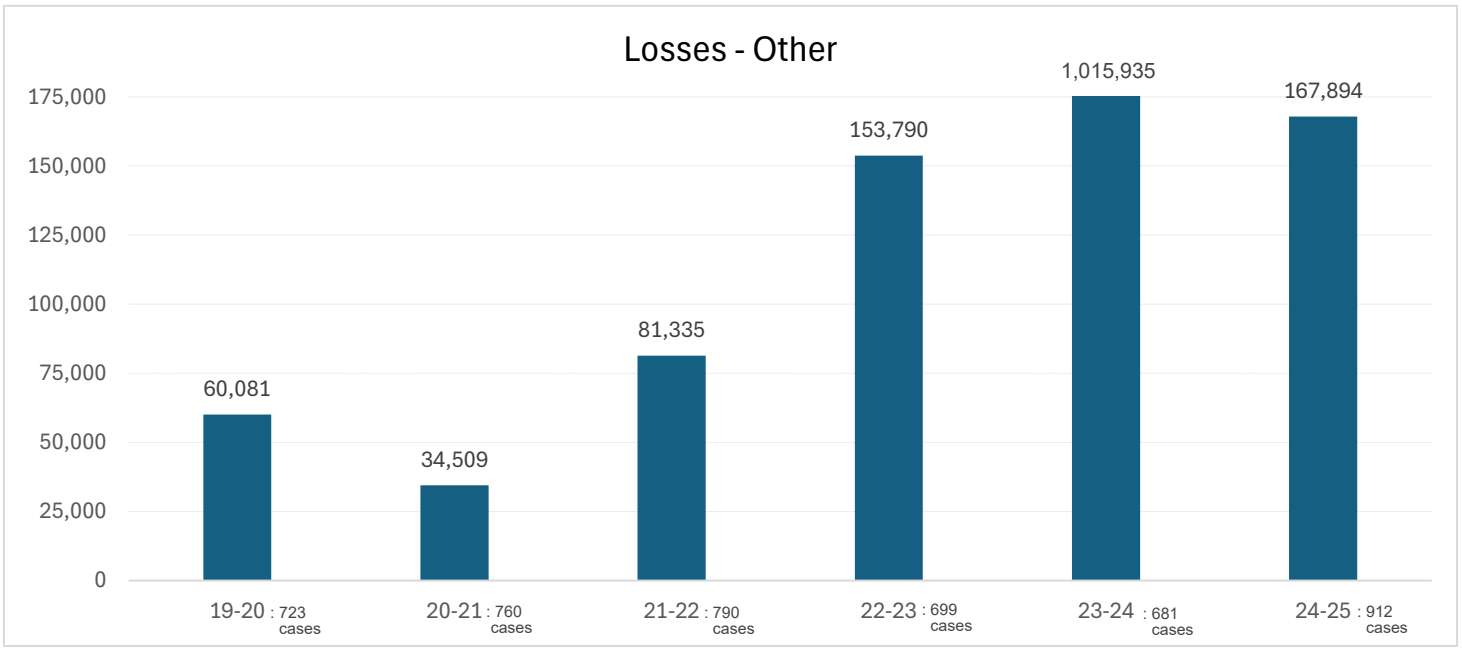
SUMMARY OF LOSSES AND SPECIAL PAYMENTS

ITEM NO.	CATEGORY	JAN-MAR'25		APR'24 - MAR'25	
	Miscellaneous / Theft / Arson / Wilful Damage				
1	Cash				
2	Stores/procurement				
3	Equipment	1	682	1	682
4	Contracts				
5	Payroll *Salary Overpayment Debtors Invoices*	11	40203	45	67419
6	Buildings & Fixtures *Vandalism*	16	6981	54	14480
7	Other				
	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				
	(c) Other *Hardship Accounts / Insurance Excess / Debtors WO's*	198	50393	760	66406
	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*	2	870	12	6661
21	Disclosed at physical check				
22	Other Causes				
	Compensation Payments - legal obligation				
23	Clinical	12	307346	23	1556479
24	Non-clinical	11	96183	16	216690
	Ex-gratia payments:				
25	Extra-contractual Payments				
26	Compensation Payments - ex-gratia - Clinical				
27	Compensation Payments - ex-gratia - Non Clinical	6	1983	21	5919
28	Compensation Payments - ex-gratia - Financial Loss				
29	Other Payments				
	Damage to Buildings and Fixtures:				
30	Incidents of the Service :				
	- Fire				
	- Flood	8	1823	19	6327
	- Accident *Vehicle Expenditure*				
	- Other Causes				
31	**Extra-Statutory & Extra-regulationary Payments**				
32	**Gifts in cash or kind**				
33	**Other Losses**				


265
506463
951
1941063


Losses - Clinical
5,000,000
4,500,000
4,000,000
3,500,000
3,000,000
2,500,000
2,000,000
1,500,000
1,000,000
500,000
0
4,213,736
4,680,487
3,913,335
3,959,832
2,817,444
1,556,479
0
19-20 : 50 cases
20-21 : 45 cases
21-22 : 30 cases
22-23 : 41 cases
23-24 : 46 cases
24-25 : 23 cases


Losses - Non Clinical
300,000
250,000
200,000
150,000
100,000
50,000
0
114,521
119,417
297,923
273,616
286,683
216,690
0
19-20 : 23 cases
20-21 : 16 cases
21-22 : 21 cases
22-23 : 27 cases
23-24 : 22 cases
24-25 : 16 cases


Losses - Other
175,000
150,000
125,000
100,000
75,000
50,000
25,000
0
60,081
34,509
81,335
153,790
1,015,935
167,894
19-20 : 723 cases
20-21 : 760 cases
21-22 : 790 cases
22-23 : 699 cases
23-24 : 681 cases
24-25 : 912 cases

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**15 May 2025**
Title:	**Waiver of Competitive Tenders Quarter 4**
Responsible Executive:	**Susan Dunsmuir, Director of Finance**
Report Author:	**Kevin Booth, Head of Financial services & Procurement**

Executive Summary:

- This paper provides a significant level of assurance on the governance arrangements followed in respects of the waivers of competitive tenders applied within the Boards procurement process in quarter 4.
- In quarter 4 (2024/25), there were 5 waivers of competitive tender; 3 for equipment and 2 for systems, with a total value of £911k, which have been approved and applied in line with NHS Fife's Standing Financial Instructions.
- The Procurement Governance Board reviewed the awarding of the 5 waivers of competitive tender in quarter 4 at the meeting on 23 April 2025.

1 Purpose

This report is presented for:

- Assurance

This report relates to a:

- Government policy/directive
- Legal requirement

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

- Safe

2 Report summary

2.1 Situation

In order to allow the Audit & Risk Committee to take assurance that the Boards Procurement Function is operating within the legal requirements of the Scottish Government. This paper presents oversight of the Contract Awards over £50,000 in quarter 4 (January 2025 – March 2025) that were subject to a waiver of competitive tender.

2.2 Background

As per the Guidance in the Public Contracts Scotland Act 2015. Any non-competitive award of a contract with an anticipated value of £50,000 or more (excluding VAT) must have a waiver of competitive tender completed prior to award and be signed off by the Head of Procurement, then approval counter signed by both the Director of Finance & Strategy and the Chief Executive.

The waiver of competitive tender confirms the restricted conditions which when in existence, the Board is permitted to award the contract without following the existing competitive process as prescribed in the Act.

The restricted, permitted conditions (as per the Code of Corporate Governance, appendix 3 Standing Financial Instructions, section 9.11) are as follows:

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 contractor's 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.

Any other justification including the unavailability of time should not be considered without the prior agreement with the Scottish Government.

2.3 Assessment

During quarter 4 the Procurement Team awarded 5 contracts subject to a waiver of competitive tender.

Operating Tables for £600k
Due to late additional capital funding provided by the Scottish Government, a time sensitive requirement had arisen to purchase 6 operating tables listed on the NHS Fife Capital Equipment Replacement Plan and Risk Register. The existing tables are over 30 years old and are regularly subject to significant repairs to keep them functional. Following various operating table trials and due to the requirement of Scottish Government to ensure the Capital Funding was utilised, a direct award to the manufacturer of the successful trial tables was agreed. As a result, a waiver of competitive tender was approved as per NHS Fife's Standing Financial Instructions (SFIs), based on point 5 (urgency – maintaining essential service provision) of the criteria noted above, to support order, delivery and payment by 31 March 2025.

Laundry Equipment for £100k
Due to late additional capital provided by the Scottish Government, a time sensitive requirement had arisen to purchase laundry folding equipment listed on the NHS Fife Capital Equipment Replacement Plan, which was highlighted following a Health Facilities Scotland audit to improve resilience of NHS laundry services across Scotland. As a result, a waiver of competitive tender was approved as per NHS Fife's Standing Financial Instructions (SFIs), based on point 5 (urgency – maintaining essential service provision) of the criteria noted above, to support order, delivery and payment by 31 March 2025.

Urology Thulium Fiber Laser Consumable Agreement for £78k
A Urology TFL Laser was required to ensure continued provision of ureteroscopy procedures, due to current laser issues and suppliers' inability to provide continuity of Fiber supplies. Following clinical trials, the Coloplast laser was deemed most suitable. A consumable deal approach was taken due to the lack of available capital funding to support

the equipment replacement. Frameworks are available to direct award for outright purchase via capital, however no framework is available for a consumable deal purchase. Therefore, a waiver of competitive tender was approved as per NHS Fife's Standing Financial Instructions (SFIs), based on point 5 (urgency – maintaining essential service provision) of the criteria noted above.

Theatre Management System Maintenance and Support Contract for £73k
Opera is a Theatre digital management system which has been in place for over 10 years. It facilitates the delivery of Theatre Services across NHS Fife, through planning and scheduling of both emergency and elective surgeries. This is an essential system to maintain and prevent service delivery risks. GE Medical Systems Ltd are the only provider with the ability and unique knowledge to maintain and support this system, therefore the waiver of competitive tender was approved as per NHS Fife's Standing Financial Instructions (SFIs), based on points 2 and 3 of the criteria noted above.

Datix Risk Management System Maintenance and Support contract for £60k
Datix is an incident and risk management system currently utilised across NHS Scotland and there is a need to extend the service contract for a further year whilst National Services Scotland explore options to replace this system in 2026. RLDatix Ltd are the only provider with the ability and unique knowledge to maintain and support this system, therefore a waiver of competitive tender was approved as per NHS Fife's Standing Financial Instructions (SFIs), based on points 2 and 3 of the criteria noted above.

All waivers have been reviewed by the Head of Procurement, then approved by both the Director of Finance and the Chief Executive, in line with NHS Fife's Standing Financial Instructions (SFIs).

This report provides the following Level of Assurance:

	Significant	Moderate	Limited	None
Level	X			
Descriptor	There is robust assurance that the system of control achieves, or will achieve, the purpose that it is designed to deliver. There may be an insignificant amount of residual risk or none at all.	There is sufficient assurance that controls upon which the organisation relies to manage the risk(s) are suitably designed and effectively applied. There remains a moderate amount of residual risk.	There is some assurance from the systems of control in place to manage the risk(s), but there remains a significant amount of residual risk, which requires further action to be taken.	No assurance can be taken from the information that has been provided. There remains a significant amount of residual risk

2.3.1 Quality, Patient and Value-Based Health & Care
A waiver of competitive tender will only ever be considered by Procurement where all applicable information is provided to a high quality, allowing for effective decision making.

2.3.2 Workforce
The current guidance for the application of a waiver of competitive tender is contained within the Financial Operating Procedures section 11(a) for staff to reference when consideration is required. The qualifying criteria contained mirrors that within the Boards Standing Financial Instructions.

2.3.3 Financial

As per the Public Contracts Scotland Act 2015 any procurement of £50,000 or above is subject to Procurement Journey Route 2 (or Route 3 if GPA threshold or above), where a tender would be posted through the Public Contracts Tender Portal. The application of the waiver of competitive tender negates the requirement for this process.

2.3.4 Risk Assessment/Management

The application of a waiver of competitive tender needs to be robustly controlled to ensure the Board does not expose itself to challenge which could result in legally imposed financial penalties and reputational damage.

2.3.5 Equality and Human Rights, including children's rights, health inequalities and Anchor Institution ambitions

The governed application of the waiver of competitive tender ensures applicable treatment of suppliers across the marketplace.

2.3.6 Climate Emergency & Sustainability Impact

The Climate Emergency and Sustainability are a key consideration for NHS Fife and the consequences from any Procurement activity are evaluated during the procurement process.

2.3.7 Communication, involvement, engagement and consultation

The consideration of the application of a waiver of competitive tender is considered by the Senior Procurement Team following discussions with the service lead, before being approved, if applicable by the Head of Procurement and then issued to the Director of Finance and the Chief Executive for final sign off.

2.3.8 Route to the Meeting

The Procurement Governance Board took assurance on the application of the waiver of competitive tender during quarter 4 at the meeting on 23 April 2025.

2.4 Recommendation

- **Assurance** – Members are asked to take a **"significant" level of assurance** that the Procurement process for the waiver of competitive tenders was correctly applied in the quarter.

3 List of appendices

N/A.

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

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**15 May 2025**
Title:	**Audit Scotland General Practice Report**
Responsible Executive:	**Dr Christopher McKenna, Medical Director**
Report Author:	**Dr Helen Hellewell, Deputy Medical Director Health & Social Care Partnership (HSCP)**

Executive Summary:

This short report details how NHS Fife and the HSCP intend responding to the Audit Scotland report - General Practice: Progress since the 2018 GMS contract.

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Emerging issue
- Government policy / directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

On 27th March 2025 Audit Scotland published a report: General Practice: Progress since 2018 General medical services Contract. (Appendix 1)

This report acknowledges that General practice plays a critical role in Scotland's ambition to improve the population health but that whole time equivalent numbers of general practitioners have decreased since 2017.

It further outlines that there is uncertainty about the strategic direction of general practice and this coupled with the lack of clarity of investment in general practice in the medium term is causing difficulty with recruitment and retention of general practitioners and the wider multidisciplinary team.

2.2 Background

The 2018 General Medical Services (GMS) contract aimed to improve the sustainability of general practice and access to care. However, several commitments that were intended to be completed by 2021 have still not been fully implemented.

2.3 Assessment

NHS Fife and Fife Health and Social care partnership has an established governance structure that oversees the delivery of the Primary Care Strategy through the Primary Care Governance and Strategic Oversight Group. Jointly chaired by the Executive Medical Director and the Director for Health and Social Care. A paper will be brought through that group and onwards to the Public Health and Wellbeing Committee, which outlines how we are going to ensure that we take forward the recommendations within the report.
This will include setting out in more detail how we are going to respond to the scenarios that will come through from the interim findings of the phased investment programme and build on the work that we have already started on further quality improvement work within the GP Clusters as part of year 2 of our primary care strategy.

Many of the recommendations within the report require strategic planning at a national level and necessitate a response from Scottish Government. Groups have been set up nationally to work through each of the recommendations. The primary care leads at board level (the Deputy medical director HSCP and the Head of Service for Primary and Preventative care) are linked into these groups and will ensure that local strategy within NHS Fife continues to align to the national direction as more details emerge.

The following areas of strategy will be considered:

1. Workforce: Roles and responsibilities of the Multidisciplinary team within primary care:
2. Medium term financial investment in primary care
3. Quality improvement through GP clusters
4. Health Inequalities
5. Communication and Engagement Plans
6. GP Premises

This report provides the following Level of Assurance:

	Significant	Moderate	Limited	None
Level		x		
Descriptor	There is robust assurance that the system of control	There is sufficient assurance that controls upon which	There is some assurance from the systems of control in	No assurance can be taken from the information that has

	achieves, or will achieve, the purpose that it is designed to deliver. There may be an insignificant amount of residual risk or none at all.	the organisation relies to manage the risk(s) are suitably designed and effectively applied. There remains a moderate amount of residual risk.	place to manage the risk(s), but there remains a significant amount of residual risk, which requires further action to be taken.	been provided. There remains a significant amount of residual risk

2.3.1 Quality, Patient and Value-Based Health & Care

Delivering high quality patient care in a General Practice is a priority for NHS Fife, the HSCP and individual GP practices. The delivery of the full GMS contract is fundamental to the sustainability of General Practices in Scotland the 'how' this can be delivered is multi-faceted and will require support from Scottish Government.

2.3.2 Workforce

The delivery of the full MDT approach to General Practice workforce is a significant ongoing challenge and will be considered a part of the HSCP response to the Audit Scotland report.

2.3.3 Financial

There remain significant financial constraints nationally as the contract as it currently stands has not had full funding. The HSPC management team will consider how to best approach ongoing delivery of the contract and the financial sustainability of the programme in the response to the audit.

2.3.4 Risk Assessment / Management

After the full assessment of the report, existing strategic and operational primary care risks will be updated.

2.3.5 Equality and Human Rights, including children's rights, health inequalities and Anchor Institution ambitions

All aspects that relate equality, inequality and human rights will be considered as part of the review of the report.

2.3.6 Climate Emergency & Sustainability Impact

NA

2.3.7 Communication, involvement, engagement and consultation

Communication and consultation is fundamental to the deliver if General Practice services will form an essential part of how the report is considered.

2.3.8 Route to the Meeting

This paper has come direct to the Audit & Risk Committee.

2.4 Recommendation

The committee is asked to the **note** the HSCP leadership teams plan to comprehensively review the report and will in turn provide assurance via a paper that will be considered by the PHWB committee.

The Committee is also asked to take a **"moderate" level of assurance**.

3 List of appendices

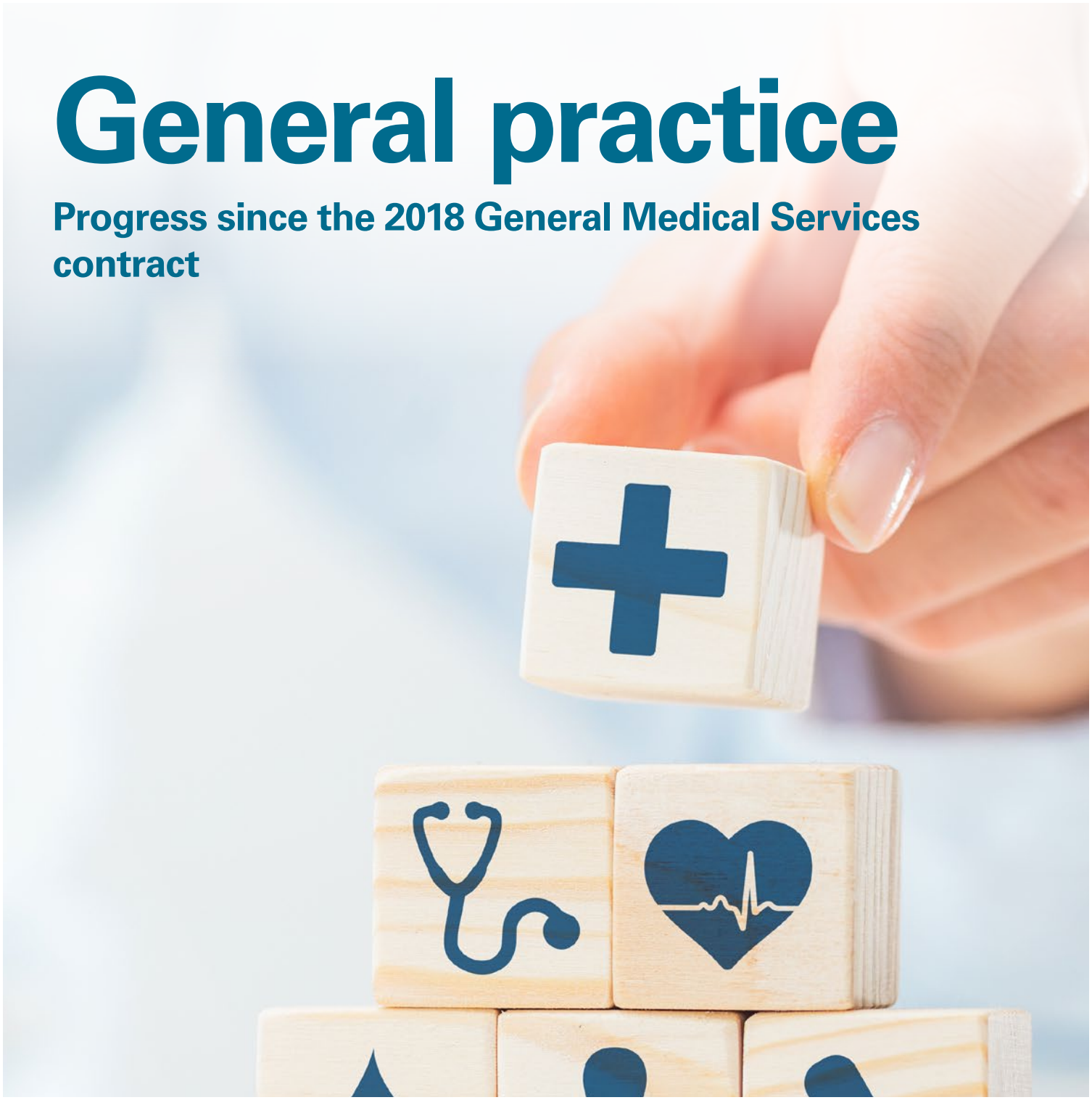
The following appendices are included with this report:

- Appendix No. 1, Audit Scotland Publication General Practice : Progress since 2018 General medical Services contract

Report Contact
Dr Helen Hellewell
Author's Deputy Medical Director HSCP
Email Helen.Hellewell@nhs.scot

General practice

Progress since the 2018 General Medical Services contract



AUDITOR GENERAL

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Audit team

The core audit team consisted of: Leigh Johnston, Eva Thomas-Tudo, Fiona Lees, Naomi Ness and Chris Dorrian, under the direction of Carol Calder.

Key facts

	**4,525**	GP headcount, excluding specialty trainees, in September 2024
	**3,453**	Estimated whole-time equivalent GPs, excluding specialty trainees, in March 2024
	**4,925**	Whole-time equivalent multidisciplinary team workforce, working in six priority services, in March 2024
	**6.5%**	Proportion of NHS spending directly on general practices in 2023/24
	**£1.09bn**	Spending directly on general practices in 2023/24
	**£194m**	Primary Care Improvement Fund spending in 2023/24
	**69%**	People rating the care at their general practice as excellent or good in 2023/24

Key messages

1 General practice plays a critical role in Scotland's ambition to improve the population's health and keep people at home and out of hospitals. However, the pressure on general practice is increasing because of a growing and ageing population, enduring and widening health inequalities, and longer waits for hospital care. Compared to 2017, there are also fewer whole-time equivalent GPs, and the Scottish Government's commitment to increase the number of GPs by 800 is unlikely to be met by 2027.

2 There is uncertainty about the strategic direction of general practice. The 2018 General Medical Services (GMS) contract aimed to improve the sustainability of general practice and access to care. However, several commitments that were intended to be completed by 2021 have still not been fully implemented. The expansion of wider primary care teams to support general practice, to include more nurses, pharmacists, physiotherapists and other specialists, has been slower than planned. And people report finding it more difficult to access care. The Scottish Government has not been transparent enough about the progress made since 2018, and has not set out whether, or when, it will implement the outstanding GMS contract commitments.

3 The Scottish Government has committed to prioritising primary care but there is a lack of clarity about investment in general practice in the medium term. In 2023/24, the Scottish Government spent £1.09 billion on general practices. However, direct spending on general practice as a proportion of overall NHS spending decreased from seven per cent to 6.5 per cent between 2017/18

and 2023/24. Direct spending on general practice has also started to decrease in real terms, and between 2021/22 and 2023/24 it fell by six per cent, exacerbating pressures on practices.

4 The data that the Scottish Government needs to make informed decisions on general practice planning and investment is inadequate. This is a long-standing issue. There remains a lack of robust information about general practice demand, workload, workforce and quality of care. This limits the Scottish Government's ability to know whether the changes introduced by the 2018 GMS contract represent value for money or have improved patient care. The Scottish Government is taking steps to improve the availability and quality of data from general practice. But longer-term work will be required to improve the consistency of data recording to support evidence-based national planning.

Recommendations

The Scottish Government should:

- As part of its work on a refreshed vision for primary care, publish a clear delivery plan for general practice by the end of 2025 that includes specific actions, timescales and costs. This should clarify whether and when it will implement the outstanding commitments from the 2018 General Medical Services contract, and include:
  - how it will work with Health and Social Care Partnerships (HSCPs) and the Scottish GP Committee to improve the way that general practice teams and multidisciplinary teams work together to provide services. This should focus on improving communication, collaboration, data sharing and clarity about responsibilities across the primary care workforce (paragraph 65)
  - a medium-term funding trajectory for general practice to provide certainty and enable better-informed financial and workforce planning (paragraph 44)
  - identifying appropriate financial and administrative support for GP clusters, and clear priorities for improvement (paragraph 71)
  - how it intends to better support general practices to contribute to tackling health inequalities (paragraph 77)
  - robust governance arrangements for how the Scottish Government will monitor, evaluate and publish progress, identifying what data is needed and how data will be obtained and validated (paragraph 42).
- Over the next six months, carry out scenario planning, based on interim findings of the phased investment programme to inform its response to this programme of work (paragraph 39).
- Within one year, work with Public Health Scotland and HSCPs to publish total spending across Scotland on the six priority services in their public financial reporting (paragraph 34).
- Within one year, work with HSCPs, GP leads and the General Practice Managers Network to develop a communications plan to increase public understanding of how and why general practice is changing. This should include targeted

national and local elements and align with the refreshed vision for primary care (paragraph 58).

- Within one year, set out its plans, including how progress will be monitored, for moving towards a model where GPs will no longer be expected to provide their own premises as part of its new approach to infrastructure planning and investment across NHS Scotland (paragraphs 102, 105 and 106).

Introduction

Background

1. Effective general practice is critical to the performance and sustainability of the health service, and in Scotland's ambition to improve the population's health and reduce health inequalities. A key strength of general practice is its unique position to focus on holistic care that considers the whole person rather than specific conditions. Anybody in Scotland can access general practice services without charge.

2. General practices are the main point of contact for people seeking general healthcare services in Scotland. General Practitioners (GPs) and wider primary care teams diagnose and treat common medical conditions, prevent illnesses and promote good health, and refer patients to specialist services where necessary. They also manage complex care in the community, preventing unnecessary admissions to hospital (Exhibit 1, page 9). This makes an effective general practice good value for money.

3. There are currently around 890 general practices across Scotland.[1] Most of these are run by GP partners as independent contractors, meaning they are private businesses that have contracts with the NHS, rather than employed by the NHS. General practices also employ staff such as salaried GPs, general practice nurses, practice managers and receptionists.

4. The Scottish Government and the Scottish GP Committee (SGPC) of the British Medical Association (BMA) negotiated and agreed the 2018 General Medical Services (GMS) contract.[2] This was the first time that a Scotland-specific contract had been negotiated, with previous arrangements agreed on a UK-wide basis. The 2018 contract set out system-wide changes that aimed to address challenges with recruiting and retaining GPs, alongside reported increases in demand for services and increasing complexity of care needs.

5. The contract was supported by an agreement between Integration Authorities, the SGPC, NHS boards and the Scottish Government, about how they would work together to deliver the wider support required by the contract.[3] The main ambitions from the 2018 GMS contract and the main ways the Scottish Government intended to achieve them are set out in Exhibit 2 (page 10). The Scottish Government planned to implement the new contract by 2021.

Exhibit 1.

Examples of primary care services in Scotland

This report focuses on general practice and multidisciplinary teams.

Primary care

Usually the first point of contact for people seeking healthcare. Examples include:

Within the scope of this report

- **General practice:**

Provides advice and treatment for medical conditions, manages complex care in the community, and refers to other health and social care services when needed. Practices are staffed by a range of professionals, such as GPs, nurses, healthcare assistants, practice managers and receptionists.

- **Multidisciplinary teams (MDTs):**

Health and care staff across a range of professions, such as nurses, pharmacists and physiotherapists. They are mostly employed by NHS boards rather than general practices and are usually based in general practice, a central hub or both, and work across six priority services:

  - Vaccination Transformation Programme (VTP): includes most vaccination programmes.
  - Pharmacotherapy: providing pharmacy and prescribing support for general practices.
  - Community Treatment and Care (CTAC) services: a range of services such as wound care, phlebotomy and chronic disease monitoring.
  - Urgent care: mostly advanced nurse practitioners and paramedics focusing on urgent and unscheduled care.
  - Additional professional roles: a range of services including mental health services, physiotherapy and occupational therapy.
  - Community link workers: provide non-medical support for personal, social, emotional and financial issues.

Examples not within the scope of this report include:

- GP out-of-hours services
- Dentistry and oral health
- Eyecare
- Community pharmacy

Source: Audit Scotland

Exhibit 2.

The Scottish Government's ambitions from the 2018 GMS contract and how it intends to achieve them

2018 GMS contract ambitions	Key Scottish Government commitments that support the contract ambitions
Improve access to care and free up GPs' time to lead multidisciplinary teams (MDTs), focus on patients with complex care needs and improve the quality of care provided	• Rolling out MDTs across six priority services (paragraphs 16–22). • Transferring the responsibility from GPs to NHS boards for providing vaccinations from October 2021, pharmacotherapy and Community Treatment and Care (CTAC) services from April 2022, and urgent care by 2023/24 (paragraph 23). • Increasing the number of GPs by 800 between 2017 and 2027 (paragraph 78). • Establishing GP clusters to focus on quality improvement (paragraphs 67–71). • Changing the roles of general practice nurses, practice managers and receptionists (paragraphs 88–94).
Changing the way general practices are funded to improve financial stability and sustainability	• A new practice funding formula to better reflect practice workloads associated with older or more deprived populations (paragraph 95). • Minimum earnings for GP partners and a practice income guarantee (Exhibit 7, page 38). • By 2021, an income range and pay progression for GPs comparable with hospital consultants, and directly reimbursing staff and practice expenses (Exhibit 7, page 38).
Moving towards a model where GPs will not be expected to provide their own premises	• Interest-free sustainability loans for GPs who own their own premises (paragraph 99). • NHS boards to take on the responsibility for leases with private landlords (paragraph 99).
Improving GP IT systems and information-sharing agreements	• New GP clinical IT systems to be in place by 2020 (paragraph 50). • New information-sharing agreements that recognise GPs as joint data controllers with NHS boards (paragraph 51).

Source: Audit Scotland and Scottish Government

6. In 2021, the Scottish Government and partners recognised that the commitments in the 2018 GMS contract that were originally intended to be delivered by April 2021 had not been fully implemented.[4] They acknowledged the impact of the Covid-19 pandemic on progress and set priorities and a new deadline of April 2023.

About this audit

7. This performance audit aims to consider the performance of general practice since the 2018 GMS contract was introduced. To do this, it aims to answer the following questions:

- How are general medical services in Scotland provided and funded?
- What progress has been made in improving patient care since the 2018 GMS contract?
- What progress has been made in improving workforce challenges and financial pressures since the 2018 GMS contract?

8. This audit looked mainly at national progress with implementing the aims of the 2018 GMS contract. It did not cover the rationale for the 2018 GMS contract. The audit focused on services provided by general practice teams and wider multidisciplinary teams outlined in Exhibit 1. It did not cover other primary care services such as dentistry and optometry, or other community care staff groups such as district nurses.

9. Our findings are based on evidence from sources including:

- interviews with the Scottish Government, national NHS boards, other public sector and third sector organisations, the SGPC of the BMA, the Royal College of GPs (RCGP) Scotland, and other GPs
- review of documentation from the Scottish Government, national NHS boards, other public sector and third sector organisations, and academic research
- focus groups with community link workers
- analysis of data from audited NHS accounts, Public Health Scotland (PHS), NHS Education for Scotland (NES), and the Scottish Government.

10. We refer to real-terms changes in this report. This means that we are showing financial information from previous years at 2023/24 prices, adjusted for inflation. We use gross domestic product (GDP) deflators to adjust for inflation, which are published quarterly by HM Treasury. GDP deflators are the standard approach adopted by the Scottish Government when analysing public spending. The Covid-19 pandemic resulted in volatility across 2020/21 and 2021/22. To compensate for this, and to provide meaningful comparisons between years, we have used an average GDP growth rate across 2020/21 and 2021/22 in our calculations.

1. Service provision and funding

Pressure on general practice has increased

11. Unlike secondary care, where waiting lists and times are regularly monitored, it is not easy to define or measure demand for services provided by general practice. There are, however, proxy measures that clearly indicate that pressure on general practice has increased. These include a growing and ageing population,[5] more people with one or more health conditions,[6] an increased impact of disease on the population,[7] and enduring and widening health inequalities (Exhibit 3, page 13).[8]

12. Waiting lists for diagnostic tests, appointments and treatments in secondary care are substantially larger, and waiting times considerably longer, than before the Covid-19 pandemic.[9] This is increasing pressure in general practices as GPs report having to provide additional support and care while patients wait for an appointment or treatment.[10]

13. The number of patients registered with a general practice in Scotland has also grown, but at a faster rate than the Scottish population.[11] The gap between the number of patients registered and the population is not new, but the gap has increased. In 2013, there were around 230,000 more patients registered with a general practice than were estimated to live in Scotland; by 2023 the gap had increased to around 450,000. The reasons for this are not currently fully understood but may be related to the transient student population. The Scottish Government has convened a short-life working group (SLWG) to look into the issue; this work is expected to be completed by summer 2025.

14. Despite growing demand for general practice, the estimated number of whole-time equivalent (WTE) GPs has decreased, increasing pressure further (paragraph 80).[12] This means that on average, each GP has a larger population to care for, so there is less GP time available for each patient. There were around 1,620 patients per WTE GP in August 2017; by March 2024 this had increased to 1,735 patients per WTE GP.

15. The number of patients per WTE GP varies widely across Scotland, from 721 in NHS Orkney to 2,373 in NHS Lanarkshire. Fewer patients per GP can indicate better access, but different areas have different needs based on geography and the demographics of the population, so some variation is to be expected.

Exhibit 3.

Indicators of increased pressure on general practice

Proxy measures clearly indicate that pressure on general practice has increased and may continue to increase.

Indicator of increased demand	
Growing population	• 2013–23: Scottish population increased by 3.3% (+173,300 people).
Ageing population	• 2013–23: proportion of people in Scotland aged 65 and over increased from 17.8% (947,400 people) to 20.3% (1,116,400 people).
More people with long-term health conditions and mental health issues	• 2011–22: proportion of people reporting a long-term illness, disease or condition increased from 18.7% (988,400 people) to 21.4% (1,163,500 people). • 2011–22: proportion of people reporting a mental health condition increased from 4.4% (232,900 people) to 11.3% (617,100 people).
Increased impact of disease on the population	• Annual disease burden forecast to increase by 21% by 2043, with two-thirds of the increase due to cardiovascular disease, cancers and neurological conditions. Many of these conditions are preventable.
Enduring and widening health inequalities	• Between 2019 and 2021, people living in the most deprived areas spent more than a third of their life in poor health. In the least deprived areas people spent around 15% of their life in poor health.
Longer waiting times for secondary care	• September 2024: 38,370 ongoing waits for inpatient or day case treatment, where patient had been waiting more than a year. Before Covid-19 (September 2019) there were around 1,640.

Note: Long-term illness, disease or condition includes a range of conditions such as arthritis, cancer, diabetes and epilepsy.

Source: Audit Scotland, National Records of Scotland and Public Health Scotland

The way general medical services are provided has changed substantially but the expansion of MDTs has been slower than planned

16. The 2018 GMS contract introduced substantial changes to the way primary care is provided by GPs and wider teams. A key commitment was expanding **multidisciplinary teams (MDTs)** across six priority services to improve access to care and reduce GP workloads, enabling GPs to focus on complex patients and quality improvement (Exhibit 1, page 9). These services are:

- Pharmacotherapy
- The Vaccination Transformation Programme (VTP)
- Community Treatment and Care (CTAC)
- Urgent care
- Additional professional roles
- Community link workers.

17. At March 2024, more than 4,900 WTE staff were working in the six priority services.[13] Of these, just over 3,500 WTE were additional staff recruited specifically to expand MDTs in line with the aims of the 2018 GMS contract. This significant expansion in the primary care workforce shows progress, but the Scottish Government aimed to complete the roll-out by 2021, and then by 2023. It has not met these deadlines and implementation gaps remain.

18. In 2021, the Scottish Government, BMA, Integration Authorities and NHS boards announced that, while all six services remained areas of focus, they would prioritise three of the six services for 2021/22 – pharmacotherapy, the VTP and CTAC services.[14] Despite this, in 2023 the Scottish Government's analysis of Health and Social Care Partnerships (HSCPs) information submissions found that many HSCPs estimated that they had less than half the staff required for full implementation.

19. The Scottish Government's analysis also estimated a substantial shortfall of around £125 million in the funding required to fully implement these three priority services and maintain current levels of spending on the other three. This is likely to be underestimated, as it does not include non-staff costs, such as additional premises or IT equipment. It also does not include additional spending needed to fully implement the three remaining services.

20. The Scottish Government identified that HSCPs' submissions on the costs and workforce needed to fully implement services varied substantially. It found that HSCPs stating that they had fully implemented services reported a much lower WTE staff requirement per weighted population than other areas. This may indicate that these areas had not actually reached full implementation, or some other areas were overestimating their staff requirements.

Multidisciplinary teams (MDTs)

MDTs are groups of healthcare staff in a range of professions such as nurses, pharmacists and physiotherapists, working in the six priority services. They are mostly employed by NHS boards rather than general practices.

21. The Scottish Government recognised that it needs better data to better understand the funding and workforce requirements for fully implementing the three priority services. It has commissioned Healthcare Improvement Scotland (HIS) to support a primary care phased investment programme (PCPIP), which aims to provide a better evidence base for future investment (paragraph 37).

22. While the Covid-19 pandemic affected progress, even before the pandemic HSCPs' submissions consistently reported that they were not likely to meet the original deadline of 2021. HSCPs have routinely highlighted the availability of funding and workforce as key constraints to progress, alongside other barriers such as a lack of space to accommodate additional staff and IT and connectivity problems. Remote and rural areas have also faced specific challenges (Case study 1).

Case study 1.

Flexible arrangements for remote and rural areas enables local decision-making about the most appropriate model for service provision

The Scottish Government has recognised that remote and rural areas can face specific challenges with expanding MDTs, such as less predictable demand for services, longer journey times and difficulties with recruitment. It has developed a process for HSCPs to consider whether some GPs should continue to provide certain services because of these challenges.

This process enables HSCPs to assess local population needs and different options for service provision, to determine the most appropriate model for providing services that are accessible and good value for money. If they determine that the best option is for some general practices to continue to provide some services, they can submit a proposal for consideration by the national GMS Oversight Group and Scottish ministers.

To date, the GMS Oversight Group has reviewed and approved three proposals. Twelve general practices in Argyll and Bute HSCP area have retained responsibility for providing vaccinations, or CTAC services, or both. One general practice in NHS Borders is continuing to provide vaccinations.

Highland HSCP in particular has faced challenges with providing vaccinations services. In January 2025, the Scottish Government accepted a proposal by Highland HSCP to implement a mixed model of vaccine provision. This means that NHS Highland will retain responsibility for providing some vaccine programmes, while some general practices will be commissioned to provide other vaccines services. The Scottish Government stated that these were exceptional circumstances and that this arrangement should not be viewed as a precedent for other services or other HSCPs or NHS boards.

Source: Scottish Government, GMS Oversight Group and NHS Highland

The Scottish Government has not fully implemented its commitments to transfer services to NHS boards

23. The Scottish Government and BMA committed to transferring the responsibility for providing the six priority services from general practices to NHS boards.[15] However, this has only partly been completed and the Scottish Government has not set out when it will fully implement these commitments:

- The Scottish Government amended regulations to transfer the responsibility away from GPs and to NHS boards, for providing vaccinations from October 2021, and pharmacotherapy and CTAC services from April 2022.
- The Scottish Government has not transferred the responsibility for providing urgent care services, as it originally committed to doing by 2023/24.
- The Scottish Government acknowledged that further work was needed to establish the 'endpoint' for the additional professional roles and community link workers commitments.[16]

24. Regulations alone, however, do not clarify the level of service that general practices are entitled to receive. Service specifications are also needed to set out the detail of, for example, how many appointments will be available. Without this, the workload may still fall to general practices, even though the responsibility for providing these services has been transferred to NHS boards. For vaccinations, the Scottish Government issued specifications, detailing how general practices would be paid if they needed to continue providing vaccinations.[17] But for CTAC and pharmacotherapy, the Scottish Government has not set out service specifications because MDTs are not sufficiently established.

25. The Scottish Government committed to providing transitionary services or payments where practices and patients do not have sufficient access to MDTs after April 2022.[18] It issued payments of £15 million in 2021/22 and £10 million 2022/23 to cover both winter support funding and transitionary support. This was £5 million less than originally committed – the Scottish Government said this was because of the impact of the UK spending review in 2022.[19]

26. These payments were not targeted, meaning that all practices received payments, regardless of whether they had full access to MDTs, no access or were somewhere in between. Since 2022/23, the Scottish Government has not provided any transitionary support, despite ongoing gaps in the availability of MDTs to provide these services.

27. It has instead advised HSCPs and NHS boards to implement local arrangements where necessary. This enables local areas to target support more equitably but relies on funding from existing budgets. This means that if HSCPs have fully spent their allocations on MDTs,

they may not be able to provide any transitionary support, even if their general practices do not have sufficient access to MDTs. The Scottish Government does not routinely monitor the extent to which local arrangements are in place.

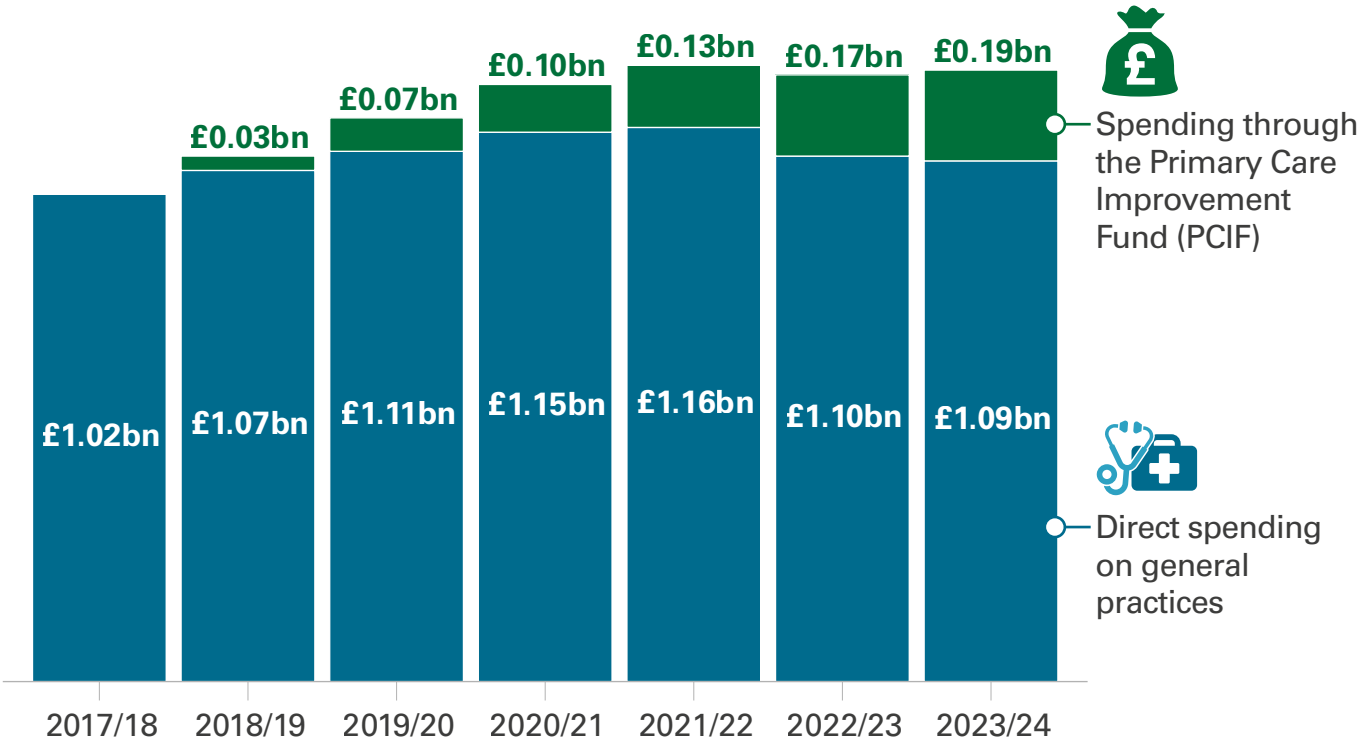
Real-terms spending on general practice is starting to decrease at a time of increasing demand

28. In 2023/24, direct spending on general practices was £1.09 billion, a 33 per cent increase in cash terms since 2017/18.[20] The increase was just below seven per cent when taking inflation into account. Since 2021/22 however, real-terms spending has decreased by six per cent, at a time of increasing demand (Exhibit 4). Additionally, direct spending on general practices as a proportion of NHS spending decreased from seven per cent to 6.5 per cent between 2017/18 and 2023/24.[21]

Exhibit 4.

Real-terms spending directly on general practices and through the PCIF, 2017/18 – 2023/24

Real-terms direct spending on general practices is beginning to decrease, while the PCIF has increased.



Source: Audit Scotland, Public Health Scotland and Scottish Government

29. The Scottish Government has invested substantially in expanding MDTs across the six priority services through the Primary Care Improvement Fund (PCIF). By 2023/24, HSCPs reported that spending through the PCIF had increased to £194 million per year (Exhibit 4). When combined with direct spending on general practices, there has been no increase in real-terms spending since 2021/22.[22]

30. In November 2024, the Scottish Government announced an additional recurring £13.6 million in general practice funding from 2024/25, to help ease cost pressures.[23] It has also set aside £10.5 million in its 2025/26 budget to develop a targeted service within general practice for early intervention and prevention in areas such as frailty and cardiovascular disease.[24] However, the details of this service have still to be agreed with GPs.

Scotland-wide spending on the six priority services is not transparent, making it difficult to assess total spending and value for money

31. The Scottish Government does not publish spending on the six priority services, which limits transparency and public scrutiny. Spending through the PCIF on these services is reported by HSCPs to the Scottish Government through regular trackers, but spending data is not included in the Scottish Government's published annual progress reports.

32. The trackers do not include spending on these services from other sources, so the Scottish Government has not assessed how much is being spent in total across Scotland. This could potentially be a considerable amount of additional spending. The Scottish Government's most recent annual progress report highlights that 3,540 WTE of the 4,925 WTE staff working across the six priority services at March 2024 were funded by the PCIF.[25] That means more than 1,300 WTE staff were funded through other sources.

33. The Scottish Government aims to better understand the impact of spending in some HSCPs through the PCPIP (paragraph 37). However, robust, comprehensive and public reporting on spending across Scotland on the six priority services is needed.

34. The Scottish Government should work with PHS and HSCPs to publish spending across Scotland on the six priority services in PHS' public financial reporting. This would help enable the Scottish Government and HSCPs to assess the full impact and value for money of MDTs and improve transparency and public scrutiny of this spending. It would also enable a better understanding of differences in spending in different geographical areas and if spending is targeted where it is most needed.

Limited information about the impact of MDTs is a barrier to making well-informed decisions

35. While some local areas have carried out analysis of the impact of MDTs, robust, routinely available information across Scotland on the impact of the roll-out of MDTs is lacking. This means that:

- the Scottish Government has not been able to define what full implementation means, in terms of appropriate staffing numbers, skill mix, or how much additional funding is required
- the Scottish Government and partners have not been able to fully scrutinise the impact of the investment in MDTs on their key aims of improving patient care or reducing GPs' workloads, or whether it is providing good value for money.

36. The Scottish Government monitors progress through regular trackers submitted by HSCPs. These submissions provide some detail about progress, such as staff numbers and qualitative information on achievements and barriers to progress. The Scottish Government has also tried to collect data on capacity and activity. However, this relies upon the Scottish Government requesting, and HSCPs providing, meaningful information. The Scottish Government's own analysis shows that data availability and quality issues limit the conclusions that can be drawn from this information.

37. The Scottish Government recognises that it needs better data to understand the impact of MDTs across Scotland. It has commissioned the PCPIP to inform its longer-term investment in MDTs. The PCPIP consists of two main parts:

- providing additional funding and support across four sites in Scotland – Ayrshire and Arran, Borders, Edinburgh City and Shetland – to demonstrate what a model of full implementation of pharmacotherapy and CTAC could look like in practice, while maintaining delivery of the VTP
- providing primary care teams across Scotland with the option to participate in improvement work and share learning.

38. The PCPIP has the potential to provide a better evidence base for decision-making. It aims to evaluate the impact of MDT working, using qualitative and quantitative data. But there are significant risks to the success of this work:

- The Scottish Government has commissioned the PCPIP until the end of December 2025. This is a very short timescale for the four sites to fully recruit staff, gather evidence and demonstrate impact.
- If the findings show that substantial additional investment is necessary to fulfil the Scottish Government's commitments, this level of funding may not be available.

- The PCPIP is focusing on fully implementing pharmacotherapy, and CTAC, while maintaining the VTP, so it will not demonstrate the impact of fully implementing all six priority services.

39. The Scottish Government should carry out scenario planning, based on interim findings of the PCPIP to inform its response to this programme of work.

The vision and strategic direction for general practice is not clear and the Scottish Government is working to refresh this

40. The Scottish Government's vision and strategic direction for general practice and wider primary care provision is unclear. There is also insufficient clarity about expected investment in general practice over the medium term. This is making it more difficult for GPs and HSCPs to plan services and reform ways of working:

- The Scottish Government has committed to increase investment in primary care by 25 per cent by the end of the parliamentary term, but it has not set out how much of this increase will be for general practice.[26] In January 2025, the First Minister committed to increase the proportion of new NHS funding that goes to primary and community care, but this also lacks detail on the proportion for general practice.[27]
- Several commitments in the 2018 GMS contract have not been implemented and the Scottish Government has not set out its plans for implementing the remaining commitments.
- There is a lack of clarity about how much additional investment will be available to fully implement MDTs across the six priority services.

41. The Scottish Government is currently developing a new plan for primary care reform. This work includes developing a refreshed vision, outcomes and strategic approach for primary care, aligned with wider health and social care reforms. The Scottish Government plans to publish this in summer 2025.

42. As part of this work, the Scottish Government should clarify whether, and when it will fully implement its outstanding commitments from the 2018 GMS contract by publishing a clear delivery plan, informed by evaluations of the changes to date. It should include specific actions, timescales and costs. It should also set out robust governance arrangements for how it will monitor and evaluate progress including identifying what data it needs, and how it will be obtained and validated.

43. The Scottish Government has refreshed its national governance arrangements relating to general practice, in recognition that previous arrangements focused too narrowly on the implementation of MDTs.

In January 2025, it established the General Practice Programme Board, replacing the previous GMS Oversight Group. The wider focus on all aspects of general practice policy is welcome, and the Scottish Government should ensure that this board has full oversight of the programme of work that will contribute to a published delivery plan for general practice (paragraph 42).

44. While the Scottish Government has committed to prioritising investment in primary care, including general practice (paragraphs 30 and 40), it should also set out a medium-term funding trajectory for general practice. This would provide certainty for GPs and HSCPs, enabling them to carry out well-informed medium-term financial and workforce planning.

A lack of robust data makes it difficult for the Scottish Government to make informed decisions or evaluate progress

45. The Scottish Government published a monitoring and evaluation strategy in 2019, setting out a ten-year approach for assessing the impact of primary care reform in Scotland.[28] We welcome the focus in the strategy on outcomes for people, workforce and the system. However, further work was needed to improve the data and arrangements in place for monitoring and evaluating progress, and this work has not progressed as planned.

46. PHS published a national baseline report highlighting gaps in the data and evidence in 2020.[29] But plans to set out annual priorities, improve national indicators and publish a series of progress reports did not go ahead as expected. Scottish Government and PHS analysts were instead needed to support the response to the Covid-19 pandemic, and post-pandemic work priorities have changed. The Scottish Government now plans to review the primary care outcomes and indicators, and update them if needed, as part of its work on primary care reform.

National data to inform, monitor and support general practice is still inadequate

47. We have long highlighted the lack of national data available for general practice and called for improvements.[30] Despite this, robust national data about demand, activity, workload, workforce and quality of care in general practice is still lacking. For instance:

- Data on the general practice workforce (apart from GP headcount) relies on estimates from an annual survey. Only around 85 per cent of practices currently provide information.[31] There is no standard definition for a vacancy in the survey and vacancy data is not completed consistently by practices. It is also not clear how many hours GPs are contracted to work (paragraph 81). NES and NHS

National Services Scotland (NSS) are working with practices to improve data collection and quality. A new application introduced by NSS in 2024 will allow practices to update workforce data throughout the year and incorporates some inbuilt data validation functionality.

- PHS publishes data about clinical and administrative activity in general practices covering around 95 per cent of the population.[32] But variation in how data is recorded means that it is not yet comparable across practices or consistent enough to fully support national planning.

48. NSS and PHS are supporting general practices to improve the consistency of activity data. They have developed guidance and a dashboard to allow practices to scrutinise their own data. Unlike secondary care, however, general practice does not routinely employ people to gather and code data to support NHS board and national decision-making. So improving the data relies on practices having the capacity and motivation to implement the guidance. There are also no arrangements for validating practice data to ensure it is consistent and comparable across Scotland. PHS only carries out basic quality checks to highlight potential data-quality issues.

49. NHS England reports more detailed appointment data from general practice clinical systems, including the number, type and duration of appointments, and the time between booking and the appointment. All practices in England were directed to record data in a standard way to enable this to be collected more consistently and are financially incentivised to do so. NHS England, however, does not report wider clinical or administrative activity for appointments.[33]

50. The Scottish Government acknowledges that primary care data and the infrastructure to support it is inadequate and has said that improving this situation is a priority:

- NSS is supporting GPs to implement a new GP clinical IT system across Scotland, a programme that was originally planned to be completed by 2020. This means that all practices will be using the same system, presenting an opportunity for more consistent activity and appointment data to be gathered in Scottish practices. However, the system supplier entered administration in December 2024. This presents a substantial risk to this programme of work, and it is currently unclear whether the new system will be fully rolled out to all practices by 2026 as now planned. NSS has formed an incident management team and has stated that arrangements are in place to ensure immediate service provision while the administrators seek a buyer. Once in place, practice teams will need time to learn how to use the new system.
- It has set up the primary care data and intelligence programme with PHS and NSS, to improve access to, and the quality of, primary

care data. The programme's current priority is to establish a primary care data and intelligence platform by March 2026.[34] It is currently unclear how this programme may be impacted by any delays to the GP clinical IT system roll-out.

51. The platform will have access to clinical coding information from all Scottish GP clinical systems. This will be used for direct care and public health surveillance purposes. It will also have access to other data, such as activity data, that can be used for other purposes including research; however, only general practices that agree to participate will have their data used for these purposes. Information governance is a major component of this project and work to agree necessary governance arrangements is ongoing. It is likely that longer-term work will be required to improve the consistency of data recording to support evidence-based national planning.

2. Progress improving patient care

People are finding it more difficult to access healthcare at their general practice

52. The biennial Health and Care Experience (HACE) Survey is the main way in which access to general practice is measured and monitored in Scotland. The results of this survey show that people are finding it more difficult to access healthcare at their general practice. For example, in 2023/24, 24 per cent of survey respondents said that it was 'not easy' to contact their general practice in the way that they wanted to. This was an increase from 13 per cent in 2017/18.[35]

53. The Scottish Government recognises that access to general practice is a major public concern and has commissioned several initiatives to help address this. One example is the HIS Primary Care Access Programme (PCAP). This programme supports general practice teams to use data to explore challenges, identify areas for improvement and improve an aspect of access over a seven-week period.[36]

54. The PCAP has helped practice teams to improve some aspects of capacity or demand, but it tends to focus on small-scale changes in individual practices. Improvements are shared more widely through national learning events and resources. The PCAP does not enable system-wide improvements and does not aim to address the most significant challenges in improving access to care, such as workforce shortages.

55. In 2023, the Scottish Government also published a set of General Practice Access Principles.[37] These principles help to define what good and appropriate access looks like and can help set and manage expectations about access to general practice. But factors such as limited capacity also affect access, and the Scottish Government has been clear that the principles are not standards that practices are measured or monitored against. It is therefore difficult to assess how well the principles have been implemented across Scotland or whether they have helped to improve patient access.

The public does not fully understand how and why general practice is changing

56. Research shows that changes in the way primary care can be accessed, and how it is provided, are not well understood by the public.[38]

To help address this, the Scottish Government ran a public awareness campaign in March 2022 to promote greater understanding of MDTs and the role receptionists have in helping people to access care.[39]

57. Towards the end of 2022, a survey of more than a thousand people who had recently consulted a GP found that most people still lacked awareness of the full range of MDT professionals working in general practice.[40] Furthermore, 29 per cent of respondents were unhappy with receptionists acting as care navigators, a view expressed more prominently by people in deprived-urban areas and people living with multiple health conditions. In-depth interviews with 30 of the survey's respondents found that people could see the value of MDTs, but they were generally unaware of the 2018 GMS contract and thought recent changes were largely a response to the Covid-19 pandemic.[41]

58. The Scottish Government has taken steps to improve this. For example, since October 2022 all general practices have been required to maintain a website showing up-to-date information about the services they provide and how to access them.[42] To help practices meet this requirement, NHS 24 has created a free-to-use national standardised website to display information specified in practice leaflets, designed in line with the GMS contract. Helping the public to understand how and why general practice is changing is an ongoing process and will require continued engagement at national, local and practice level.

Satisfaction with the care that people receive from their general practices has decreased

59. Progress in improving outcomes for people using general practice services is measured through the HACE survey.[43] The most recent survey results indicate that people were less satisfied about the care they received from their general practice in 2023/24, compared with 2017/18 (Exhibit 5, page 26).

60. When asked to rate the overall care provided by their general practice, 69 per cent of survey respondents said the care was excellent or good. But this is 14 percentage points lower than in 2017/18, a substantial decrease. Positive responses had already begun to fall before the Covid-19 pandemic; but they dropped sharply in 2021/22 when rigorous infection prevention controls were used to help mitigate the spread of Covid-19.

61. Positive responses increased only slightly in 2023/24, remaining substantially below pre-pandemic levels. The proportion of people describing the overall care at their practice as excellent or good increased only by two percentage points between 2021/22 and 2023/24.

Exhibit 5.

Health and Care Experience Survey 2023/24

People are less satisfied about the care provided by their general practice than in 2017/18.

Primary care outcome indicators for people	2023/24 (%)	Percentage point change from 2017/18
Rated the care provided by their general practice as excellent or good	69	-14
Said they understood the information they were given	91	-4
Said staff helped them to feel in control of their treatment and care	66	-16
Found it easy to contact their general practice in the way they wanted	76	-11
Could book an appointment three or more working days in advance	50	-18
Could see or speak to a doctor or nurse within two working days, when urgent	84	-3
Thought arrangements for speaking to a doctor were excellent or good	63	-3
Thought their treatment and care was well coordinated	74	-4
Said they were given the chance to involve people that mattered to them	49	-10
Felt they were listened to by the healthcare professional they saw	87	-6
Thought they were given enough time by the healthcare professional	83	-5
Felt they were treated with compassion and understanding	84	-4

Note: All percentage point changes are based on unrounded results. The question about people feeling in control of their treatment and care has been updated since the 2017/18 survey, and this may have influenced how people responded to this question.

Source: Audit Scotland, Scottish Government and Public Health Scotland

62. People's experiences vary widely according to a combination of factors such as age, whether the person has a disability, socio-economic status and where the person lives. People living in the most deprived areas reported poorer experiences than people in more affluent areas, and people from island board areas reported higher satisfaction than average:

- Sixty-three per cent of respondents living in the most deprived areas rated the overall care provided by their general practice as excellent or good; eight percentage points lower than people living in the least deprived areas.[44]
- Overall care was rated positively by 86–90 per cent of respondents in island boards; in NHS Shetland positive ratings increased by four percentage points between 2017/18 and 2023/24.[45]
- In NHS Lanarkshire, respondents were substantially less positive than average; only 55 per cent of respondents rated the overall care at their general practice as excellent or good, a decrease of 24 percentage points since 2017/18.

MDTs' potential to improve patient care and reduce general practice workloads is not yet being realised

63. The expansion of MDTs has the potential to improve patient care and free up GP time to focus on the most complex patients and on quality improvement, but this potential has not yet been realised. In November 2023, PHS published a report covering a survey of GPs' views on the expansion of MDTs.[46] Almost all GPs that took part felt that there was potential for the MDTs to make a positive difference. But four themes emerged as barriers to achieving this:

- There are not enough MDT staff to make a meaningful difference and to meet the needs of the GPs and patients – this was the most strongly highlighted issue.
- The input from MDTs is not reliable – staff availability was inconsistent, making planning difficult. There was a lack of cover for clinics and for time off, and short-notice absences cause disruptions and additional pressures.
- The variation in skills, experience and ways of working among the available members of staff caused challenges. Experienced and qualified staff were seen as sufficiently resilient but there were concerns about less experienced staff because of ongoing training needs and in some cases a slower pace of work.
- Some GPs felt that the MDTs had actually increased their workload. Some respondents reflected that this was because MDTs in some cases created more work, and GPs needed to spend a lot of time supervising and training MDTs.

64. PHS also surveyed MDTs for their feedback.[47] This found that MDTs were broadly positive about the impact of their roles on GP workloads but more mixed for the impact on wider practice teams' workloads. The roll-out of MDTs has not been completed, so the impact on GPs and practice teams' workloads is likely to improve with greater availability of MDT staff. But increasing staffing alone is not enough. Challenges with different ways of working and a lack of shared expectations and teamwork are limiting the potential success of the expansion.

65. The Scottish Government needs to work with the SGPC and HSCPs to set out clear actions that will improve the way that general practice teams, MDTs, and wider community-based primary care teams work together to provide services. This should include how it will improve communication, collaboration, data sharing and clarity about roles and responsibilities across the whole primary care workforce. This work should draw on the findings of the PCPIP.

There is insufficient transparency and assurance about the quality of care in general practice

66. The quality of services in general practice is not routinely monitored, which limits transparency and assurance about the quality of care. Between 2004 and 2016, the **Quality and Outcomes Framework (QOF)** was used to record and report on the quality of care. Several studies have highlighted examples of both benefits and limitations to this approach:

- QOF provided data to measure the quality of healthcare, which is essential to effectively plan services, address health inequalities, carry out clinical research and provide assurance about value for money.[48]
- QOF accelerated the shift towards multidisciplinary care of long-term conditions, for instance nurse-led clinics for diabetes and cardiovascular and respiratory disease.[49]
- Because QOF provided financial incentives, it may have led GPs to prioritise improvements in managing the conditions included within QOF at the expense of more patient-centred care.[50]

67. In 2016/17, the Scottish Government removed QOF and replaced it by establishing **GP clusters**.[51] Clusters have two key roles – improving the quality of care in general practice and influencing the wider healthcare system on priorities and how services work.

68. GP clusters have the potential to achieve these aims but are not yet working as intended. The Scottish Government and HSCPs have not done enough to create the conditions for clusters to succeed. The Scottish Government issued guidance in 2019 that set out the role of clusters and recommended minimum inputs required for Practice Quality Leads (PQLs) and Cluster Quality Leads (CQLs). It also recognised that administrative support is critical to the success of clusters.[52]

Quality and Outcomes Framework (QOF)

The QOF was a voluntary system that aimed to incentivise general practices to provide high-quality care by paying them for meeting certain quality indicators. These indicators focused on specific long-term conditions such as diabetes, asthma and heart disease, and on carrying out targeted health checks such as blood pressure monitoring and cervical screening.

GP clusters

GP clusters are groups of between five and eight general practices within a geographical area. Each general practice is represented by a Practice Quality Lead in a GP cluster. Each GP cluster has a Cluster Quality Lead to facilitate quality improvement work and engage with the wider healthcare system.

69. The Scottish Government has not, however, fully funded these recommendations or prioritised implementation of the guidance. This has led to variation in the extent to which GP clusters have been funded and supported across Scotland:

- The RCGP and BMA surveyed PQLs and CQLs in 2024, which found substantial variation in the time they spent in that role.[53] The survey identified that additional funding and administrative support is needed to increase the focus on quality improvement in general practice.
- In 2022, HIS published a report covering progress with GP clusters, which found that implementation had not been fully supported or prioritised.[54] It identified that the main barriers to effective cluster working were a lack of time, support, meaningful data, and clarity about the purpose, roles and responsibilities of clusters.
- Other research has identified similar challenges that clusters are facing, and many of these were identified when clusters were established.[55]

70. Establishing GP clusters has brought some benefits. It has brought GPs from different practices together for the first time to discuss quality issues. This has improved collaboration and HIS found that it proved invaluable during the Covid-19 pandemic – clusters enabled peer support, sharing information, and working together to continue providing services during the pandemic. HIS has also established a cluster improvement network that aims to support cluster working and share learning.

71. However, this has not addressed the fundamental issues that clusters are facing. Since QOF was removed, recorded quality of care has decreased for most performance indicators.[56] The Scottish Government should identify appropriate financial and administrative support for clusters, clear priorities for improvement and robust governance arrangements for monitoring progress.

The Scottish Government's efforts to support general practices to address health inequalities have had limited impact

72. General practice has a long-standing role in helping to address health inequalities, but the Scottish Government has not done enough to maximise its potential. A recent report funded by the Health Foundation found that:

- there is a major implementation gap between Scotland's policy ambitions to address health inequalities, and sustainable implementation of improvements
- despite higher levels of need in the most deprived areas, there were fewer GPs, clinical staff and administrative staff per patient in

general practices serving the most deprived areas compared with the most affluent areas

- it is not clear whether additional MDT staff have been adequately distributed based on local population need.[57]

73. Addressing health inequalities is one of the Scottish Government's priorities. Despite this, there was very little detail in the 2018 GMS contract that focused on this. The commitments that do link to addressing health inequalities have not progressed as well as planned:

- Community link workers have a direct remit in addressing health inequalities, but they were not one of the three services prioritised from 2021 (paragraph 18). Short-term funding and contracts make the service and workforce vulnerable to budget cuts (Case study 2, page 31).
- A key part of GP clusters' role was to reduce health inequalities, but clusters have not progressed as intended (paragraphs 67–71).
- The new practice funding formula better reflects the impact of deprivation on practice workloads than the previous formula (paragraph 95). Despite this improvement, stakeholders have raised concerns that the formula still does not sufficiently account for the workload associated with deprivation, avoidable mortality and disability, and the burden of disease.[58]

74. Some programmes of work have aimed to address inequalities through general practice. For example, the Scottish Deep End project was established in 2009 comprising GPs, both clinical and academic, working in the 100 most socio-economically deprived communities. It has advocated for service developments, education and research to help general practice better address inequalities.

75. More recently, the Scottish Government has taken steps to increase its focus on how general practice and primary care can help address inequalities. It has established an inequalities unit in the primary care directorate and commissioned a primary care health inequalities SLWG, which has now evolved into a reference group. These developments have helped to improve the way that the Scottish Government considers health inequalities within primary care, but much of this work is at an early stage.

76. The Scottish Government also provided additional funding of £2.3 million between 2022/23 and 2024/25 for around 66 Deep End practices in Greater Glasgow and Clyde. This funding has allowed general practice teams to provide extended consultations and outreach appointments, access enhanced training and improve patient participation forums.[59] While this is promising, the funding is short term, relatively small scale and limited to some practices in Greater Glasgow and Clyde serving some of the most deprived communities.

Case study 2.

Community link workers are vital parts of the primary care workforce, but their roles are often insecure and vulnerable to budget cuts

Community link workers work with general practices to help patients access non-medical support for personal, social, emotional and financial issues. They often support people with complex needs and people facing socio-economic deprivation. The Scottish Community Link Worker Network has reported increasing demand for a wide range of support, particularly for mental health and for social issues such as loneliness, housing and financial support. It also highlighted that patients often require longer-term support because of the complexity of their cases or while they are on waiting lists for other services. This can add pressure to link workers' workloads and reduce the opportunity for others to access support.

Community link workers are usually employed by third sector organisations. Short-term funding and contracts for third sector organisations mean that link workers' jobs are often insecure and vulnerable to budget cuts. The Scottish Government provided Glasgow City HSCP with £3.6 million additional funding over three years from 2024/25 to maintain its link worker programme. However, link worker services across Scotland remain at risk because of financial pressures.

Variation in service models and inconsistent monitoring and evaluation makes it difficult to assess the impact of community link workers and the extent to which support is targeted to those most in need. A report funded by the Health Foundation found several factors that made success more likely. These included embedding link workers within practices, good engagement and support from the practice team, continuity of care, clarity of roles, sustainable funding, adequate room space, IT and administrative support, and learning from monitoring and evaluation.

The Scottish Government is carrying out a national review of community link worker services. This will cover funding, data and evidence, and workforce. The Scottish Government should use the findings from this review to set out a long-term plan for link worker services (paragraph 77). HSCPs also have a role to ensure they commission link worker services in ways that most effectively meet the needs of their communities.

Source: Audit Scotland, Scottish Community Link Worker Network, Health Foundation and Scottish Government

77. Tackling health inequalities requires cross-sector, systemic action that is targeted and sustained. The Primary Care Health Inequalities SLWG highlighted the pivotal role of primary care in mitigating the effects of health inequalities but found that existing commitments to reform primary care would not alone be sufficient to address the challenges of health inequality.[60] The Scottish Government needs to set out a clear plan for how it intends to better support general practices to contribute to tackling health inequalities.

3. Progress addressing financial and workforce challenges

The commitment to increase the number of GPs by 800 is unlikely to be met by 2027

78. In 2017, the Scottish Government committed to increasing the number of GPs working in Scotland by at least 800 by 2027.[61] In our NHS in Scotland 2022 report, we noted that this commitment was not on track. Based on progress to 2024, this commitment will not be met. Between September 2017 and September 2024 the number of GPs, excluding specialty trainees, increased by 135 (Exhibit 6, page 34).[62]

79. Our NHS workforce planning – part 2 report highlighted that this commitment is based on a headcount of GPs, rather than WTE. A headcount target does not sufficiently demonstrate the intended increase in GP capacity. The estimated number of WTE GPs has decreased since 2017, indicating that increases in headcount will not necessarily translate to additional WTE GPs.

80. Between August 2017 and March 2024 the estimated number of WTE GPs, excluding specialty trainees, decreased by 67, or 1.9 per cent.[63] By comparison, over a similar period (September 2017 – March 2024), the number of WTE medical and dental consultants working in NHS Scotland territorial boards increased by 791 WTE, or 15.6 per cent.[64]

81. There is, however, no official information about the number of hours worked by GPs in Scotland. The General Practice Workforce Survey defines GP WTE as eight contracted sessions per week, and assumes a session length of four hours and ten minutes. But it does not record the number of hours actually worked per session. In August 2017, the average number of sessions worked by GPs was estimated to be 6.4; by March 2024 this had decreased to 6.2 (-0.2 sessions). But the length of a session varies among practices.[65] It is therefore not clear if the average number of hours worked has also fallen. This makes it difficult to assess the extent to which workforce capacity has changed since the GP commitment was introduced in 2017.

82. The Scottish Government's National Health and Social Care Workforce Plan noted that the commitment to increase GP headcount by 800 would require constant monitoring and review.[66] While headcount numbers are routinely published, no formal review arrangements were put in place to monitor whether progress towards this commitment

was increasing GP capacity as anticipated, particularly in terms of WTE. Furthermore, the Scottish Government has not provided practices with specific additional funding to achieve this commitment, and a lack of robust data means it is not clear whether general practice is able to afford this level of increase. It is also not clear that an additional 800 GPs is sufficient to meet population health needs (paragraph 96).

Exhibit 6.

GP headcount, 30 September 2017 – 30 September 2024 and estimated GP WTE, August 2017 – March 2024

While GP headcount increased between 2017 and 2024, the estimated number of WTE GPs has decreased since 2017.

GP headcount	September 2017	September 2024		Change
GPs (excluding specialty trainees)	**4,390**	**4,525**	↑	**+135**
GP specialty trainees	514	687	↑	+173
GPs (including specialty trainees)	4,904	5,211	↑	+307
Estimated GP whole-time equivalent (WTE)	**August 2017**	**March 2024**		**Change**
GPs (excluding specialty trainees)	**3,520**	**3,453**	↓	**-67**

Notes: Headcount figures for September 2024 are provisional. A GP can be recorded as having more than one type of post, so the sum of GPs (excluding specialty trainees) and GP specialty trainees may not equal GPs (including specialty trainees). Whole-time equivalent figures are estimated based on data collected via an annual survey.

Source: Audit Scotland and NHS Education for Scotland

The number of GP trainees has increased, but retaining the existing workforce is also vital to increasing GP capacity

83. There has been progress in increasing the number of doctors training to become a GP in Scotland, known as GP Specialty Trainees (GPSTs). This has the potential to increase the GP workforce in future. Between 2017 and 2024, the number of GPSTs on placement in general practice increased by 173 (Exhibit 6). These figures are a snapshot as at September 2017 and 2024, and do not include GPSTs working in hospital posts as part of their GPST training. NES has confirmed that there are more than 1,200 GPSTs in Scotland in total.

84. Between 2018 and 2023, the number of people starting the GPST programme also increased, from 292 to 342, and nearly all training places

were filled in 2023. The GPST programme, however, often takes longer than the standard three years and the number of applications to work less than full time has risen. NES told us that trainees sometimes opt to work less than full time to help manage the challenging workload, but GPST places are currently funded on a headcount basis. This could result in fewer WTE GPSTs.

85. The current pipeline of GPSTs is not, on its own, sufficient to increase GP capacity in Scotland. There are no guarantees that GPSTs will complete the programme and go on to work as GPs in Scotland. NES told us that between 2017/18 and 2023/24, more than 1,800 people completed their training in Scotland. However, after accounting for GPs who have joined or left the GP workforce, the number of GPs, excluding specialty trainees, working in general practice has increased by only 135 since September 2017.

86. Attracting and retaining the GP workforce is therefore key to increasing capacity. In November 2024, the Scottish Government published an action plan, based on the recommendations of the GP Retention Working Group.[67] The plan sets out 20 actions to improve GP recruitment and retention to 2026 and has been welcomed by the RCGP.[68] The plan also confirmed that its implementation would require an increase in funding for general practice.

87. Many of the plan's actions describe continuing current activity, exploring opportunities for improvement, or enhancing understanding and data quality over the next two years. Some actions also await the publication of ongoing evaluation work to inform next steps. It is therefore not yet clear what changes will be implemented or what the impact of those changes will be. The Scottish Government has committed to reviewing progress against the plan annually.

Success in transforming the role of general practice nurses depends on practice priorities and GP support

88. The 2018 GMS contract aimed to support general practice nurses (GPNs) to become expert nursing generalists, supporting patients to manage short- and long-term health conditions. This refocused role for GPNs aims to help meet the demands of a growing and ageing Scottish population with higher levels of need (Exhibit 3, page 13).

89. Work to refocus the GPN role is ongoing and is supported by a refreshed definition of the role and work to align competencies and training with population healthcare needs.[69]

90. Transforming the role of GPNs requires GPs, as their employers, to actively support GPNs in making this change. Competing priorities in general practices can reduce the amount of time GPNs have to focus on prevention or to support patients with long-term conditions. For example, GPNs may need to focus on responding to unscheduled care demand, or work in a practice without sufficient access to wider MDT support.

91. Unlike for GPs, there is no commitment to increase the number of GPNs, but there are indications that there may be fewer nurses available to work in general practice in future years. This is a particular concern given that more than half of GPNs are aged 50 years or over:

- Between August 2017 and March 2024, the estimated number of WTE GPNs in Scotland increased by 11 per cent to 1,710 but numbers have levelled off since 2019.[70]
- Intake targets for pre-registration nursing and midwifery undergraduate education have increased since the contract was introduced, but applications have dropped in the last three years and intake targets were not achieved in 2022 or 2023.[71]

Non-clinical staff are a key part of the general practice workforce but the progress towards, and impact of, planned changes to these roles is not clear

92. Non-clinical staff form a critical part of the general practice workforce. Approximately 9,000 administrative and non-clinical staff work within general practice.[72] This includes around 1,200 practice managers and 5,600 receptionists. As with GPs and GPNs, the 2018 GMS contract set out an enhanced role for practice managers and receptionists:

- practice managers would take on an additional role in coordinating MDTs
- receptionists would take on a greater role in providing information for patients about the range of services available to them.

93. Information is lacking to determine the extent to which these changes have been achieved. While GPs and MDT staff have been surveyed to help understand the impact of primary care reforms on their roles (paragraphs 63–64), similar evaluations for non-clinical staff have not been carried out.

94. The Covid-19 pandemic accelerated changes, particularly for receptionists' role in informing patients about how and where to access services, before support and training resources were in place. The Scottish Government and NES have taken steps to address this gap by introducing a competency framework for practice managers and administrative staff in September 2023. However, the impact of this work has yet to be evaluated.[73]

There are substantial risks and uncertainty about fully implementing changes in how general practices are funded

95. The Scottish Government has not fully implemented contractual changes aimed at improving financial stability in general practice.

These changes were intended to be implemented across two phases (Exhibit 7, page 38). Phase one was completed but phase two was delayed. This means that financial pressures faced by GPs have not fully been addressed:

- The new practice funding formula better accounts for workload associated with deprivation and older patients than the previous formula, but it is based on out-of-date data and does not address unmet need.
- GPs in rural areas have highlighted that current funding arrangements do not address the higher costs, unique workload, and workforce challenges that rural areas face, all of which are contributing to financial challenges for practices.

96. The Scottish Government delayed work towards phase two because of the Covid-19 pandemic and challenges collecting data from practices, but progress since then has been slow. The Scottish Government is working with the SGPC to prioritise and plan how it will implement the second phase of changing how practices are funded. This work will be complex and the Scottish Government has not set out how long it will take. It involves:

- collecting data on GP earnings and practice expenses, to improve transparency and enable practice expenses to be directly reimbursed
- agreeing an income range and pay progression comparable to NHS consultants
- identifying the GP workforce needed to meet population health needs and contribute to addressing health inequalities and the challenges faced by rural communities.

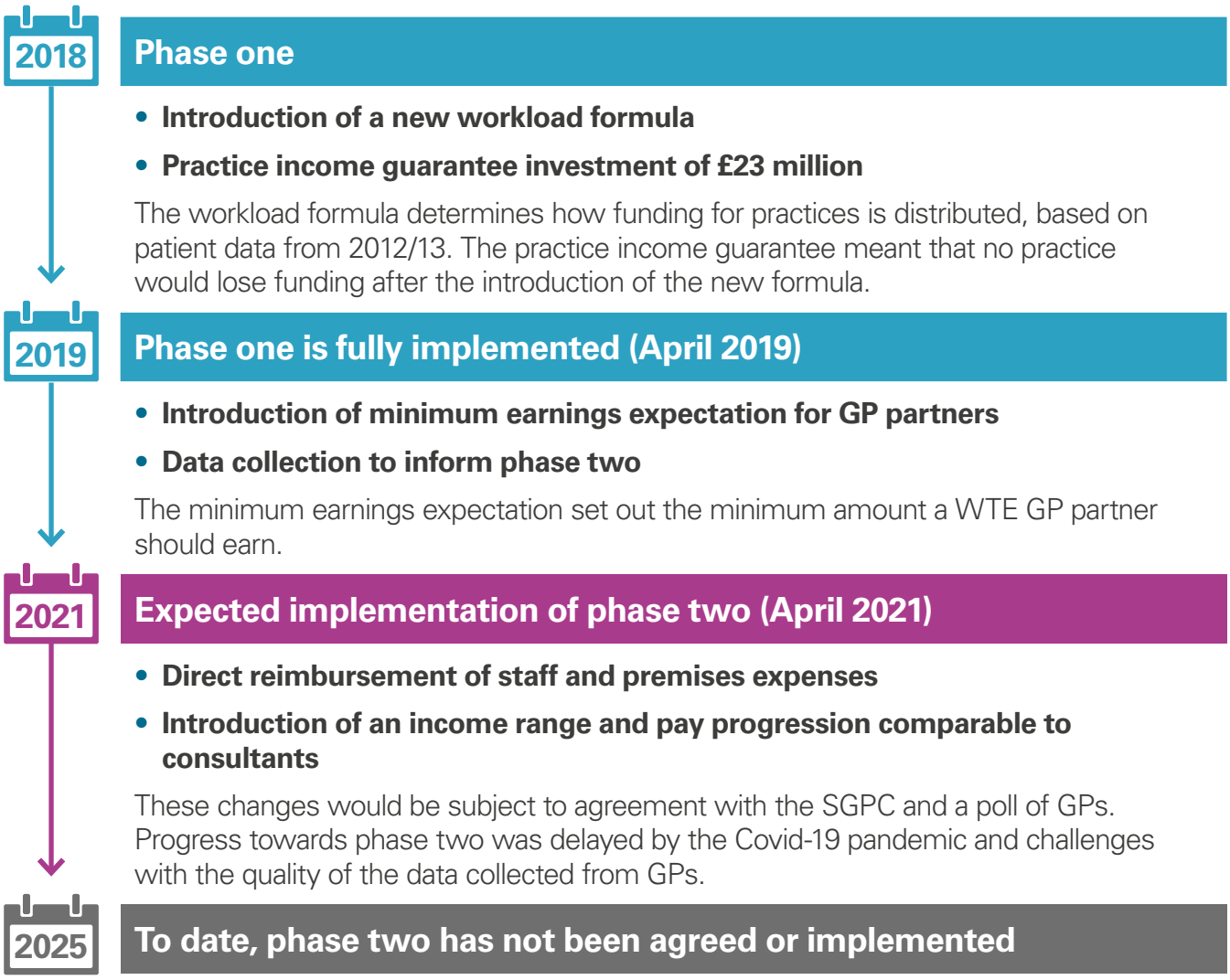
97. In the 2018 GMS contract, the Scottish Government recognised that it does not have a full understanding of what phase two will look like in practice or how much it will cost. It does not have a full understanding about the current expenses of running a general practice or how much GPs earn. It could therefore not provide assurance that this model is affordable. But it has not set out what it would do if this model is deemed unaffordable. This lack of strategic and financial planning has created uncertainty for GPs about how they will be funded in future.

98. Progressing with phase two has the potential to address substantial challenges. Better data from general practices would improve transparency and enable a better understanding of the investment needed to meet the needs of Scotland's population. Directly reimbursing expenses would support the long-term sustainability of general practices. Without this, GPs are at risk of bearing the financial burden of increasing costs, which risks damaging trust with GPs and buy-in for future reforms or contractual changes.

Exhibit 7.

Timeline of proposed changes to practice funding arrangements

The Scottish Government has not fully implemented commitments to change how practices are funded and it is not clear when it will implement the outstanding commitments.



Notes: The practice income guarantee of £23 million has reached £30 million in 2023/24.

Source: Audit Scotland and Scottish Government

The Scottish Government has not been transparent about progress with premises commitments and barriers to implementation remain

99. The 2018 GMS contract set out the Scottish Government's plans for moving to a model where GPs are no longer expected to provide their own premises, as part of measures introduced to reduce risks for GP partners. To facilitate this change in responsibility, the Scottish Government and the SGPC agreed a National Code of Practice for GP Premises, which outlines responsibilities for GPs, NHS boards and the Scottish Government.[74] The main commitments were:

- GPs who own their own premises would be eligible for an interest-free sustainability loan of up to 20 per cent of the value of the property every five years, with the intention that the NHS board will own the premises by 2043.
- GPs who lease their premises would be eligible to apply for their NHS board to either negotiate a new lease for the GP premises, take responsibility for the current practice lease, or provide the practice with alternative, board managed, premises. The transfer of leases is expected to take place over a 15-year period.

100. The Scottish Government has not been transparent about the investment in sustainability loans and has made a misleading announcement about the uptake of the loans:

- The Scottish Government committed £30 million for the sustainability loan scheme, at £10 million per year between 2018 and 2021.[75] In 2019, the Scottish Government said it was increasing investment to £50 million by 2021.[76] However, delays to the scheme meant that no loans were issued until 2020/21, when just two loans totalling £0.6 million were provided. Unused funding was not able to be carried forward to the next year. The scheme was paused in March 2024 because it was oversubscribed, after just £15.1 million of loans were issued over a period of five years.
- In 2019, the Scottish Government reported that 172 practices had successfully applied for the sustainability loan scheme.[77] However, to date just 63 loans have been issued. The Scottish Government told us that the 172 figure actually referred to the number of practices that expressed interest in the scheme.

101. Since 2020, NHS Scotland has been monitoring progress regularly and has found the pace of progress to be slow. Common barriers found to be impacting the progress of loan applications include the high cost of legal fees, work required to correct historical issues, and securing agreements with mortgage providers. It also found that boards may be reluctant to take on some leases because of the level of maintenance costs required for the properties.

102. Future funding for the loan scheme is uncertain, which means its successful implementation is at risk. The scheme relied on financial transaction capital issued by the UK Government. Since 2024/25, the Scottish budget has not included any financial transaction capital for the health portfolio.[78] The Scottish Government has not yet confirmed an alternative source of funding and is currently reviewing options. Following this work the Scottish Government should set out whether and how it plans to implement the loan scheme.

The Scottish Government does not have sufficient oversight of whether GP premises are fit for purpose

103. The Scottish Government commissioned a national survey of premises owned or independently leased by GPs in 2018 to benchmark the condition of the estate. The survey results showed that there was a maintenance backlog of £59.2 million for premises owned or independently leased by GPs. Twelve per cent of the maintenance required was classed as high or significant risk.

104. An extract from NSS' Strategic Asset Management System (SAMS) from July 2024 shows that the maintenance backlog for premises owned or independently leased by GPs, classed as high or significant risk, has decreased to nine per cent. The cause for this reduction, however, is not recorded. For example, it could be that maintenance work has been carried out and SAMS has been updated accordingly, or that some premises are no longer in use, or that ownership of the premises has changed, including the transfer of leases to NHS boards. SAMS is a dynamic system and is updated as required, therefore system reports represent a snapshot in time. It is NHS boards' responsibility to ensure that data in SAMS is kept up to date.

105. The National Code of Practice for GP Premises states that there is a need for GP premises to be surveyed on a regular basis. No further national surveys have taken place, but NHS boards are required to survey their estates on a regular basis. The Scottish Government asked NHS boards to provide an infrastructure plan by January 2025 as part of a new approach to infrastructure planning and investment across NHS Scotland.[79]

106. These plans should include details of the condition of GP owned and leased premises, as required by the National Code of Practice for GP Premises. This will provide an up-to-date picture on the condition of GP premises nationally to help inform the NHS national capital investment strategy. This is important, given the expectation that NHS boards will be taking on responsibility for more GP premises over the coming years.

Endnotes

1 General practice list size and demographics information, Public Health Scotland, January 2025.

2 The 2018 General Medical Services Contract in Scotland, Scottish Government, November 2017.

3 Memorandum of Understanding between Scottish Government, British Medical Association, Integration Authorities and NHS Boards: GMS Contract Implementation in the Context of Primary Care Service Redesign, Scottish Government, November 2017.

4 Memorandum of Understanding 2, GMS Contract Implementation for Primary Care Improvement, Scottish Government, July 2021.

5 Mid-year population estimates for Scotland: Population estimates time series data, National Records of Scotland, January 2025.

6 Scotland's Census 2022 – Health, disability and unpaid care, National Records of Scotland, October 2024.

7 Scottish Burden of Disease study, Forecasting the future burden of disease: Incorporating the impact of demographic transition over the next 20 years, Public Health Scotland, November 2022.

8 Healthy Life Expectancy 2019–2021, National Records of Scotland, December 2022.

9 Diagnostic Waiting Times: Quarter ending 30 September 2024, Public Health Scotland, November 2024; Inpatient, Day Case and Outpatient Stage of Treatment Waiting Times: Quarter ending 30 September 2024, Public Health Scotland, November 2024.

10 Scottish local medical committee conference: agenda and guide, British Medical Association, November 2024.

11 General practice list size and demographics information, Public Health Scotland, January 2025; Mid-year population estimates for Scotland: Population estimates time series data, National Records of Scotland, January 2025.

12 General Practice Workforce Survey 2024, NHS Education for Scotland, December 2024.

13 Primary care improvement plans: implementation progress summary – March 2024, Scottish Government, June 2024.

14 Memorandum of Understanding 2, GMS Contract Implementation for Primary Care Improvement, Scottish Government, July 2021.

15 Joint letter – GMS contract update for 2021/22 and beyond, Scottish Government and BMA, December 2020.

16 Ibid.

17 Item of service fees for GP practices continuing to provide vaccinations after 1 April 2022, PCA(M)(2022)07, Scottish Government, March 2022.

18 Memorandum of Understanding 2, GMS Contract Implementation for Primary Care Improvement, Scottish Government, July 2021.

19 GP practices – Sustainability Payment – 2022–23, PCA(M)(2022)15, Scottish Government, October 2022.

20 NHSScotland costs summary for 2019/20 and 2023/24 (R100T), Scottish Health Service Costs 2019/20 and 2023/24, Public Health Scotland, February 2021 and February 2025.

21 Audit Scotland analysis of Scottish Health Service Costs 2019/20 and 2023/24, Public Health Scotland, February 2021 and February 2025, and NHS accounts 2017/18 – 2023/24.

22 Audit Scotland analysis of Scottish Health Service Costs 2023/24, Public Health Scotland, February 2025, and Primary Care Improvement Plan Trackers, Scottish Government.

23 Additional investment in general practice, Scottish Government, November 2024.

24 Scottish Budget 2025 to 2026, Scottish Government, December 2024.

25 Primary care improvement plans: implementation progress summary – March 2024, Scottish Government, June 2024.

26 NHS Recovery Plan 2021–26, Scottish Government, August 2021.

27 Improving public services and NHS renewal: First Minister's speech, Scottish Government, January 2025.

28 National Monitoring and Evaluation Strategy for Primary Care in Scotland, Scottish Government, March 2019.

29 Monitoring and evaluation of primary care in Scotland: the baseline position, Public Health Scotland, September 2020.

30 Review of the new General Medical Services contract, Audit Scotland, July 2008; NHS workforce planning – part 2: The clinical workforce in general practice, Audit Scotland, August 2019.

31 General Practice Workforce Survey 2024, NHS Education for Scotland, December 2024.

32 General Practice In-hours Activity Visualisation as at 30 September 2024, Public Health Scotland, November 2024.

33 Appointments in general practice: supporting information, NHS England Digital, April 2024.

34 Care in the Digital Age: Delivery Plan 2024–25, Scottish Government and COSLA, April 2024.

35 Health and Care Experience Survey 2023/24: National Results, Scottish Government, May 2024.

36 Primary Care Access Programme: Evaluation Report, Healthcare Improvement Scotland, July 2023.

37 General Practice Access Principles, Scottish Government, November 2023.

38 Alternative pathways to Primary Care Report, Health, Social Care and Sport Committee, June 2022; Public Understanding and Expectations of Primary Care in Scotland: Survey Analysis Report, Scottish Government, November 2022.

39 Right Care Right Place – Receptionist Campaign, Scottish Government, March 2022.

40 Patients' views on primary care multidisciplinary teams in Scotland: a mixed-methods evaluation, British Journal of General Practice Open, September 2024.

41 Primary care transformation in Scotland: qualitative evaluation of the views of patients, British Journal of General Practice, October 2024.

42 GP websites update and requirements for GP providers, Scottish Government, September 2022.

43 Health and Care Experience Survey 2023/24: National Results, Scottish Government, May 2024.

44 Measuring progress – Health, Quality of care experience, Scottish Government, August 2024.

45 Health and Care Experience Survey Dashboard, Public Health Scotland, May 2024.

46 Primary care reforms: GP feedback survey, Public Health Scotland, November 2023.

47 Primary care reforms: Multidisciplinary team feedback survey, February 2024.

48 The future role of the GP Quality and Outcomes Framework in England, BJGP Open, July 2023.

49 Quality and Outcomes Framework: what have we learnt? British Medical Journal, August 2016.

50 Quality after the QOF? Before dismantling it, we need a redefined measure of 'quality', British Journal of General Practice, July 2018.

51 Improving together, a national framework for quality and GP clusters in Scotland, Scottish Government, January 2017.

52 National guidance for GP clusters, Scottish Government, June 2019.

53 RCGP and SGPC – GP quality clusters, Royal College of GPs Scotland and BMA Scotland, November 2024.

54 GP cluster working learning cycle, Healthcare Improvement Scotland, March 2022.

55 Collaborative improvement in Scottish GP clusters after the Quality and Outcomes Framework: a qualitative study, British Journal of General Practice, August 2021; Challenges in implementing GP clusters in Scotland: a comparison of the views of senior primary care stakeholders in 2016 and 2021, British Journal of General Practice, March 2023.

56 Estimated impact from the withdrawal of primary care financial incentives on selected indicators of quality of care in Scotland: controlled interrupted time series analysis, British Medical Journal, March 2023.

57 Tackling the inverse care law in Scottish general practice, University of Glasgow, University of Edinburgh, April 2024.

58 Report of the Primary Care Health Inequalities Short-Life Working Group, Scottish Government, March 2022; Tackling the inverse care law in Scottish general practice, University of Glasgow, University of Edinburgh, April 2024.

59 Inclusion Health Action in General Practice: Early Evaluation Report, Scottish Government, July 2024.

60 Report of the Primary Care Health Inequalities Short-Life Working Group, Scottish Government, March 2022.

61 BMA Scottish Local Medical Committee: Speech, Scottish Government, March 2017.

62 NHSScotland Workforce 30 September 2024, NHS Education for Scotland, December 2024.

63 General Practice Workforce Survey 2024, NHS Education for Scotland, December 2024.

64 NHSScotland Workforce 30 September 2024, NHS Education for Scotland, December 2024.

65 Statement of financial entitlements 2024–25, Scottish Government, February 2024.

66 National Health and Social Care Workforce Plan: Part 3 – Improving workforce planning for primary care in Scotland, Scottish Government, April 2018.

67 General Practitioner Recruitment and Retention Action Plan 2024 – 2026, Scottish Government, November 2024; Improving GP Retention – Recommendations from the GP Retention Working Group, Scottish Government, November 2024.

68 RCGP Scotland response to the General Practice Workforce Survey, Royal College of General Practitioners, December 2024.

69 Transforming Roles paper 6: role of the general practice nurse 2025, Scottish Government, February 2025.

70 General Practice Workforce Survey 2024, NHS Education for Scotland, December 2024.

71 University intake targets for pre-registration Nursing and Midwifery 2024–25, Scottish Funding Council, June 2024; UCAS undergraduate applicant releases for 2024 cycle: 2024 cycle applicant figures – 30 June deadline, UCAS, July 2024.

72 General Practice Workforce Survey 2024, NHS Education for Scotland, December 2024.

73 General Practice Managers and Administrative Staff Core Competency Framework, NHS Education for Scotland, September 2023.

74 The National Code of Practice for GP Premises, Scottish Government, 2017.
75 The 2018 General Medical Services Contract in Scotland, Scottish Government, November 2017.
76 Press Release – £50m support for GP practices, Scottish Government, February 2019.
77 Ibid.
78 Scottish Budget 2025 to 2026, Scottish Government, December 2024.
79 Scottish capital investment manual, Programme Initial Agreement for Whole System Infrastructure Planning, Scottish Government, January 2024.

Appendix

Advisory group

We establish advisory groups for most performance audits, with members coming from outside of Audit Scotland. We choose members of advisory groups based on their knowledge and expertise of the topic area, and the organisations they work for.

The advisory group provided advice and feedback at key stages of the audit process. However, Audit Scotland retains responsibility for, and ownership of, the audit work, the audit report, and the judgements contained within this.

We would like to thank the members of the advisory group for their contributions to this audit:

- Evan Beswick – Chief Officer, Argyll and Bute IJB
- Lorna Kelly – National Strategic Lead for Primary Care, Health and Social Care Scotland
- Dr Carey Lunan – Chair, Scottish Deep End Project
- Dr Susan Gallacher – Deputy Director, GP Policy, Primary Care Directorate, Scottish Government
- Professor Stewart Mercer – Professor of Primary Care and Multimorbidity, University of Edinburgh
- Dr Iain Morrison – Chair of the Scottish GP Committee, BMA, preceded by Dr Andrew Buist until August 2024
- Dr Chris Provan – Chair, Royal College of GPs Scotland
- Margaret Reid-Arbuckle – Director of Development, the Alliance
- Elaine Strange – Head of Service, Data and Digital Innovation, Public Health Scotland

General practice

Progress since the 2018 General Medical Services contract

AUDIT SCOTLAND

Audit Scotland, 4th Floor, 102 West Port, Edinburgh EH3 9DN
Phone: 0131 625 1500 Email: **info@audit.scot**
www.audit.scot

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AUDIT & RISK COMMITTEE

ANNUAL WORKPLAN 2025 / 2026

Governance – General						
	Lead	**15/05/25**	**19/06/25**	**18/09/25**	**11/12/25**	**12/03/26**
Minutes of Previous Meetings	**Chair**	✓	✓	✓	✓	✓
Action Plan	**Chair**	✓	✓	✓	✓	✓
Escalation of Issues to NHS Board	**Chair**	✓	✓	✓	✓	✓
Governance Matters						
	Lead	**15/05/25**	**19/06/25**	**18/09/25**	**11/12/25**	**12/03/26**
Audit Scotland Technical Bulletin	**Head of Financial Services**		✓ **2025/1**	✓ **2025/2**	✓ **2025/3**	✓ **2025/4**
Annual Assurance Statement 2024/25	**Board Secretary**	✓ Draft	✓ Final			
Annual Assurance Statements from Standing Committees 2024/25	**Board Secretary**		✓			
Annual Review of Code of Corporate Governance	**Board Secretary**	✓				
Committee Self-Assessment	**Board Secretary**					✓
Corporate Calendar / Committee Dates 2026/27	**Board Secretary**			✓		
Delivery of Annual Workplan 2025/26	**Director of Finance**	✓	✓	✓	✓	✓
Financial Operating Procedures Review (2 yearly review)	**Head of Financial Services**				✓	
Governance Statement	**Director of Finance**	✓ Draft	✓ Final			
IJB Annual Assurance Statement 2024/25	**Board Secretary**		✓			
Internal Audit Review of Property Transactions Report 2024/25	**Regional Audit Manager**			✓		

Governance Matters (cont.)						
	Lead	**15/05/25**	**19/06/25**	**18/09/25**	**11/12/25**	**12/03/26**
Losses & Special Payments	**Head of Financial Services**	✓ Q4		✓ Q1	✓ Q2	✓ Q3
Procurement Tender Waivers Compliance 2024/25	**Head of Financial Services**	✓ Q4		✓ Q1	✓ Q2	✓ Q3
Review of Annual Workplan 2026/27	**Board Secretary**				✓ Draft	✓ Approval
Review of Terms of Reference	**Board Secretary**	✓ Approval **c/f from March '25**				✓ Approval
Risk						
	Lead	**15/05/25**	**19/06/25**	**18/09/25**	**11/12/25**	**12/03/26**
Annual Risk Management Report 2024/25	**Associate Director of Risk & Professional Standards**	✓ Draft	✓ Final			
Corporate Risk Register	**Associate Director of Risk & Professional Standards**	✓		✓	✓	✓
Risk Management Key Performance Indicators 2024/25	**Associate Director of Risk & Professional Standards**	✓		✓		
Progress Report on Delivery of the Risk Management Strategic Framework	**Associate Director of Risk & Professional Standards**			✓ TBC		
Risks & Opportunities Group Progress Report	**Associate Director of Risk & Professional Standards**	✓ **Annual Statement of Assurance**		✓	✓	✓
Governance – Internal Audit						
	Lead	**15/05/25**	**19/06/25**	**18/09/25**	**11/12/25**	**12/03/26**
External Quality Assessment (5 yearly – due March 2025)	**Chief Internal Auditor**	Private Session				
Global International Accounting Standards Changes in 2025 - Improvement Plan	**Chief Internal Auditor**	✓		✓ **Update**		✓ **Update**
Internal Audit Framework	**Chief Internal Auditor**	✓ **c/f from March '25**				✓
Internal Audit Progress Report	**Regional Audit Manager**	✓		✓	✓	✓

Governance – Internal Audit (cont.)						
	Lead	**15/05/25**	**19/06/25**	**18/09/25**	**11/12/25**	**12/03/26**
Internal Audit Annual Plan 2025/26	**Chief Internal Auditor**	✓ Draft	✓ Final			
Internal Audit Annual Report 2024/25	**Chief Internal Auditor**		✓			
Internal Audit – Follow Up Report on Audit Recommendations 2024/25	**Regional Audit Manager/ Principal Auditor**	✓		✓		✓
Internal Controls Evaluation Report 2024/25	**Chief Internal Auditor**				✓	
Governance – External Audit						
	Lead	**15/05/25**	**19/06/25**	**18/09/25**	**11/12/25**	**12/03/26**
Annual Audit Plan 2024/25	**External Audit**				✓	
External Audit – Follow Up Report on Audit Recommendations	**Director of Finance**					✓
Patients' Private Funds - Audit Planning Memorandum	**Head of Financial Services**					✓
Service Auditor Reports on Third Party Services	**Head of Financial Services**		✓			
Annual Accounts						
	Lead	**15/05/25**	**19/06/25**	**18/09/25**	**11/12/25**	**12/03/26**
Annual Accounts Preparation Timeline	**Head of Financial Services**	✓ Follow Up				✓ Initial
External Auditors Annual Accounts Progress Update	**External Auditor**	✓ Verbal				✓
Annual Accounts & Financial Statements 2024/25	**Director of Finance / External Audit**		✓			
Annual Audit Report 2024/25	**External Audit**		✓			
Letter of Representation 2024/25	**Director of Finance / External Audit**		✓			
Patients' Funds Accounts 2024/25	**Head of Financial Services**		✓			
Annual Statement of Assurance to the NHS Board 2024/25	**Board Secretary**		✓			

Counter Fraud						
	Lead	**15/05/25**	**19/06/25**	**18/09/25**	**11/12/25**	**12/03/26**
Counter Fraud Service – Quarterly Report (Alerts & Referrals)	**Head of Financial Services**	Private Session		Private Session	Private Session	Private Session
Counter Fraud Standards Assessment	**Head of Financial Services**	**Deferred due to timings**	Private Session			
Counter Fraud Action Plan 2025/26	**Head of Financial Services**			Private Session		
Counter Fraud Annual Report 2024/25	**Head of Financial Services**	**Deferred due to timings**		Private Session		
Adhoc						
	Lead	**15/05/25**	**19/06/25**	**18/09/25**	**11/12/25**	**12/03/26**
Private Meeting with Internal / External Auditors	**Committee**			Private Session		Private Session
Appointment of Patients' Private Funds Auditor	**Director of Finance**	**As required**				
Legal & regulatory updates (e.g. Audit Scotland reports 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	**15/05/25**	**19/06/25**	**18/09/25**	**11/12/25**	**12/03/26**
Training Sessions Delivered / Development Sessions						
	Lead	**15/05/25**	**19/06/25**	**18/09/25**	**11/12/25**	**12/03/26**
Members' Training Session – the Annual Accounts: The Role & Function of the Audit & Risk Committee	**External Auditors**	✓				
Corporate Risks - to better understand the evidence around managing corporate risks	**Medical Director**	**TBC**				
Losses & Special Payments - to enhance the understanding of reporting	**Head of Procurement & Financial Services**	**TBC**				