NHS Fife Audit & Risk Committee

Wed 18 May 2022, 14:00 - 16:00

MS Teams

Agenda

14:00 - 14:00
0 min

1. Apologies for Absence

Martin Black

14:00 - 14:00
0 min

2. Declaration of Members' Interests

Martin Black

14:00 - 14:00
0 min

3. Minutes of Previous Meeting held on Thursday 17 March 2022

Enclosed *Martin Black*

Item 3 - Audit & Risk Committee Minutes (unconfirmed) - 20220317.pdf (8 pages)

14:00 - 14:05
5 min

4. Matters Arising / Action List

Enclosed *Martin Black*

Item 4 - Audit & Risk Committee Action List - 20220518.pdf (1 pages)

14:05 - 14:35
30 min

5. GOVERNANCE MATTERS

5.1. Draft Governance Statement

Enclosed *Gillian MacIntosh*

Item 5.1 - SBAR Draft Governance Statement .pdf (3 pages)
Item 5.1 - Draft Governance Statement .pdf (11 pages)

5.2. Review of Annual Workplan

Enclosed *Gillian MacIntosh*

Item 5.2 - SBAR Review of Annual Workplan.pdf (6 pages)

5.3. Notification of External Audit Appointment from 2022/2023

Enclosed *Margo Mcgurk*

Item 5.3 - SBAR Notification of External Audit Appointment from 2022-2023 .pdf (3 pages)

5.4. Annual Accounts Preparation Timeline

Enclosed *Kevin Booth*

Item 5.4 - SBAR Annual Accounts Preparation Timeline.pdf (3 pages)

14:35 - 15:05
30 min

6. RISK

6.1. Draft Risk Management Annual Report 2021/2022

Enclosed *Pauline Cumming*

- Item 6.1 - SBAR Draft Risk Management Annual Report 2021-2022.pdf (3 pages)
- Item 6.1 - Draft Risk Management Annual Report 2021-2022.pdf (11 pages)

6.2. Risk Management Improvement Programme – Progress Report

Enclosed *Pauline Cumming*

- Item 6.2 - SBAR Risk Management Improvement Programme – Progress Report .pdf (13 pages)

6.3. Board Assurance Framework

Enclosed *Pauline Cumming*

- Item 6.3 - SBAR Board Assurance Framework .pdf (8 pages)
- Item 6.3 - Appendix 1 NHS Fife BAF Financial Sustainability .pdf (1 pages)
- Item 6.3 - Appendix 2 NHS Fife BAF Environmental Sustainability .pdf (1 pages)
- Item 6.3 - Appendix 3 NHS Fife BAF Workforce Sustainability .pdf (2 pages)
- Item 6.3 - Appendix 4 NHS Fife BAF Quality & Safety .pdf (2 pages)
- Item 6.3 - Appendix 5 NHS Fife BAF Strategic Planning.pdf (1 pages)
- Item 6.3 - Appendix 6 NHS Fife BAF Integration Joint Board.pdf (1 pages)
- Item 6.3 - Appendix 7 NHS Fife BAF Digital & Information .pdf (2 pages)

15:05 - 15:35
30 min

7. GOVERNANCE – INTERNAL AUDIT

7.1. Internal Audit Framework

Enclosed *Tony Gaskin*

- Item 7.1 - SBAR Internal Audit Framework .pdf (4 pages)
- Item 7.1 - Appendix 1 FTF Audit Charter and Specification for Internal Audit Services.pdf (29 pages)

7.2. Internal Audit Progress Report 2021/2022

Enclosed *Barry Hudson*

- Item 7.2 - SBAR Internal Audit Progress Report 2021-2022.pdf (3 pages)
- Item 7.2 - Appendix A Internal Audit Progress Report.pdf (8 pages)

7.3. Draft Annual Internal Audit Plan 2022/2023

Enclosed *Tony Gaskin*

- Item 7.3 - SBAR Draft Annual Internal Audit Plan 2022-2023.pdf (8 pages)

15:35 - 15:50
15 min

8. GOVERNANCE – EXTERNAL AUDIT

8.1. Patients' Private Funds - Audit Planning Memorandum

Enclosed *Margo Mcgurk*

- Item 8.1 - SBAR Patients' Private Funds - Audit Planning Memorandum .pdf (2 pages)
- Item 8.1 - Appendix 1 Fife NHS Board Patients' Private Funds Audit Planning Memorandum 2021-22.pdf (25 pages)

15:50 - 15:55
5 min

9. ESCALATION OF ISSUES TO NHS FIFE BOARD

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

Martin Black

15:55 - 16:00
5 min

10. ANY OTHER BUSINESS

16:00 - 16:00
0 min

11. DATE OF NEXT MEETING - THURSDAY 16 JUNE 2022 AT 2PM

MINUTE OF THE AUDIT & RISK COMMITTEE MEETING HELD ON THURSDAY 17 MARCH 2022 AT 2PM VIA MS TEAMS

Present:
M Black, Non-Executive Member (Chair)
D Graham, Non-Executive Member *(part)*
K MacDonald, Non-Executive Member

In Attendance:
K Booth, Head of Financial Services & Procurement
A Clyne, Audit Scotland
G Couser, Associate Director of Quality & Clinical Governance
P Cumming, Risk Manager
T Gaskin, Chief Internal Auditor
T Fraser, Audit Scotland
B Hudson, Regional Audit Manager
G MacIntosh, Head of Corporate Governance & Board Secretary
M McGurk, Director of Finance & Strategy *(part)*
M Michie, Deputy Director of Finance
H Thomson, Board Committee Support Officer (Minutes)

1. Welcome / Apologies for Absence

The Chair welcomed everyone to the meeting and extended a warm welcome to M Michie who is attending alongside M McGurk.

Apologies were received from members A Grant (Non-Executive Member) and A Lawrie (Non-Executive Member) and from attendee C Potter (Chief Executive).

2. Declaration of Members' Interests

There were no declarations of interest made by members.

3. Minutes of the Previous Meeting held on 9 December 2021

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

4. Action List / Matters Arising

The Committee **noted** the updates and also the closed items on the Action List.

National Datix System

The Risk Manager advised that a business case is being developed in April 2022 for NHS Fife, and the preferred upgrade package is Datix Cloud IQ. It was noted this may

not be the same approach taken nationally. An update will be brought back to the Committee on developments as the business case is finalised.

Corporate Risk Register

The Director of Finance & Strategy advised that the Corporate Risk Register will be available in June 2022, and an update on progress of each of the workstreams on the risk management improvement plan will be provided to the Committee at the May meeting. The action list will be updated accordingly.

5. STRATEGY / PLANNING

5.1 NHS Fife Population Health & Wellbeing Strategy Development Proposal

The Director of Finance & Strategy advised that it was important that the Audit & Risk Committee review and take assurance from the proposed process in terms of the strategy development work, and the proposed governance route for each of the different aspects of work in phase 2. The proposal tabled was presented to all the Standing Committees this month and will also go to the full Board.

The paper sets out the journey so far in terms of taking forward the strategy development. Although Covid has held back progress, some of the initial stages and governance arrangements have progressed. The Public Health & Wellbeing Committee and the Portfolio Board will both have a significant role in terms of oversight and scrutiny in relation to the strategy development work as it develops.

The phased approach to the strategy work and milestone plan was outlined, and it was advised that the Board and Governance Committees will have an ongoing involvement and review, with the ability to influence each of the specific parts of the strategy work.

The Chief Internal Auditor stated the strategy work will feature in audit plans and will be considered in detail.

The Committee took **assurance** on the process described in the proposal to phase the development of the strategy as set out in section 2.3 of the paper.

6. GOVERNANCE – GENERAL

6.1 Losses & Special Payments Quarter 3 Report (Oct – Dec 2021)

The Head of Financial Services & Procurement advised that a 12-month comparison has been added to the report, to give context on spend and the volume of payments.

It was highlighted that there are two negligence payments (one clinical payment and one non-clinical payment) that have significantly increased the figures in this reporting period. Vandalism claims have increased in Quarter 3, and work is planned at year end in terms of an analysis on the spend categories. An update will be provided in the next report.

Further detail was requested on the ex-gratia payments, and it was advised £2.8m was the total amount of clinical payments and non-clinical payments was £260k. It was noted that it was not appropriate to provide detail on specific claims from a confidentiality perspective.

The governance process for approval of payments was queried. In response, it was advised that there is both and national and local process in place to respond to any claims relating to negligence and that it can be a lengthy process involving national bodies such as the Central Legal Office. The process was explained, and it was advised that large claims are approved at Scottish Government level and funded through the CNORIS scheme. An explanation was provided on the Scottish Government's involvement in larger claims, in addition to the local consideration of such claims.

The Committee **noted** the Losses & Special Payment Quarter 3 Report and specifically took assurance on the approvals process.

6.2 Annual Review of Committee's Terms of Reference

The Board Secretary advised that the Terms of Reference (ToR) paper is presented to the Committee annually at the March Committee meetings for review. It was reported there are no substantial changes proposed in the ToR.

A request was made to consider including explicit reference to the new national Whistleblowing Standards, as there is a section within the internal audit plan on Whistleblowing. The Chief Internal Auditor advised that the primary responsibility of Whistleblowing, and its processes, sits with the Staff Governance Committee. It was also noted the general elements of staff concerns are covered under the existing wording of section 5.33 of the ToR.

K MacDonald, Non-Executive Member, advised she will have a discussion with the Staff Governance Committee on adapting the report on Whistleblowing to include more information (including metrics on the number of concerns, outcomes, themes and responses), which can then be used in conjunction with the audit findings report that goes to the Board. This would give a more nuanced report than one focused solely on the number of cases. The Board Secretary advised that there is a Board Away Day scheduled for the end of April 2022. Values and having an open and transparent culture will form part of the discussion, with a dedicated session on the Whistleblowing Standards.

The Committee **considered** the remit and **approved** the final draft version for further consideration by the Board.

6.3 Committee Self-Assessment Report

The Board Secretary thanked everyone involved for their honest and open feedback in completing the self-assessment survey at a busy time of Covid-related activity, noting the importance of receiving feedback and taking time to reflect on the operations of this Committee.

The paper summarises the main points from the self-assessment report, and it was advised there are common themes apparent across all of the Board's Standing Committees. The main findings from the self-assessment exercise were outlined, including the need for completion of the risk management improvement programme and ensuring scrutiny around the governance statement in preparation of the Annual Accounts. It was advised the Audit Scotland Technical Bulletins will be reintroduced into the Committee.

The Committee welcomed and agreed to have a development session, twice a year, to delve deeper into topics relevant to the Committee's remit. Members and attendees were requested to suggest topics to be covered.

Action: Committee Members & Attendees

The Committee **noted** the outcome of this year's self-assessment exercise and **took assurance** from its findings.

6.4 Annual Audit & Risk Committee Workplan 2022/23

The Director of Finance & Strategy advised that the workplan is presented annually to the Committee and noted there are no major changes that are being proposed.

The Governance and Assurance Statements for the Annual Accounts will be presented to the Committee in draft format at the June meeting, where comments on the assurance statements can be taken and actioned in advance of the accounts being considered. The additional meeting scheduled for the July will focus solely on the Annual Accounts, and the Board will conclude the review and approvals process for the Annual Accounts at their meeting on 2 August 2022. It was noted the timeline for approval of the Annual Accounts is an improved position compared to the previous year.

The Committee **approved** the Audit & Risk Committee Workplan 2022/23.

7. RISK

7.1 Risk Management Framework Refresh

The Associate Director of Quality & Clinical Governance provided an update and advised that the ethos of the refresh of the risk management framework is to raise the profile of risk management within the organisation and to ensure it is being used effectively to support strategic planning and decision-making.

Five workstreams will be involved in the process, and an overview was provided on the roles of the workstreams.

The identification of strategic risks will support decision-making, particularly as we move forward with the strategic plans in relation to the Population Health & Wellbeing Strategy and other strategic frameworks that are in development across the organisation.

A draft of the Corporate Risk Register will be brought to the Committee in June 2022. The number of risks within the register will be reviewed on an ongoing basis. It was questioned if staff feedback and the staff voice could be added to elements of the risk

register. It was advised the staff voice will be integrated in various aspects of the work being carried out, and into the risk management processes themselves.

It was advised the development of an annual risk appetite statement on behalf of the Board will support the risk management framework.

The Committee thanked all those involved for their hard work in the process of the refresh.

The Committee took **assurance** from the proposed workplan to refresh the Risk Management Framework.

7.2 Board Assurance Framework (BAF)

The Risk Manager advised that the paper is a summary of the BAF reports and positions on each component of the BAF that have been reported to the Governance Committees in recent weeks.

A summary of the BAFs was provided, and it was advised there have been some improvements to the financial sustainability arrangements and the risk level has moved from high to moderate since the last report in November 2021.

It was reported there will be a transition from the BAF to a corporate risk register, and an update will be brought to the Committee in June 2022. As part of the transition, the presentation of risks will be reviewed and improved.

The Committee **approved** the Board Assurance Framework.

8. GOVERNANCE - INTERNAL AUDIT

8.1 Internal Audit Progress Report

The Regional Audit Manager advised that the amendments are provided in the cover paper and this provides the detail and rationale for the reviews, which forms part of the risk assessment for the 2022/23 audit plan development.

In terms of the improvement activity, this is now in its final stage of completion on the FTF audit website, and a link will be sent out to members in the coming weeks for comment. An update on Public Sector Internal Audit Standards requirement will be provided to the Committee in May 2022. It was noted there was a requirement for a self-assessment to be completed, and this has now been carried out and will be brought for assurance to this Committee.

It was reported that Appendix A provides the status of remaining reviews since the last Audit & Risk Committee.

The Committee:

- **Noted** the progress on the delivery of the Internal Audit Plan; and

- **Noted** the audits from the 2021/22 plan, which are to be risk assessed as part of the development of the 2022/23 audit plan

8.2 Internal Audit – Follow Up Report on Audit Recommendations

The Regional Audit Manager provided an update and advised the follow up report represents the progress and recommendations up to 28 February 2022. There are currently 34 remaining recommendations, with 3 not yet due.

Reports that have been completed and validated are highlighted within the paper.

The status of actions to address recommendations arising from the Internal Audit Annual Report and Internal Control Evaluation Report will be reported to the May Audit and Risk Committee. It was advised responsible officers had been contacted in relation to the actions, and positive feedback had been received.

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

D Graham left the meeting at this point and the Committee was thus inquorate. The Chair advised that the meeting could continue and that any decisions to be made would be homologated by correspondence or agenda items deferred to the next meeting.

8.3 Internal Audit Framework

Assurance was provided that the framework sets out the relationship between the Internal Auditors and the organisation. The current text is generic in nature and will require further review to make this of specific relevance to NHS Fife.

Due to the meeting now being inquorate, the Chief Internal Auditor suggested any comments on the draft text be shared, and that this item will be deferred to the next meeting for further consideration.

The Committee **agreed** to this proposal.

8.4 Internal Control Evaluation – Final Report

The Chief Internal Auditor advised that the draft responses within the Internal Control Evaluation had been received, and some management responses have since been amended. The report is now in its final version.

The Committee **noted** the finalised Internal Control Evaluation, with updated management responses to the audit recommendations.

9. GOVERNANCE - EXTERNAL AUDIT

9.1 Audit Scotland Annual Audit Plan

A Clyne, Audit Scotland, highlighted the significant risks of material misstatement to the financial statements, and provided an overview of these risks.

It was confirmed the sign-off date for the Annual Accounts will be 2 August 2022, which is almost two months earlier than last year.

The Committee **noted** the Audit Scotland Annual Audit Plan.

9.2 Annual Accounts 2021/22 - Follow up Report on External Audit Recommendations

The Deputy Director of Finance spoke to the follow up report.

An update was provided on the issue of recruitment of payroll staff, and it was reported a recent review of the job description re-banded the Payroll Officer role to a Band 5, which is more comparable with other NHS Boards and will hopefully put us in a more positive position with recruitment success going forward.

In terms of the reference to reliance on funding from the Scottish Government to cover our legacy saving targets, it was confirmed that the funding from the Scottish Government was received in February 2022, and there will be a break-even position at the end of this financial year.

The Head of Financial Services & Procurement advised four out of the five recommendations are still in development and further discussion on these with Audit Scotland is anticipated during the audit process.

The Committee took **assurance** from the progress made against the 2020/21 External Audit recommendations.

9.3 NHS in Scotland 2021 Report

T Fraser, Audit Scotland, advised that the 2021 report builds on the coverage of the responses to the pandemic, which were detailed in last year's NHS in Scotland 2020 report. The report considers the Scottish Government's recovery plans and how services might be delivered in the future to meet changing demand. An overview of the report was provided.

The Chief Internal Auditor highlighted the difficult position, noting the risk for NHS Fife's recovery plan in terms of how interlinked this is with national initiatives and their delivery timescales.

T Fraser noted that, since the report was compiled, detailed strategies have since been received from Scottish Government, including the Health & Social Care Workforce Strategy, which has just been released.

Inequalities data was highlighted, and it was advised that this data is being considered and addressed and will form part of the audit work.

The Board Secretary advised that the report has been considered at the Executive Directors' Group and it has also been circulated to the full Board, as there are areas within the report of importance to other Governance Committees.

The Committee **noted** the findings of the NHS in Scotland 2021 Report.

10. COUNTER FRAUD

10.1 Partnership Agreement between Health Boards & Counter Fraud

The Head of Financial Services & Procurement provided an update and advised that the partnership agreement is due for renewal this year. The revised version of the partnership agreement has not been received to date, and an update will be brought back to the Committee.

Action: Head of Financial Services & Procurement

The Committee **noted** the update.

11. ESCALATION OF ISSUES TO NHS FIFE BOARD

There were no issues to highlight to the Board.

12. ANY OTHER BUSINESS

There was no other business.

Date of Next Meeting: Wednesday 18 May 2022 at 2pm via MS Teams

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

AUDIT & RISK COMMITTEE – ACTION LIST

Meeting Date: Wednesday 18 May 2022

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	TIMESCALE	COMMENTS / PROGRESS	RAG
1.	16/09/2021	**National Risk Management System**	Exploratory discussions are ongoing at a national level around procurement of risk management systems. Currently, the local preference is for Datix Cloud IQ. The outcome of national discussions is awaited.	**PC**	On hold	17/03/22 - A business case is being developed in April 2022 for NHS Fife, and the preferred upgrade package is Datix Cloud IQ. An update will be brought back to the Committee on developments as the business case is finalised.	On hold
2.	17/03/2022	**Committee Development Session Topics**	Members and attendees to suggest topics to be covered at a development session, twice a year, to delve deeper into topics relevant to the Committee's remit.	**All**	Dates of Development Sessions to be confirmed	Committee Assurance Principals suggested as a topic, to date. Further suggestions for topics awaited.	In progress
3.	17/03/2022	**Corporate Risk Register**	A full report will be provided to the Committee on the outcomes of the review of the Corporate Risk Register at the June meeting.	**PC**	June 2022		Deadline not reached
4.	16/09/2021		An update on progress of each of the workstreams on the risk management improvement plan will be provided to the Committee at the May meeting.	**PC**	May 2022	On agenda	Closed
5.	17/03/2022	**Partnership Agreement between Health Boards & Counter Fraud**	The revised version of the partnership agreement has not been received to date, and an update will be brought back to the Committee.	**KB**	May 2022	On agenda	Closed

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**18 May 2022**
Title:	**Draft Governance Statement**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Gillian MacIntosh, Head of Corporate Governance & Board Secretary**

1 Purpose

This is presented to the Audit & Risk Committee for:

- Approval

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 2021/22, 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 2021/22. These include:

- appropriately reflecting the impact of Covid-19 on the Board's governance arrangements during the year, reflecting the fact that the Board has worked under Scottish Government direction for the full reporting year;
- a section outlining the Strategic Planning & Resource Allocation process, including the Remobilisation Planning work undertaken in-year; and
- details on the revised Fife Integration Scheme, approved during the reporting year.

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, including 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 Audit Scotland) 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.

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.

2.3.4 Risk Assessment / Management

The Draft Governance Statement reflects the effectiveness of risk management arrangements operating across the organisation. Further information is contained with the Risk Management Annual Report, given as a separate agenda item to this meeting.

2.3.5 Equality and Diversity, including health inequalities

No specific issues to report regarding equality and diversity.

2.3.6 Other impact

N/A.

2.3.7 Communication, involvement, engagement and consultation

Appropriate communication, involvement, engagement and consultation within the organisation and with key external stakeholders (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: **Approval**. The Committee is invited to review the draft Governance Statement as attached and provide any comments as required.

3 List of appendices

The following appendices are included with this report:

- Appendix 1 – Draft Governance Statement (submitted in draft to Audit Scotland and Internal Audit)

Report Contact
Gillian MacIntosh
Head 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 2 August 2022.

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 appointed Brian Howarth, Audit Director, Audit Scotland 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 2021 to 31 March 2022 were as follows:

Non-Executive Members

Tricia Marwick	Chairperson
Rona Laing	Non-Executive Board Member / Vice Chairperson (from 01.04.21)
Martin Black	Non-Executive Board Member
Sinead Braiden	Non-Executive Board Member
Eugene Clarke	Non-Executive Board Member (until 31.07.21)
Christina Cooper	Non-Executive Board Member
Alastair Grant	Non-Executive Board Member (from 13.09.21)
Kirsty Macdonald	Non-Executive Board Member & Whistleblowing Champion
Mansoor Mahmood	Non-Executive Board Member (from 13.09.21)
Alistair Morris	Non-Executive Board Member
Margaret Wells	Non-Executive Board Member (until 31.07.21)
Arlene Wood	Non-Executive Board Member (from 13.09.21)
Wilma Brown	Stakeholder Member, Employee Director (Co-Chair, Area Partnership Forum)
Aileen Lawrie	Stakeholder Member (Chairperson, Area Clinical Forum)
Councillor David Graham	Stakeholder Member (Fife Councillor)

Executive Members

Carol Potter	Chief Executive
Janette Owens	Director of Nursing
Margo McGurk	Director of Finance & Strategy (and Deputy Chief Executive from 11.08.21)
Dr Chris McKenna	Medical Director
Dona Milne	Director of Public Health (until 03.06.21)
Dr Joy Tomlinson	Director of Public Health (from 01.06.21)

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 2022 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 on a reasonable basis.

- 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 Services Manager, Hayfield House, Hayfield Road, Kirkcaldy, KY2 5AH (fife.boardadministration@nhs.scot). A copy is also provided online at the following link: https://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 Audit Scotland or the Fife Health Charity auditors, Thomson Cooper, during 2021/22.

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:
https://www.nhsfife.org/about-us/annual-reporting-and-strategic-planning/

Information Governance and Security Incidents reported to the Competent Authority
One outstanding personal data-related incident / data protection breach from Financial Year 2020/21 was closed in April 2021, with the Information Commissioner (ICO) confirming they were taking no further action.

For Financial Year 2021/22, there were 14 incidents reported to the ICO and/or the Scottish Government. Of the 14 incidents, no further action was required for 12 of the incidents. At the time of writing, we await a response from the ICO on two incidents (one reported in January 2022, and one reported in February 2022).

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. In response to the pandemic during 2021/22, some governance meetings took place with prioritised agendas, as detailed in the *Covid-19 Pandemic – Governance Arrangements* section on page **.

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, including health improvement activities.

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
- One Patient Representative

Chair:
Christina Cooper, 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 and Risk Committee are in accordance with the Scottish Government Audit and Assurance Committee Handbook, dated March 2018, and associated Treasury guidance on assurance mapping.

Membership:
- Five Non-Executive or Stakeholder Members of the Board

Chair:
Martin Black, 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:
Margaret Wells, Non-Executive Board Member (until 31 July 2021)
Sinead Braiden, Non-Executive Board Member (from 1 August 2021)

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
- Chief Executive
- Employee Director

Chair:
Tricia Marwick, Chairperson of Fife NHS Board

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:
Rona Laing, 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:
- Fife NHS Board Chairperson
- Three Non-Executive Members of the Board
- Employee Director
- Chief Executive
- Director of Finance & Strategy
- Director of Nursing
- Director of Public Health
- Medical Director

Chair:
Tricia Marwick, Chairperson of Fife NHS Board

Frequency of Meetings:
Initially, on a monthly cycle, though bi-monthly thereafter.

Other Governance Arrangements

The conduct and proceedings of the NHS Board are set out in the 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 2021/22.

The Standing Orders also include the Code of Conduct that Board members must comply with, and, along with 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.

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 assurances provided, Best Value, risk management and to demonstrate they have fully fulfilled their roles and remit. The format and content of these reports have been further expanded and improved in the current year, and a template for the respective sub-committees / groups that formally report into a Standing Committee has been followed to ensure consistency.

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 2021/22, the Executive Directors embarked on a 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 and this work continues into 2022/23.

Ongoing work to improve Board effectiveness builds on the proposals originally approved by the Board in 2017 and 2018, in relation to the Chair's review of governance arrangements in NHS Fife. It also reflects the requirements of the NHS Scotland Blueprint for Good Governance (https://learn.nes.nhs.scot/28418/board-development/blueprint-for-good-governance), which has been implemented across all Boards. In mapping 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. A recent internal audit review has been undertaken of NHS Fife's compliance with the Blueprint, with the conclusion that 'comprehensive assurance' can be taken from the implementation work progressed thus far. National work aimed at developing the individual workstreams from the Blueprint has largely paused during the pandemic period. However, the Board participated in an Active Governance all-day workshop in November 2021, facilitated by national colleagues from the Board Development team. A series of actions were identified as an outcome of this session, including reviewing the data provided in the Board's regular performance reporting and enhancing the presentation of risk, both of which are being taken forward by short life working groups, with the ambition to conclude both by summer 2022.

During 2019, Board members were each invited to complete a diagnostic self-assessment questionnaire assessing the Board against the Blueprint's initial requirements, to identify common themes and areas for improved effectiveness at Board-level. The outcome of the self-assessment process was presented to Board members at the April 2019 Development Session and, following discussion, an action plan was approved at the May 2019 Board meeting. Progress updates were considered by the Board in November 2019 and September 2020. A summary of the most recent self-assessment process undertaken in December 2021, noting the largely positive evaluation of governance arrangements in place in NHS Fife and completion of the initial Blueprint action plan, can be found at the link below: https://www.nhsfife.org/media/36723/boardblueprint_dec21.pdf

Each year, each Board committee also undertake 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 development sessions. An enhanced induction programme has been established to support new members and a dedicated Induction Pack (available at https://www.nhsfife.org/about-us/nhs-fife-board/board-members-induction-pack/) is update 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 (https://learn.nes.nhs.scot/17367/board-development) and related resources, and discussions around individual member development 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), internal policies and procedures, are directed to Senior Managers who are held responsible for implementation. A dedicated Covid-19 log has continued to operate throughout the current year to capture and track all relevant correspondence. 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 work-plans. Directors and Managers are encouraged to review, identify, and improve the efficient and effective use of resources.

During 2021/22, 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. The Board's Staff Governance Committee has undertaken review of the National Whistleblowing Standards and have overseen their adoption locally, including the initial cycle of regular reporting on the number of cases raised under the Standards and also any anonymous concerns raised. 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 Board's Management of Employee Conduct policy.

There is a well-established 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.

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.

An Integrated Performance & Quality Report (IPQR) was presented to each Clinical Governance Committee, Finance, Performance & Resources Committee, Staff Governance Committee and Board meeting. This provides detailed monitoring information on a range of measures covering financial and clinical delivery. The ongoing impact of Covid-19 on performance against key metrics has been significant and the Board notes the challenges to be faced in recovering the position, particularly in relation to reducing waiting times and the number of referrals. As a result of the Covid-19 measures and the Covid-19 activity surges experienced throughout last year, the performance management framework was replaced nationally by performance against projected activity. The NHS Board also considers at each meeting the most up-to-date information available in relation to the financial position. In addition, an Executive Summary is prepared for the NHS Board and incorporates all matters escalated by each Committee from its own review of the IPQR. A review of the IPQR's content and format is currently underway, to address actions from the Board's Active Governance session and to ensure it remains relevant and clear to Board members.

A robust action plan was developed following Health Improvement Scotland (HIS) external inspection visit to Victoria Hospital (4-6 May 2021), which was focused on the Board's Covid-19 control measures. The report is available at https://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/hosp_nhs_fife/victoria_hospital_jun_21.aspx. The inspection resulted in the identification of seven areas of good practice (largely related to robust infection control measures being in place, safeguarding patient, staff, and visitor health during the pandemic) and two requirements for further action. The two requirements for further action related to, firstly, ensuring that an enhanced in-patient Covid-19 testing protocol was in place and, secondly, to ensuring that the condition of both patient equipment and the environment in wards in the older part of the Victoria Hospital building allows for effective decontamination until the wards are relocated as planned. The action plan created in response to the inspection has now been completed and a report submitted thereon to the Board's Clinical Governance Committee.

During 2021/22 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 Clinical & Care Governance 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 Clinical & Care Governance 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 2021/22 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 joint local review of the Fife Integration Scheme was originally scheduled to conclude by 31 March 2020 (as per the five-year review cycle required by legislation). The review of the Scheme was delayed due to the Covid-19 pandemic and an extension to the submission date, to December 2021, was granted by the Scottish Government. The review successfully concluded by this timescale and the revised Scheme received formal sign-off by the Scottish Government on 8 March 2021. The format of the reviewed Scheme continues to follow the Model Integration Scheme introduced across Scotland, and the Fife version has been refreshed to give more clarity to the agreed governance and assurance arrangements and to remove repetition and duplication. The main changes can be summarised as follows:

- Improved clarification around 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.
- Enhanced 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.
- Clarification 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.
- Removal of specific reference to the IJB's Clinical & Care Governance Committee, Finance & Performance Committee and Audit & Risk Committee, to enable to the IJB to develop and reflect its own Scheme of Delegation for its operation.
- Changes to 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).

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.

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 2021/22, 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 Board Assurance Framework (BAF) to the governance committees, and subsequently to the Audit & Risk Committee and the Board. Due to the emerging Omicron wave of Covid-19 infection and resultant system pressures, the January 2022 governance committees took place with condensed agendas prioritised to reflect Covid-19 related business, which did not include the BAF. There was however frequent reporting to the full Board during this period on the impact of Omicron and the risks emerging from it. Regular reports recommenced as scheduled to the committees in March 2022.

NHS Fife is committed to maintaining and fully embracing an effective risk culture across the organisation. To this end risk management development sessions with the EDG on 23 September 2021 and at the Board Development Session on 21 December 2021 took place to initiate the plan to refresh the NHS Fife Risk Management Framework. These sessions discussed a range of aspects of risk management and created an improvement plan to support the active governance of risk which includes the following improvements and developments:

- a review of the Board Risk Appetite Statement
- a review of the current Board Strategic Risk Profile
- the establishment of a Corporate Risk Register to replace the current Board Assurance Framework
- the creation of a risk dashboard to complement the updated Integrated Performance and Quality Report (IPQR) and to support effective performance management
- an updated process to support the escalation, oversight and governance of risk and
- the creation of a Risks and Opportunities Group.

Good progress is being made with this improvement plan which will support operational teams to identify and manage risks effectively and will also refocus reporting to the Board on corporate level risk. The plan will ensure alignment with the SPRA process to identify organisational or external risks associated with the delivery of corporate objectives. It will also support the identification and mitigation of risks identified through development and delivery of the Population Health and Wellbeing Strategy.

This work is underpinned by acknowledgment of the need to promote a culture that encourages the proactive identification and mitigation of risks from ward to Board.

During 2020/21, the Director of Finance & Strategy, as Executive Lead for Risk Management, reported on all of the above to the Audit & Risk Committee. The outcomes from this improvement work will be reported to the Board in June 2022 for implementation thereafter.

Strategy Development and Strategic Planning and Resource Allocation (SPRA) process

In April 2021, the NHS Fife Board agreed to the development of a new organisational strategy, focused on delivering excellence in clinical care, reducing health and inequalities, and improving population health and wellbeing for the people of Fife. The development of the new strategy has been slower than originally planned, due to the ongoing impact of Covid-19 pressures on our services. However, work has continued on our annual Strategic Planning & Resource Allocation (SPRA) process, to create a transitional 1-year Strategic Plan and specific objectives for 2022/23, including a proposed financial plan. This 1-year plan was reviewed by the governance committees and approved by the Board in March 2022.

The proposal for the progression of the medium to longer-term Population Health & Wellbeing strategy, envisages that we will embark on a series of specific activities during April through to December 2022 to progress this work. The proposed sequencing of activities reflects the interdependence between activities and how each individually influences the development of our strategy. At each stage of development, the governance committees and the Board will review, influence, and prioritise this work. This iterative engagement reflects the importance of the Board role in supporting and guiding strategy development and delivery for the organisation.

Covid-19 Pandemic – Governance Arrangements

The business of the Board during the year continued to be impacted greatly by the need for NHS Fife as a whole to address the ongoing challenges of the global pandemic, with all NHS Boards operating on an emergency footing basis and consequently under the direction of the Scottish Government. Given the recent assessment of the status and impact of the pandemic, all Boards were notified by the Director General Health and Social Care on 29 April 2022 that the emergency footing basis would cease from 1 May 2022. The Board continued to hold its bi-monthly meetings remotely, utilising videoconferencing via MS Teams, with a prioritised agenda in place for Board meetings at times of extremely high clinical activity and pressure. Whilst it has not been possible to meet physically in a public setting due to the ongoing lockdown restrictions and social distancing measures, from the May 2020 Board meeting onwards, representatives from the local media were invited to listen in via Teams. Arrangements for members of the public to join virtual meetings have also been in place since shortly after that date, with NHS Fife one of the first Boards to establish a process for remote public access. Board papers continue to be published in advance on the NHS Fife website, as do the Board minutes after each meeting has taken place. Given the lifting of most restrictions during April 2022 the Board has begun consideration of the plan required to begin to meet face-to-face where it is safe and appropriate to do so. This was tested successfully at our first face to face meeting for 2 years at a development session of the Board in April 2022.

During times of high activity, weekly meetings of the Chair, Vice-Chair and members of the Executive Team were held, with a detailed note circulated to Board members for their information. The Chair and Vice-Chair additionally had regular contact with the Chief Executive and other key members of the Executive Team on priority items as and when required. Regular meetings with local elected representatives (MPs/MSPs) also continued to operate on a monthly basis.

Agendas for Committee meetings during the year have reflected the priorities of the Board's ongoing response to Covid-19, in addition to the consideration of business otherwise requiring formal approval or scrutiny for assurance purposes. The Chair, Vice-Chair and Committee Chairs have liaised closely with the Executive Team to identify what business must be considered by the Board and its committees and what must be prioritised in agenda planning. In the period covered by this report, some routine business was suspended or deferred, with a number of meetings running with prioritised agendas. Each Committee's workplan has, however, been reviewed to ensure that new items related to Covid-19 have been covered appropriately and that the required assurances could be provided to the Board as part of the year-end process.

During the initial phase of the pandemic, NHS Fife established an organisational command structure to provide direction, decision-making, escalation, and communication functions during the busiest times of activity. The Gold Command meeting process, utilised successfully in the first two phases of the pandemic, was re-introduced in July 2021, to respond to the impact of rising Covid-19 case numbers. Meetings continued on a regular basis since then, increasing in frequency over the 2021/22 winter period, particularly in response to the Omicron wave of infections. A supporting sub-structure of Silver and Bronze commands also continued to meet, to provide rapid response and direction to address key operational pressures. Routine meetings, such as the fortnightly formal Executive Directors' Group (EDG) meeting, have resumed, and a new monthly Portfolio Board has been established to take forward the individual workstreams of NHS Fife's new Population Health & Wellbeing Strategy development work.

Disclosures

During the 2021/22 financial year, no other significant control weaknesses or issues have arisen, in the expected standards for good governance, risk management and control.

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**18 May 2022**
Title:	**Review of Annual Workplan**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Hazel Thomson, Board Committee Support Officer**

1 Purpose

This is presented to the Audit & Risk Committee for:

- Approval

This report relates to a:

- Local policy

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

- Effective

2 Report summary

2.1 Situation

The Audit & Risk Committee approved the Annual Workplan at the March 2022 meeting. For assurance, the Annual Workplan, presented as a tracked version, will go to each future Committee meeting to enable the Committee to clearly monitor items that have been covered, carried forward to a future meeting, or removed.

2.2 Background

The Audit & Risk Committee sets out the planned work for the financial year in its annual workplan, which is used to inform the content of individual meeting agendas.

2.3 Assessment

The Workplan attached sets out the key plans, reports, business cases and proposals which the Committee will receive and be asked to consider, endorse or take assurance from during 2022/23.

2.3.1 Quality/ Patient Care

Delivering robust governance across the organisation supports sustaining and improving patient care and quality standards.

2.3.2 Workforce

Workforce considerations are included as appropriate in proposals considered by the Committee.

2.3.3 Financial

Ensuring appropriate scrutiny of the NHS Fife financial planning and financial performance is a core part of the Committee's remit.

2.3.4 Risk Assessment/Management

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

2.3.5 Equality and Diversity, including health inequalities

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

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

N/A

2.3.8 Route to the Meeting

N/A

2.4 Recommendation

The paper is provided for:

- **Approval**

3 List of appendices

- Audit & Risk Annual Workplan 2022/23

Report Author
Hazel Thomson
Board Committee Support Officer
hazel.thomson4@nhs.scot

Appendix 1

AUDIT & RISK COMMITTEE

ANNUAL WORKPLAN 2022/23

Governance - General							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**08/12/22**	**16/03/23**
Minutes of Previous Meetings	**Chair**	✓	✓	✓	✓	✓	✓
Action Plan	**Chair**	✓	✓	✓	✓	✓	✓
Escalation of Issues to NHS Board	**Chair**	✓	✓	✓	✓	✓	✓
Governance Matters							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**08/12/22**	**16/03/23**
Committee Self-Assessment	**Board Secretary**						✓
Corporate Calendar / Committee Dates	**Board Secretary**				✓		
Review of Annual Workplan	**Board Secretary**	✓	✓	✓	✓	✓	✓ Approval
Review of Terms of Reference	**Board Secretary**						✓ Approval
Annual Review of Code of Corporate Governance	**Board Secretary**	**Deferred to next mtg**	✓				
Annual Assurance Statement 2021/22	**Board Secretary**		✓ Draft	✓			
Annual Assurance Statements from Standing Committees 2021/22	**Board Secretary**		✓				
IJB Annual Assurance Statement 2021/22	**Board Secretary**		✓				
Significant Issues of Wider Interest	**Director of Finance & Strategy**		✓ Draft	✓			
Governance Statement	**Director of Finance & Strategy**	✓ Draft	✓				
Internal Audit Review of Property Transactions Report 2021/22	**Internal Audit**				✓		
Losses & Special Payments	**Head of Financial Services**		✓		✓	✓	✓

Risk							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**08/12/22**	**16/03/23**
Annual Risk Management Report 2021/22	**Risk Manager**	✓ Draft	✓				
Risk Management Key Performance Indicators 2021/22	**Risk Manager**	**Deferred until work on framework concluded**			✓	✓	✓
Board Assurance Framework (BAF)	**Risk Manager**	✓			✓	✓	✓
Risk Management Improvement Programme – Progress Report	**Risk Manager**	✓			✓	✓	✓
Governance – Internal Audit							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**08/12/22**	**16/03/23**
Internal Audit Progress Report 2021/22	**Internal Audit**	✓			✓	✓	✓
Internal Audit Annual Report 2021/22	**Internal Audit**	**Draft not available due to timings**	✓ Final				
Internal Audit – Follow Up Report on Audit Recommendations 2021/22	**Internal Audit**	✓			✓	✓	✓
Annual Internal Audit Plan 2022/23	**Internal Audit**	✓ Draft	✓				
FTF Shared Service Agreement / Service Specification	**Internal Audit**					✓	
External Quality Assessment (5 yearly)	**Internal Audit**				✓		
Governance – External Audit							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**08/12/22**	**16/03/23**
Annual Audit Plan 2022/23	**External Audit**						✓
Audit Planning Memorandum – Patients' Private Funds	**Director of Finance & Strategy**	✓					

Governance – External Audit (cont.)							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**08/12/22**	**16/03/23**
External Audit – Follow Up Report on Audit Recommendations	**Director of Finance & Strategy**					✓	✓
Service Auditor Reports on Third Party Services	**Director of Finance & Strategy**		**Deferred to next mtg**	✓			
Annual Accounts							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**08/12/22**	**16/03/23**
Annual Accounts & Financial Statements 2021/22	**Director of Finance & Strategy / External Audit**			✓			
Annual Audit Report (including ISA 260) 2021/22	**External Audit**			✓			
Letter of Representation (ISA 580) 2021/22	**Director of Finance & Strategy / External Audit**			✓			
Patients' Funds Accounts 2021/22	**Head of Financial Services**		✓	**Brought forward to June**			
Annual Statement of Assurance to the NHS Board 2021/22	**Board Secretary**			✓			
Counter Fraud							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**08/12/22**	**16/03/23**
Counter Fraud Service – Quarterly Report (Alerts & Referrals)	**Head of Financial Services**	Private Session			Private Session	Private Session	Private Session
Adhoc							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**08/12/22**	**16/03/23**
Private Meeting with Internal / External Auditors	**Committee**				✓		✓

Adhoc (cont.)							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**08/12/22**	**16/03/23**
Appointment of Patients' Funds Auditor	**Director of Finance & Strategy**	**As required**					
Progress on National Fraud Initiative (NFI)	**Head of Financial Services**	**As required**					
Legal & regulatory updates (e.g. Audit Scotland reports; Technical Bulletin etc)	**Head of Financial Services**						
Additional Agenda Items (Not on the Workplan e.g. Actions from Committee)							
	Lead	**18/05/22**	**16/06/22**	**29/07/22**	**15/09/22**	**08/12/22**	**16/03/23**
Annual Accounts Preparation Timeline	**Head of Financial Services**	✓					
Internal Audit Framework	**Chief Internal Auditor**	✓ **Deferred from 17/03/22**					
Notification of External Audit Appointment from 2022/2023	**Director of Finance & Strategy**	✓					
Partnership Agreement between Health Boards & Counter Fraud - Update	**Head of Financial Services**	Private Session					
Training Sessions Delivered							
	Lead		**16/06/22**				
Members' Training Session – the Annual Accounts: The Role & Function of the Audit & Risk Committee	**External Auditors**		✓				

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**18 May 2022**
Title:	**Notification of External Audit Appointment from 2022/23**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Kevin Booth, Head of Financial Services & Procurement**

1 Purpose

This is presented to the Audit & Risk Committee for:

- Assurance

This report relates to a:

- Government policy/directive

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

- Safe
- Effective

2 Report summary

2.1 Situation

Audit Scotland have held the position of External Auditor for NHS Fife since 2016/17 and the 2021/22 Annual Accounts Process will be the final assignment before the planned rotation of External Auditor ahead of the 2022/23 assignment.

2.2 Background

The rotation of Auditors for the public sector normally follows a five-year cycle, however this process was disrupted as a result of Covid-19 and as such 2021/22 marks the sixth year of the current rotation.

Audit Scotland recently conducted an audit tender exercise on behalf of the Auditor General for Scotland (for Health, Central Government and further education bodies) and the Accounts Commission for Scotland (for local Government).

The Auditor General and Accounts Commission selected six firms of Accountants (Azets Audit Services, Deloitte, Ernst & Young, Grant Thornton, KPMG and Mazars) who, alongside Audit Scotland's own audit teams, will undertake the public sector audits in Scotland for the financial years 2022/23 through to 2026/27. Across all sectors, the noted private firms will undertake 38% of the total audit portfolio.

2.3 Assessment

Following the completion of the Audit Scotland Tender process it has been confirmed that Azets Audit Services will take over the appointment of External Auditor for NHS Fife for the financial years 2022/23 through to 2026/27.

2.3.1 Quality/ Patient Care

N/A

2.3.2 Workforce

David Eardley, Director of Audit and Assurance is Azets Audit Services lead public sector auditor and is a current member of the NHS Technical Accounting Group.

2.3.3 Financial

The financial implications have been managed by Audit Scotland during the tender exercise and will be communicated in due course.

2.3.4 Risk Assessment/Management

In constructing the provisional allocation of audits, the following criteria were applied:

- Considering any Conflicts of Interest, such as Internal Audit provision
- Grouping of audits to align health boards and councils where possible
- Rotation of Auditors
- Equal Portfolio size
- Balanced Portfolios

2.3.5 Equality and Diversity, including health inequalities

N/A

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

The Directors of Finance for all boards were asked to provide any comments or to raise any impediment to the proposed appointments to Audit Scotland before the 2022/23 appointments were confirmed.

2.3.8 Route to the Meeting

This paper is brought to the Audit and Risk Committee ahead of the 2022/23 assignment and the Audit team from Azets Audit Services will be asked to attend and introduce themselves to the committee once the 2021/22 assignment is completed by Audit Scotland.

2.4 Recommendation

- The Committee is asked to take **Assurance** from this appointment process.

3 List of appendices

N/A

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

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**18 May 2022**
Title:	**Annual Accounts Preparation Timeline**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Kevin Booth, Head of Financial Services & Procurement**

1 Purpose

This is presented to the Audit & Risk Committee for:

- Assurance

This report relates to a:

- Government policy/directive
- Legal requirement

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

- Effective

2 Report summary

2.1 Situation

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 on the 2nd of August 2022.

2.2 Background

At the previous Audit and Risk Committee on the 17th of March 2022, Audit Scotland presented the NHS Fife Annual Audit Plan 2021/22. The timelines contained within this plan were formed following discussions with the Head of Financial Services and the Deputy Director of Finance. It was agreed that the draft Annual Accounts, Annual Report and the associated working papers would be provided to Audit Scotland no later than 16th May 2022.

2.3 Assessment

The Draft Annual Accounts incorporating the Front-End Narrative section, the Remuneration report and the consolidated template have all been completed as per the internal timetable and have been submitted to the Director of Finance for final review and approval prior to them being submitted to Audit Scotland by the 16th of May 2022, in line with the Audit Scotland Planning Memorandum.

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 expected submission of the draft accounts to audit Scotland by the 16th of May 2022, the next key milestone date is the 30th of June 2022, which is the latest planned date for the final clearance meeting with the Director of Finance & Strategy and Audit Scotland.

2.3.1 Quality/ Patient Care

N/A

2.3.2 Workforce

The Finance staff's required input for the Annual Accounts process is communicated to them at the internal planning stage.

2.3.3 Financial

The Annual Accounts process is the key part of the Boards disclosure of its Financial Performance for the year 2021/22.

2.3.4 Risk Assessment/Management

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

2.3.5 Equality and Diversity, including health inequalities

N/A

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

The Head of Financial Services has produced an internal timetable to ensure that all steps in the Annual Accounts process have been considered and are completed within the appropriate time.

2.3.8 Route to the Meeting

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

2.4 Recommendation

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

3 List of appendices

N/A

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

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**18 May 2022**
Title:	**Draft Risk Management Annual Report 2021-2022**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Report Author:	**Pauline Cumming, Risk Manager**

1 Purpose

This is presented to the Audit and Risk Committee for:

- Assurance

This report relates to a:

- Local framework and policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This report provides the Committee with an overview of the risk management activity undertaken during the period 2021 - 2022.

2.2 Background

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

2.3 Assessment

NHS Fife is committed to embedding an effective risk culture. During 2021.2022, it was recognised that the profile of risk management in NHS Fife required to be elevated to support delivery of the strategic priorities, and specifically two key strategic work streams:

1. The further development of the Strategic Planning and Resource Allocation (SPRA) process.
2. Transformation of the NHS Fife Clinical Strategy into a Population Health and Wellbeing Strategy for NHS Fife, with the Board aspiring to become an Anchor Institution.

Delivery of both work streams requires close alignment of strategic planning and risk management. Effective risk management arrangements will contribute to delivery through:

- Enabling operational teams to identify and manage operational risks effectively;
- Alignment with the SPRA process to identify organisational risks to assist in informing organisational objectives;
- Identifying risks which may compromise delivery of the objectives;
- Foreseeing and managing risks generated through delivery of the Population Health and Wellbeing Strategy and;
- Supporting the organisation to identify possible opportunities for innovation

To achieve the above and following engagement with EDG and the Board, it was agreed that the Risk Management Framework should be refreshed to implement:

I. A Board Strategic Risk Profile
II. A Corporate Risk Register to replace the current Board Assurance Framework
III. A Risk Dashboard to complement the updated Integrated Performance and Quality Report (IPQR) and to support effective performance management
IV. An updated process to support the escalation, oversight and governance of risks
V. A Risks and Opportunities Group

This report summarises progress in relation to the above and the focus for 2022/2023.

2.3.1 Quality/ Patient Care

Elevating the risk management framework in NHS Fife will further support achievement of the quality ambitions of safe, effective, person - centred care through improved operational governance and better alignment with strategic planning.

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2.3.2 Workforce

All staff in the organisation have a responsibility for identifying risk. Staff must be enabled to do this by being appropriately informed and involved in operational risk management. Education will be provided to support the development of necessary capability and capacity.

2.3.3 Financial

There are no direct financial implications linked to this paper. Those associated with the upgrade to the Board's risk management system referenced in the report, will be considered in the related business case which is currently being prepared.

2.3.4 Risk Assessment / Management

The report summarises activities to develop the Board's risk management arrangements in order to identify risks to, and support delivery of the strategic priorities.

2.3.5 Equality and Diversity, including health inequalities

An Equality and Diversity (E&D) assessment has not been conducted but there are not considered to be direct E&D implications associated with this report.

2.3.6 Other impact

None identified.

2.3.7 Communication, involvement, engagement and consultation

The content of the report reflects the results of engagement with the following:

- Director of Finance and Strategy
- Associate Director of Quality and Clinical Governance
- Senior Leadership Teams
- Risk Management Coordinators

2.3.8 Route to the Meeting Margo McGurk**,** Director of Finance and Strategy on 11/05/22

2.4 Recommendation

- **Consider** and **take assurance** from the content of the report

3 List of appendices

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

DRAFT

Risk Management Annual Report

2021-2022

1. RECOMMENDATION

The Board is asked to note and take assurance from the risk management activities carried out during the period April 2021- March 2022.

2. INTRODUCTION

NHS Fife is committed to embedding a culture in which risk management is central to our strategic planning and decision making, and underpins how we address the risks to achieving the priorities within the developing Population Health and Wellbeing Strategy; in this way it will support delivery of safe, effective, person-centred health care to the people of Fife.

This report outlines the risk management activities undertaken during 2021 to date, and highlights future developments and opportunities to improve the current arrangements and to support the delivery of NHS Fife's strategic priorities.

3. RISK MANAGEMENT GOVERNANCE

The Director of Finance and Strategy provides strategic leadership and direction for risk management in NHS Fife.

The Audit & Risk Committee has responsibility for evaluating the overall effectiveness of the risk management arrangements within the internal control framework, and will review and challenge how these are operating across the organisation.

Throughout 2021/22, Internal Audit have consistently offered important challenge and constructive critique on the approach and activities to improve the Board's risk management arrangements. Of note, further to issues highlighted within the Internal Audit 2020/21 Annual Report, the Internal Control Evaluation 2021/22 Report No. B08/22 includes positive comment in relation to progress being made in the continuing development of those arrangements.

The Board Assurance Framework (BAF),brings together information on key risks including controls, mitigating actions, assurances, gaps, linked operational risks and an assessment of current performance. Table 1 sets out the BAF components and the assigned committees.

Table 1	
Board Assurance Component	**Governance Committee**
Quality & Safety	Clinical Governance Committee
Digital & Information	Clinical Governance Committee
Strategic Planning	Clinical Governance Committee Finance, Performance & Resources Committee
Financial Sustainability	Finance, Performance & Resources Committee
Environmental Sustainability	Finance, Performance & Resources Committee
Workforce Sustainability	Staff Governance Committee
Integration Joint Board (IJB	IJB and the Board

Executive Directors responsible for each component of the BAF are required to provide an assurance report, bi - monthly to the aligned governance committee.

During 2021/22, the high level risks under the above categories 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 BAF to the governance committees, and subsequently to the Audit & Risk Committee and Fife NHS Board. The exceptions were reports on the BAF to the governance committees scheduled for January 2022. Due to the emerging Omicron wave of COVID-19 infection and resultant system pressures, the governance committees took place with condensed agendas prioritised to reflect COVID-related business, which did not include the BAF. Regular assurance reports recommenced as scheduled to the committees in March 2022. Table 2 summarises the reporting schedule.

Table 2		**Board Assurance (BAF) Committee Reporting Schedule**							
Committee		Apr 2021	May 2021	Jul 2021	Sep 2021	Oct 2021	Nov 2021	Jan 2022	Mar 2022
Finance, Performance & Resources (FPRC)									
BAF	Financial Sustainability	N/A	√	√	√	N/ A	√	x	√
	Environmental Sustainability	N/A	√	√	√	N/ A	√	x	√
	Strategic Planning	N/A	√	√	√	N/ A	√	x	√
Clinical Governance (CGC)									
BAF	Quality & Safety	√	N/A	√	√	N/ A	√	x	√
	Digital & information	√	N/A	√	√	N/ A	√	x	√
	Strategic Planning	√	N/A	√	√	N/ A	√		√
Staff Governance (SGC)									
BAF	Workforce Sustainability	√	√	√	√	√	N/A	x	√

During 2021- 2022, and in response to Internal Audit recommendations, each component of the BAF was updated to reflect the impacts of the COVID-19 pandemic.

4. RISK MANAGEMENT IN 2021-2022

During 2021/22, there has been a reset across NHS Fife, with two key strategic work streams being progressed:

1. Consolidation and further development of the Strategic Planning and Resource Allocation (SPRA) process; and
2. Refresh of the NHS Fife Clinical Strategy, which will transform into a Fife Population Health & Wellbeing Strategy, reflecting our aspiration to become an Anchor Institution.

It was recognised that effective organisational risk management arrangements are crucial to the successful delivery of these work streams and that there was an opportunity to elevate the profile of risk management by fully integrating it within the strategic planning process. To support this work, it was agreed that the Risk Management Framework should be refreshed.

In May 2021, the need for dedicated resource and leadership for risk management was recognised and funding was secured to support a secondment to allow the Risk Manager to be released from adverse events and other portfolios of work, in order to focus on the refresh of the Risk Management Framework. In February 2022, the need to sustain this position was acknowledged and funding was secured on a substantive basis.

Effective risk management requires supportive and enlightened senior leadership to ensure it contributes to creating a culture that encourages the proactive identification and mitigation of risks from ward to Board. This means promoting risk management as part of business as usual, enabling it to be embedded into daily work, and making it integral to planning, performance and transformational change. In the past year, the Executive Directors and the Board have demonstrated their commitment to this goal by engaging in discussions and workshops about the refresh of the Framework, and through their endorsement of improvement priorities.

Risk Maturity

As part of the review of its risk management processes and to support their further development, in September 2021, NHS Fife took the opportunity to assess its risk management maturity. This was designed to:

- enable the EDG to have a discussion on the current level of maturity
- identify the actions required to further develop our risk management arrangements
- highlight areas of good practice on which to build

The methodology involved a review of our risk management processes against 6 elements:

1. Leadership
2. Risk Strategy & Policy
3. People
4. Processes
5. Risk Handling
6. Outcomes

The review informed the development of a risk management improvement programme designed to strengthen our processes by supporting a structured and consistent approach to identifying and analysing risks and opportunities. In turn, this will give Executive Directors and the Board visibility of the organisation's risk profile, enable informed and effective decision making, and help create the conditions in which to capitalise on opportunities.

In December 2021, later than planned but unavoidable as a consequence of the ongoing pandemic, as part of the plan to refresh the Risk Framework, the Board approved the proposal to replace the Board Assurance Framework process, reinstate a corporate risk register and develop complementary dashboard reporting.

It was felt this would simplify and add focus to our reporting, fulfil the Board's requirements in terms of active governance of risk and provide enhanced assurance.

Work to refresh the Framework is now in progress. Key elements include the following:

Engagement with Senior Leadership Teams

It is recognised that to achieve consistent and effective application of risk management, it must be part of Business as Usual (BAU). Risk Management when deployed effectively, should add value by being integral to daily work and support activities as opposed to being seen as a separate, self-contained process. To ensure that the refreshed framework achieves this goal, it was agreed there should be engagement with Senior Leadership Teams (SLT) to:

- set the Framework refresh in context
- provide an opportunity to discuss plans to improve our risk management arrangements
- encourage teams to reflect on their risks and consider if these reflect their risk landscape

Two methods of engagement are being used:

1. meetings with SLTs via MS TEAMs
2. a FORMS Survey

Engagement sessions are being held during April and May 2022. Feedback from the sessions and survey will be analysed, and emergent themes will inform the improvement programme.

5. STRATEGIC RISK

Strategic Risk Profile

A draft Board Strategic Risk Profile which aligns to the Population Health and Wellbeing Strategy has been drafted. See Appendix 1. Following a presentation to the Board in March 2022, it was agreed that additional risks should be developed in relation to environmental sustainability, specifically climate change, and health inequalities. The Directors of Property & Asset Management and Public Health are working to develop the respective risks. As the NHS moves from an emergency footing, the risk profile will be reviewed and refined to ensure it reflects the current risk landscape, and mitigations plans will be developed before submission to the Board for approval.

Risk Appetite

The update of the Board's risk appetite on the type and level of risks to be accepted will be taken forward in collaboration with EDG and the Board during May and June 2022. This will be considered through the types of risk - clinical quality and safety, workforce, property & infrastructure including digital and information, and finance, in relation to our strategic priorities: Key reflections will include:

- What is our learning from experience during the last 26 months?
- What have been the key risks and opportunities over this period?
- Will these continue to present in the future?
- Are there additional risks we are willing to take as we develop the new strategy?

Risk Assurance

During 2021/22, an Assurance Mapping Group made up of members of Boards covered by the FTF Internal Audit Service and facilitated by the Chief Internal Auditor, continued to meet. NHS Fife is represented by the Head of Corporate Governance & Board Secretary, and the

Risk Manager. The group has developed a set of assurance principles. A plan to use these to support delivery of the refreshed Framework will be developed in Q2 2022/23.

Risk Leadership and Focus: Risks and Opportunities Group

Based on the model used in NHS 24, a Risks and Opportunities Group will be established. The group will be chaired by the Associate Director of Quality and Clinical Governance, with membership likely to include the Risk Manager and Associate and Deputy Directors. Governance lines are to be confirmed but the group is likely to report into EDG. Draft Terms of Reference are being developed and it is anticipated that the group will meet initially in August 2022. The Group's broad remit will be to:

- Promote effective risk management and seek opportunity for the organisation
- Consider risks and opportunities to the strategic priorities of the organisation
- Review aggregation of risk across the organisation to determine the most appropriate response on behalf of the whole organisation
- Based on changing risk levels, provide direction and focus to the assurance functions
- Horizon scan for future opportunities, threats and risks aligned to the strategic priorities
- Ensure continuous improvement of the internal control environment

6. CORPORATE RISK

Corporate Risk Register

A Corporate Risk Register (CRR) will be established to replace the BAF. This will contain the highest scoring risks from across the organisation that have the potential to affect the whole organisation, or operational risks which have been escalated i.e. can no longer be managed by a service or require senior ownership and support to mitigate. It has been agreed that the register will comprise risks under the following categories:

1. Clinical Quality and Safety
2. Property and Infrastructure (including Digital and Information)
3. Workforce
4. Finance

The corporate risk profile is being developed through discussions involving EDG, the governance committees, and Senior Leadership Teams (SLTs) by considering existing risks, and identifying new risks. Indicative areas of risk for inclusion are: staffing; system capacity; unscheduled care; waiting times; COVID 19; prescribing and medicines management; infrastructure; cyber resilience, financial planning, public protection and CAMHS.

The process to support the escalation, oversight and governance of risks is under development; this will include the requirement to have Director sign- off for any risks escalating to or de-escalating from the CRR. In addition, when risks are escalated to CRR, the Directors will recommend the committee to which the risk should be aligned.

RISK DASHBOARD

A dashboard will be introduced which aligns to the refreshed Integrated Performance & Quality Report (IPQR) and will include metrics related to corporate risks. The dashboard will provide a

simple, visual, high level overview for assurance, weave risk management into business as usual (BAU), and allow for regular scrutiny of corporate risks. It will align to improvement actions within the IPQR and integrate with Key Performance Indicators (KPIs) and Quality Performance Indicators (QPIs).

Each risk category will be aligned to a governance committee; this will be noted on the risk register and referenced in the risk narrative of the IPQR. Some risks may need to be assigned to more than one committee. Following agreement on the corporate risks, the dashboard will be compiled and included in the IPQR.

7. OPERATIONAL RISK

A key area for improvement in 2022/23 will be to strengthen the approach to operational risk management.

Risk registers are currently held in Datix, and risks are reported and monitored through the governance structures including at local management team, SLT, service, directorate and divisional level across the organisation. Feedback from SLTs indicates that approaches to managing operational risk vary in terms of prioritisation, consistency, and reliability. It is expected that the revised arrangements will strengthen existing processes.

Education and support will be provided to enable staff to develop their capability to effectively participate in risk management. Emphasis will be placed on the importance of connecting risk to objectives and ensuring that risks are appropriately assessed, articulated and managed.

8. COVID- 19

During 2021- 22, COVID -19 risks continued to be identified and managed across the system. These reflected the volatile and multi-faceted COVID -19 risk landscape across the Acute Services Division (ASD) and the Fife Health and Social Care Partnership (HSCP); this included risks associated with planning, service delivery, workforce, pharmacy, estates and facilities, medical physics, procurement, personal protective equipment (PPE), infection control, vaccination programmes, and public health considerations.

During 2021/22, monthly high level risk reports were prepared for EDG. Over time, the overall number of risks has reduced from 94 to 40. There are currently no procurement or pharmacy COVID risks. There are currently10 high level risks.

At EDG on 5 May 2022, it was agreed that while some elements of the risks may remain, such as workforce pressures, these are no longer primarily linked to the pandemic. Risks will now be managed as business as usual, included in the operational risk registers or escalated to the corporate risk register as required. The EDG high level risks report is no longer required.

9. DATIX RISK MANAGEMENT SYSTEM

Datix is the repository for risks, incidents (adverse events), safety alerts, complaints and claims within the ASD and Fife HSCP. The system has more than 1400 registered users.

As previously reported, RL Datix do not intend to further develop the web versions, and will offer only problem fixes. Datix Cloud IQ is the upgrade path from DatixWeb. At time of writing, a business case is being developed for NHS Fife.

Datix Module Development
During 2021/2022, a significant amount of work was carried out on Datix. Where possible, in order to improve user experience, we engage proactively with staff on system developments and in response to user feedback and organisational requirements.

Risk Register Module
Pending a system upgrade, work is underway to redesign the module to support key developments in the Risk Management Framework.

Learning from Excellence (Greatix)
Greatix functionality has been expanded allowing staff to record examples of good practice in relation to their colleagues. The reporting form is available to all NHS Fife staff to complete; no login is required; feedback can be given locally to staff who have had their excellence recorded. 86 Greatix reports were submitted in 2021-22.This enhancement demonstrates the value that the organisation places on the contribution of staff to care and service delivery in Fife, to recognising excellence and connects to our commitment to embed a just culture.

Restructure of Community Services
During 2021-22, risk management staff supported a major restructure of HSCP services which involved making significant changes within Datix, including amending hundreds of user permissions to ensure that access to data was seamlessly maintained.

User Permissions
During 2021-2022, in response to changes to staff roles due to the pandemic, and to maintain system efficiency, work has continued to improve user access to Datix records, in particular to remove leavers more timeously and improve the communication and update processes in relation to significant adverse events and safety alerts/hazard notices.

Communications
The DatixWeb Feedback Newsletter, which reports on system changes and improvements was paused due to COVID-19 with information issued on Staff Link; it has now been reinstated. The format is being evaluated and may change to SWAY; hardcopies will be available for staff without easy access to email or Staff Link. Issue 300 was recently published.

10. RISK MANAGEMENT TRAINING

During 2021/22, training was delivered on topics including risk management principles and the Datix modules. Risk management Learnpro modules and user guides are available on Blink. The latter are now available on TURAS with risk register and actions modules in development. The team has continued to deliver training via MS Teams during 2021-22.Uptake has continued to be very good with 57 sessions delivered to over 370 staff.

11. ORGANISATIONAL LEARNING

In 2021, the NHS Fife Organisational Learning Group was set up. The Group is co chaired by the Associate Director of Quality and Clinical Governance and the Associate Nurse Director, Corporate Nursing Directorate. The remit includes promoting effective risk management to support organisational learning, quality improvement and decision making.

12. RISK MANAGEMENT INPUT TO GROUPS AND COMMITTEES in 2021/22

Input to NHS Fife Groups and Committees in reports and / or representation	
• COVID - 19 Vaccination Programme • Safe & Secure Use of Medicines, Policy and Procedures Group • Medical Gas Committee • Point of Care Testing Committee • Adverse Events & Duty of Candour Group • Audit & Risk Committee • Clinical Governance Committee • Clinical Governance Oversight Group • Decontamination Group	• HSCP Health & Safety Forum • Hospital Transfusion Committee • Infection Control Committee • Information Governance Operational Group • IPQR Review Group • Local Partnership Forum • Organisational Learning Group • Tissue Viability Working Group • Violence & Aggression Management Forum

Input to National Groups	
• Datix Scottish User Group - Chair, Paul Smith, Risk Management Coordinator • Healthcare Improvement Scotland (HIS) Adverse Events Network • HIS Expert Reference Group • Scottish Government Digital Strategy Group - Paul Smith	• MHRA and IRIC national working group led by MHRA: Standardisation of medical device coding in line with international standards. To report through NHS National Services Scotland and HIS once completed. • Healthcare IT Incidents SLWG

13. RISK MANAGEMENT OBJECTIVES 2022/23

In 2022/23, the focus will be to roll out a refreshed Risk Management Framework, specifically:

- promote a culture that encourages the proactive identification and mitigation of risk from ward to Board
- agree the Board risk appetite and work to embed and reflect in risk management practice
- align the organisational risk profile to the strategic planning agenda
- implement a structured approach to the review and management of risks through appropriate governance structures
- review the format and content of the reports presented to governance committees
- apply assurance principles into 'business as usual' based on active governance
- improve the approach to operational risk management
- update risk key performance indicators and promote their use as a management tool
- develop the policy and guidance components of the Framework
- deliver an education and development programme to support Framework implementation

Appendix 1

DRAFT RISKS TO NHS FIFE'S STRATEGIC PRIORITIES

STRATEGIC PRIORITY: To Improve Health and Wellbeing
1.There is a risk that after more than 2 years of reduced levels of healthcare service as a consequence of the COVID -19 pandemic, and foreseeable continuation into the future compounded by the challenges of emerging variants and other respiratory pathogens, population health and wellbeing will be adversely affected which could result in: • increased population morbidity and mortality • increased pressure on healthcare and support services affecting service delivery • reduced capacity for non urgent services • high levels of employee absence due to personal illness and caring responsibilities • limited capacity to develop, transform and sustain services • non delivery on key quality performance measures •
2.There is a risk that the development and the delivery of the NHS Fife Population Health and Wellbeing Strategy is not adequately supported by the required planning and programme management capacity, capability and governance arrangements, resulting in delays to progression and implementation of this critical component of Fife's strategic approach to delivering the 4 national Care Programmes: Integrated Unscheduled Care; Integrated Planned Care; Place and Wellbeing; and Preventative and Proactive Care.
3. There is a risk that if the Population Health and Wellbeing Strategy does not incorporate learning from the COVID-19 pandemic and align with the motivations, aspirations and expectations of the people of Fife, the Board's vision, corporate objectives and key priorities will not be achieved, resulting in services that are neither transformational nor sustainable in the long term.
STRATEGIC PRIORITY:To Improve the Quality of Health and Care Services
1.There is a risk that due to failure of clinical governance, performance and management systems (including information governance & information security), NHS Fife may be unable to provide safe, effective, person centred care. Additionally, there is a risk that the effects of the COVID - 19 pandemic, including restricted capacity, reduced elective & non urgent services, and workforce pressures, will impact on the quality & safety of patient care and service delivery.
2. There is a risk that sustained whole system pressures due to factors including COVID -19, and demand outstripping capacity within acute, primary and social care services will result in: • inability to timeously discharge medically fit patients, thus increasing their length of stay resulting in: • increased clinical risk including healthcare associated infection and deconditioning • reduced number of downstream beds • delayed patient pathways and negative impacts on safe capacity and patient flow • financial and workforce impacts due to the need to open and staff additional beds • increased Emergency Department (ED) attendances • unmet performance targets including 4 hour ED access, patients in delay, waiting times, treatment times, Remobilisation Plan • sub optimal patient experience and outcomes • reputational harm
3.There is a risk that if we do not implement effective strategic workforce planning (including aligning funding requirements), we will not have the right size of workforce, with the right skills and competencies, organised appropriately within an affordable budget, to deliver business as usual services, respond to the ongoing challenges of COVID-19, and implement necessary transformation, resulting in sub optimal delivery, reputational harm, and further impacts on staff wellbeing and recruitment / retention rates.
4.There is a risk that failure to invest appropriately in D&I resilience including the D&I Strategy and current operational lifecycle commitment, may result in an inablity to make essential transformation across Health and Social care to deliver sustainable and integrated services that are safe, secure and compliant with governance frameworks and associated legislation including Cyber Essentials and Network & Informations Systems

Regulations, and future proofed as far as reasonable and practicable.

STRATEGIC PRIORITY:To Improve Staff Experience and Wellbeing

1. There is a risk that because of current pressures and capacity challenges, staff may be unable to fully engage with the development of the Population Health and Wellbeing Strategy which underpins our aspiration to be an Anchor Institution i.e. one that positively influences the health and wellbeing of our communities, which may result in a strategy which does not:

- recognise staff opinions and experiences
- reflect staff values and motivations
- reinforce the vital contribution of staff to creating a listening and learning organisation
- relate to staff understanding of how we will achieve our ambition to develop and deliver a person-centred health and care system that reduces health inequalities and improves health and wellbeing for all citizens across Fife

2. There is a risk that operating under restrictions including social distancing and working from home through subsequent waves of the pandemic whilst trying to recover / maintain services and manage increased public need, expectations and tensions, may result in

- sub optimal working relationships
- staff feeling isolated
- reduced staff resilience
- increased staff absence
- impact on safety and quality of patient care and services

3. There is a risk that at a time of significant pace and scale of change, we are unable to meet our obligations in relation to required staff training and development, resulting in:

- staff feeling unsupported and vulnerable due to not having the correct competencies
- reduced staff resilience
- reduced job satisfaction
- negative impacts on role performance and the safety and quality of patient care and services
- reputational damage
- impacts on retention and recruitment rates

STRATEGIC PRIORITY:To Deliver Value and Sustainability

1.There is a risk that the funding required to deliver the current and anticipated future service models, particularly in the context of the EU exit and the COVID - 19 pandemic, and associated supply chain issues and increased prices, will not match costs incurred, which may result in an inability to maintain and develop services and meet legislative requirements.

2.There is a risk that failure to implement, monitor and review an effective financial planning, management and performance framework, including fully identifying the level of savings required to achieve recurring financial balance, may result in the Board being unable to deliver on its required financial targets.

3.There is a risk that failure to assess our property and assets, and secure resources to support improvements to the condition, capacity and resilience of the estate and infrastructure may:

- affect compliance with statutory obligations in relation to environmental & sustainability legislation
- limit our ability to redesign and accommodate reconfigured services and different models of care to meet clinical demand
- impede delivery of the Population Health and Wellbeing Strategy

NHS Fife DRAFT

Meeting:	**Audit & Risk Committee**
Meeting date:	**18 May 2022**
Title:	**Risk Management Improvement Programme Update**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Report Author:	**Pauline Cumming, Risk Manager**

1 Purpose

This is presented to the Audit & Risk Committee for:

- Assurance

This report relates to a:

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

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This paper provides an update on the progress made since the risk management improvement programme was approved by the NHS Fife Board in March 2022; and outlines developments in key components of the refreshed framework.

2.2 Background

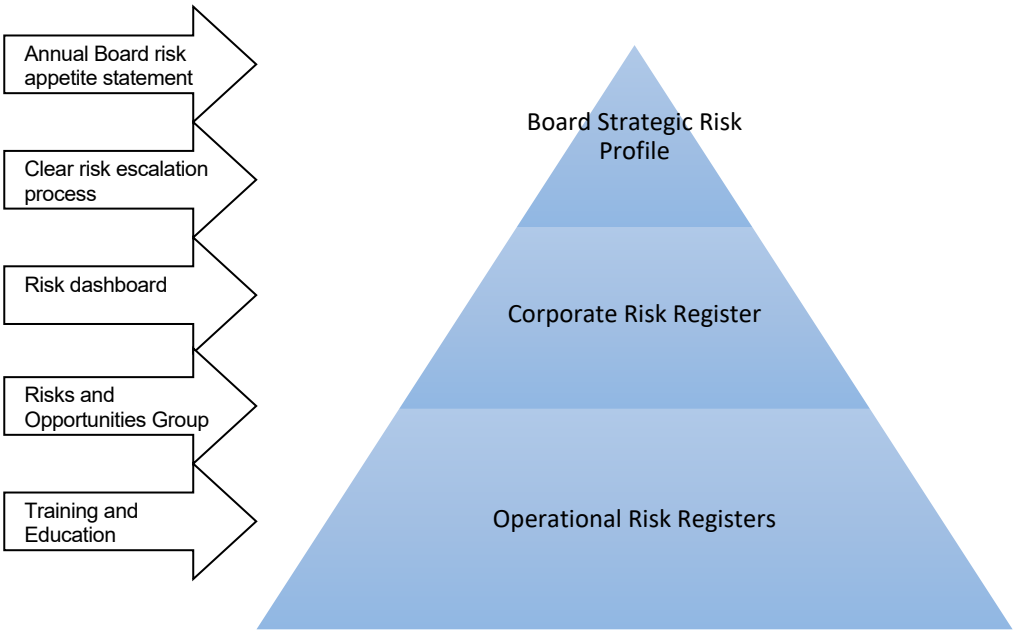
NHS Fife is committed to delivering this risk management improvement programme.

2.3 Assessment

Strategic and operational risks are an inherent part of healthcare delivery. An effective risk management structure and approach are paramount in supporting the organisation to achieve its strategic priorities. The objective is to deliver:

- A structured approach where risks are reviewed, addressed and controlled through governance structures of the Board
- Alignment of the organisational risk profile to the strategic planning agenda
- Promotion of a just culture to encourage the proactive identification and mitigation of risks from ward to Board
- Development of an annual Board risk appetite statement; stating the nature/ level of risks to be accepted/tolerated and the balance of risk versus reward

As previously reported, the current Risk Management Framework will be replaced with the following structure:



A summary of progress on the Risk Management Improvement Programme is provided below:

Board Strategic Risk Profile

Initial feedback has indicated the requirement to include risks related to the following:

i. environmental sustainability, specifically climate change

ii. health inequalities

The Director of Property and Asset Management and the Director of Public Health are working to develop the respective risks.

Engagement with Senior Leadership Teams

It is recognised that to achieve consistent and effective application of risk management, it must be embedded into all core processes, and form part of Business as Usual (BAU). Risk Management, when deployed effectively, should add value by being integral to daily work and support activities rather than be seen as a separate, self-contained process.

As previously reported to the Committee, to ensure that the refreshed framework achieves this goal, it was agreed that there should be engagement with Senior Leadership Teams (SLT) to:

- set in context the Framework refresh and discuss the proposed way forward;
- outline the plans to improve the effectiveness of our risk management arrangements;
- encourage teams to reflect on their risks and consider if these reflect their risk landscape

The methods of engagement are:

- meetings with SLTs via MS TEAMs
- a FORMS Survey

Engagement sessions have been held during April and May 2022. See Appendix 1. The FORMS Survey is open until 09/05/22.

The following broad themes have emerged from the sessions:

- **Timeliness of Framework refresh** in the aftermath of the past 2 years of the pandemic
- **Transition from BAF to Corporate Risk Register** - welcomed to simplify, ease and increase the visibility of risk reporting
- **Importance of Context** - risks should be set against our strategic priorities and objectives
- **Operational Focus** - need to prioritise risk as part of BAU and effective management
- **Risk Coverage** - consider if this reflect the risk landscape i.e. priorities and link to SPRA
- **Risk versus Issue** - recognising the difference, and how to address both
- **Retention of Risks** - necessary to explore factors underlying reluctance in places to close
- **Risk Appetite** - understanding the concept and how to use it in day to day work
- **Risk Categorisation** - streamlining will make it easier to identify and report consistently
  Risk Control & Containment - need to recognise importance of consensus on risks
- **Risk Dashboard** - simple visual way to present key risk metrics and performance
- **Board SBAR Template** - could it be modified to ask about risk and the subject of report?
- **DATIX Risk Register Module** - a more user friendly system is required
- **Risk Description** - introduce a form of words to help staff to clearly articulate a risk
- **Risk Assessment** - collaboration and consensus important when calibrating risks
- **Risks & Opportunities Group** - the group will provide dedicated leadership and focus

Appendix 2 contains a more detailed summary and staff comments.

FORMS Survey

A questionnaire was issued to EDG members to complete on behalf of their SLTs. Questions cover the focus of team discussions about risk, their use of risk information e.g.to inform decision making or plan services, and the support that teams need to effectively manage risk including education and training. Feedback will be used to develop an effective and visible framework that connects with and is used by staff from ward to board.

Responses to date align with feedback from the engagement sessions, indicating .that teams use risk management information to improve patient safety, prioritise the use of resources, support business cases and plan services.

The most popular topics for education and training are risk appetite, risk methods such as failure modes and effects analysis (FMEA), and risk reporting and assurance.

In response to the question 'What would help you manage risk more effectively in your area? All respondents selected a risk dashboard, and a majority would value a group such as the Risks & Opportunities Group cited above. When the survey is concluded, responses will be analysed and actions taken forward through the improvement programme.

Corporate Risk Register (CRR)

A Corporate Risk Register (CRR) contains the highest scoring risks from across the organisation that have the potential to affect the whole organisation, or operational risks which have been escalated i.e. can no longer be managed by a service or require senior ownership and support to mitigate. It has been agreed that register will comprise risks under the following categories:

1. Clinical Quality and Safety
2. Property and Infrastructure (including Digital and Information)
3. Workforce
4. Finance

At the last meeting of the Committee on 17 March 2022, we committed to provide indicative risks for potential inclusion in the CRR. The process to identify risks has been iterative and involved EDG, the governance committees, SLTs, reviews of existing risks, and identification of new risks.

Table 1 provides high level detail of areas of risk to be considered for inclusion.

Table 1

CLINICAL QUALITY & SAFETY	WORKFORCE
• Quality & Safety • Cancer Waiting Times • Coronavirus Disease 2019 (COVID-19) Pandemic • Public Health Oversight of COVID-19 in Care Homes • Psychiatric Assessment & Care for Children & Young People • Unscheduled Care • Waiting Times & Referral to Treatment (RTT) • Patient Relations - National Targets • Public Protection • Reputation & Regulatory Compliance	• Staff Governance -Sickness Absence • Nursing Workforce* • Midwifery Workforce* • Allied Health Professional (AHP) Workforce* • Medical Workforce* (*have impact on clinical quality & safety)
PROPERTY & INFRASTRUCTURE (incl Digital & Information)	**FINANCE**
• Prioritisation & Management of Capital funding to deliver the Property & Asset Management Strategy (PAMS) • Emergency Evacuation, VHK Phase 2 Tower Block • Cyber Resilience	• Financial Planning, Management and Performance (Short - medium term) • Prescribing & Medicines Management - Prescribing Budget

The proposed risks will initially be presented to EDG for consideration prior to wider consultation.

Risk Dashboard

Effective risk management is critical to organisational performance. The review of the IPQR, determined that a risk component should be developed for inclusion. The key areas for development are: (1) risk dashboard, (2) narrative for risk component and (3) committee links.

The purpose of the dashboard is to enable oversight of the risk level of corporate risks, provide assurance that adequate controls are in place to proactively manage risks, align to improvement actions contained within IPQR and integrate with Key Performance Indicators (KPIs) and Quality Performance Indicators (QPIs).

The dashboard will provide a simple, visual high level overview for assurance, weave risk management into business as usual (BAU), and allow for regular scrutiny of corporate risks. The risks will be captured under the risk categories mentioned above. It is proposed that the risk content in the IPQR will be presented as a dashboard at the start of the IPQR supported by a heat map. A dashboard mock up is shown below in Table 2.

Table 2

Category	Risk ID	Risk Title	Initial Risk Level	Previous Month Risk Level	Current Risk Level	Risk Trend	Target Risk Level	Assurance Committee	Linked KPI/QPI
Clinical Quality and Safety	2297	Cancer Waiting Times Access Standards	15	15	15	⟺	12	CGC	Cancer 62-Day RTT
Workforce	2214	Nursing and Midwifery Staffing	20	20	20	⟺	9	SGC	Sickness Absence (TBC)

As the Corporate Risk Register is still under development, further work is required before it can be included in the IPQR.

Narrative for Risk

It is necessary to provide supporting but succinct high level narrative within the respective assessment sections of the IPQR. Several options were considered;the IPQR Review Group agreed that the narrative should be woven into the respective components of the IPQR and this would be signed off by the respective director.

Committee Links

Each risk category will be aligned to a governance committee; this will be noted on the risk register and referenced in the risk content of the IPQR. Some risks may need to be assigned to more than one committee. The escalation process for risk which is under development will include the requirement to have Director sign off for any risks escalating or de-escalating from the CRR. In addition, when risks are escalated to CRR, the Director will recommend the committee to which the risk should be assigned.

Risk Appetite

The development of the Board risk appetite statement will be taken forward in consultation with EDG and the Board during May and June 2022.

Key considerations will include the following:

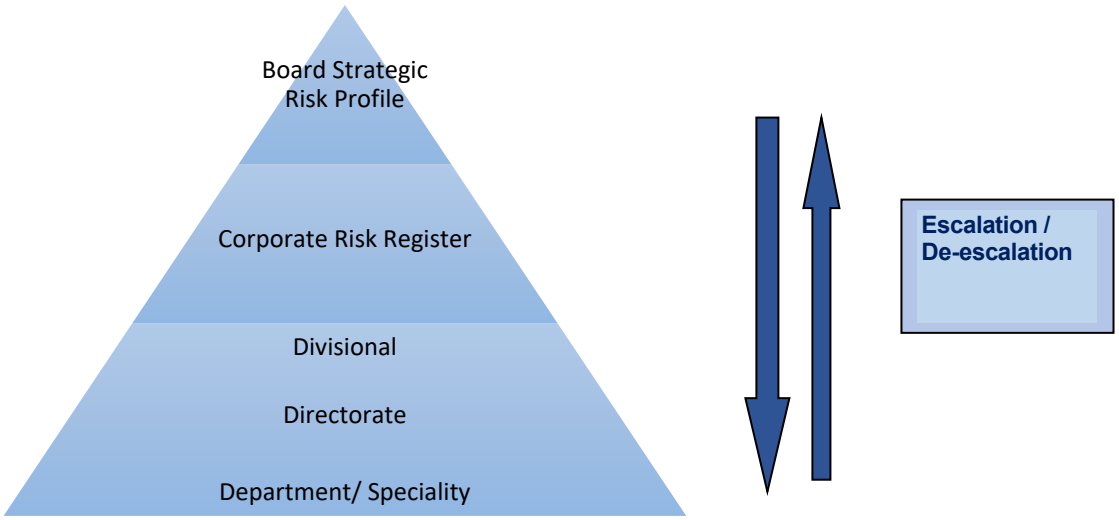
- What is our learning from experience during the past 2 years?
- What have been the key risks and opportunities over this period? Will they continue to present in the future?
- Are there additional risks we are willing to take as we consider the development of the new strategy?

Risk Architecture

Defining a consistent approach to how and where risk information is communicated is essential to creating a positive risk culture and to ensuring effective organisational risk management. Risks, once identified, are captured on risk registers.

Overall there will be five levels of risk register with an escalation route for risks that cannot be fully mitigated at the Department / Speciality level. The proposed hierarchy is outlined below:

Risk Register Hierarchy



Risk Escalation

All staff have a responsibility for identifying risk. To ensure that risks are managed effectively, they must be escalated to the appropriate levels in the organisation and to external stakeholders where necessary in accordance with the hierarchy and line management arrangements.

Directors will have overall responsibility for establishing effective risk escalation supported by:

- Risk reviews
- Governance group risk reviews; and
- Risk Leads who chair the Management Groups and provide advice on risk under the following broad risk categories :Clinical Quality and Safety, Property and Infrastructure (including Digital and Information), Workforce and Finance
- EDG will review risks and escalate any significant risks to the Board

The following key questions should be asked when deciding whether to escalate a risk:

- Does the risk present a significant threat to the achievement of organisational or national objectives and/or standards?
- Does the risk have a widespread impact beyond a local area, e.g. does it affect multiple Departments or Directorates or does it have dependencies on multiple Departments or Directorates to mitigate?
- Does the risk present a significant cost beyond the scope of the budget holder?
- Is the risk score assessed to be intolerable or outwit the organisation's risk appetite?

The risk score and organisational risk appetite should be key considerations when recommending risks for escalation, as well as the following:

All Staff
- Can the risk be managed as part of BAU?
- What is the impact and likelihood of the risk?
- Escalate to line manager

Line Manager, Risk Owners, Portfolio, Project and Programme leads

- Can this risk be managed locally?
- Is the risk on the register?
- Who is the risk owner? Other directorate?
- Escalate to appropriate Directorate / Service senior manager
- Escalate to Executive risk owner

EDG

- Discuss risk at EDG and / or proposed Risk & Opportunities Group
- Request an action plan is developed
- Manage through risk register and Directorate or equivalent Management Group

Executive Risk Owner

- Can this risk be managed within directorate / service?
- Does the risk impact on the wider organisation?
- Share with EDG

Strategic Risk Profile
This contains the risks to achieving our strategic priorities that may impact the longer term ambitions of the organisation. Risks will not be escalated/de-escalated from lower level risk registers to the Strategic Risk Profile. Risk identification for the Profile will be facilitated through twice yearly review and horizon scanning sessions by EDG, or as otherwise required.

Corporate Risk Register (CRR)
This contains the highest scoring risks from across the organisation that have the potential to affect the whole organisation, or operational risks which have been escalated i.e. can no longer be managed by a service or require senior ownership and support to mitigate.

Escalation
Any risk to be considered for escalation to the CRR must be submitted by the responsible executive director to EDG for discussion and decision. The decision to add a risk to the CRR will be communicated to the Risk Manager who will arrange for entry in Datix.

De - escalation
EDG will communicate decisions to de-escalate a risk from the CRR to the Risk Manager for action; such decisions will indicate the rationale for de-escalation and the register on which the risk is to be placed or other action.

Divisional / Service Risk Registers
These registers contain the high level or cross cutting risks that present a significant short-medium term threat to multiple directorates / services.

Escalation
Any risk to be considered for escalation to a Divisional Risk Register (Acute Services Division (ASD)), or Service Risk Register (Health & Social Care Partnership (HSCP)) must be submitted

by the responsible senior manager to the Director of Acute Services / HSCP Head of Service for discussion and decision at the respective SLT.

The SLT will communicate decisions to add a risk to a DRR to the responsible senior manager who will arrange for entry in Datix.

De - escalation
SLTs will communicate decisions to de-escalate a risk from the Divisional / Service Risk Registers to the responsible manager for action; such decisions will indicate the rationale for de-escalation, and the register on which the risk is to be placed, or other action.

Directorate Risk Registers
Each Directorate or Service will hold a risk register that contains the most significant risks from its component Departments / Specialties.

Escalation
Any risk to be considered for escalation to a Directorate / Service Risk register must be submitted by the manager of the individual Department / Specialty to the General Manager (ASD) / Senior Manager (HSCP) for discussion and decision at the management team meeting. Decisions to add a risk to the register will be communicated to the responsible manager who will arrange for entry in Datix.

De - escalation
Decisions to de-escalate a risk from a Directorate / Service Risk Register will be communicated to the responsible manager for action; such decisions will indicate the rationale for de-escalation, and the register on which the risk is to be placed, or other action.

Departments and Specialty Risk Register
Each department and specialty will hold a risk register for its area; these form the foundation level of the risk register hierarchy.

Risks & Opportunities Group
As previously reported, a Risks and Opportunities Group is to be established. This will be chaired by the Associate Director of Quality and Clinical Governance, with membership likely to include the Risk Manager and Associate and Deputy Directors. Governance lines are to be confirmed but the group is likely to report into EDG. Draft Terms of Reference are being developed and it is anticipated that the group will meet for the first time in August 2022.

2.3.1 Quality/ Patient Care

Elevating the risk management framework in NHS Fife will support the further progression of the quality and patient safety ambitions through improved operational governance and strategic planning.

2.3.2 Workforce

It is necessary to ensure that the appropriate workforce is in place to support the changes to the framework including updates to the Datix system. Arrangements for this are currently being explored.

The Risk Management Framework the will include a training needs analysis to inform the design of an effective training and education strategy to support implementation.

2.3.3 Financial

Once the workforce arrangements to support this change are confirmed, an update to summarise any financial impact will be provided.

2.3.4 Risk Assessment/Management

This paper summarises progress in the development of NHS Fife's refreshed risk management framework and culture to support delivery of the strategic priorities.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment has not been conducted.

2.3.6 Other impact

None

2.3.7 Communication, involvement, engagement and consultation

This paper has been developed in discussion with key stakeholders and following.

2.3.8 Route to the Meeting

Earlier versions of this paper were considered and supported by:

- EDG, 17 February 2022
- Audit & Risk Committee, 17 March 2022
- Fife NHS Board, 29 March 2022
- An earlier version of this paper is on the agenda of the Clinical Governance, Finance, Performance & Resources, Staff Governance and Population Health and Wellbeing Committees being held during April and May 2022

2.4 Recommendation

The Committee is asked to take assurance from this update on the programme to refresh and improve the Risk Management Framework.

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

Appendix 1

TIMETABLE OF RISK MANAGEMENT FRAMEWORK REFRESH SENIOR LEADERSHIP (SLT) ENGAGEMENT MEETINGS

Department	Lead	Date
Public Health	Dr Joy Tomlinson	6 April 2022
Pharmacy	Ben Hannan	13 April 2022
Research & Development	Frances Quirk	20 April 2022
Finance	Margo McGurk	25 April 2022
Workforce	Linda Douglas	25 April 2022
Property & Asset Management	Neil McCormick	27April 2022
Nursing	Janette Owens	29 April 2022
Digital & Information	Alistair Graham	3 May 2022
Acute Services	Claire Dobson	19 May 2022 (deferred from 5 May due to system pressures)
Medicine	Dr Chris McKenna	5 May 2022
HSCP	Nicky Connor	TBC

Appendix 2

Themes identified from SLT Engagement Sessions	
Timeliness of Framework Refresh	There has been a positive response to the sessions, with colleagues welcoming the opportunity for discussion. It is clear that refreshing the Framework now is timely, as we emerge from the recent phase of the pandemic and from more than 2 years when there was a degree of 'fire fighting'. Teams have indicated they are now taking stock, revising their portfolios and moving into a period of focussed planning.
Transition from Board Assurance Framework (BAF) to Corporate Risk Register (CRR)	The plan to transition from the BAF to a CRR has been well received, with a sense that the CRR will be simpler, easier to use, and enable more focussed reporting and visible assurance. Discussion around the CRR register content was wide ranging, including should programme and project risks be included? It was felt this should be considered if these relate to delivery of key programmes. Risks for possible inclusion on the register are identified later in this paper.
Importance of Context	Teams recognise we must identify risks within the context of the team, specialty, department and the overall organisation, as well as the internal and external drivers that could create risk. Risks should be set against what we are trying to achieve as an organisation - our strategic priorities and corporate objectives. It is therefore important to ensure there is a common understanding of what those objectives mean at every level to ensure that risk identification is not arbitrary or based on an inconsistent set of assumptions.
Operational Focus	While it is acknowledged that that risk management is 'everybody's business', i.e. not an adjunct, it is sometimes still "fitted in". Teams recognise the need to: • revise operational meeting structures to include and prioritise risk management on agenda; • make risk integral to BAU by having planned, focused, and active discussions about risks, "rather than a 'box tick 'exercise". "PMO approach makes a difference" ; • rationalise risk registers to simplify and add focus; • maintain managerial oversight, consider 'granularity' of risks including scoring, improvement or deterioration towards target, ownership, coverage, need for escalation
Risk Coverage	Colleagues felt their risk coverage was 'patchy' in places; the need to carry out a wholesale review of

	the risk landscape and to assess if risks reflect this was seen as important, specifically: Do the risks reflect priorities? i.e. • link to SPRA • critical operational risks
Risk versus Issue	This came up frequently. How dynamic is our risk management? How alert are we to identifying when a risk has become an issue? How do we move from that more nimbly?
Retention of Risks	The reluctance to close risks was frequently raised. It is thought this may be due to factors including fear- 'what if…' culture, or staff turnover and the need to maintain risk visibility.
Risk Appetite	It was recognised that sometimes we must take risk to exploit opportunities and achieve better outcomes. For innovation to flourish, we should be open to 'doing things differently'. It is felt that the Population Health and Wellbeing Strategy (PHWB) may increase our appetite to take more risk and encourage creativity. Some questioned the importance of risk appetite. Don't we tend to default to lowest appetite? Others felt it is fundamental and should influence our planning and decision making. An example related to statutory compliance. If our appetite for this is low, we may need to increase our appetite for doing things that are radical, costly and involve short to medium term logistical challenges, e.g. replacing buildings. It is recognised that 'unlocking traditional reticence' can be uncomfortable and often requires difficult decisions and pragmatism.
Risk Categorisation	Teams welcomed the intention to streamline categories (risk types and subtypes) as this will make it easier to identify and report more consistently on risks.
Risk Control and Containment	Teams welcomed the intention to establish a clear mechanism for risk escalation. They feel it will also be important to reinforce that the first step should be to discuss a perceived risk with colleagues. A risk should not be placed on a register until consensus is reached through line management structures. Comments: 'We sometimes lose sight of what is important and what should be on the register. Before escalation, there need to be quality conversations." "How do we make sensible decisions to have a smaller number of important risks?" "Can we link risks in order to identify if there are common themes to ensure people are aware of

	risks that have already been identified and are on a register? “We need a coherent strategy, rather than inventing more registers e.g. Brexit, COVID, Ukraine.”
Dashboard	There is widespread support for the decision to add a simple, visual summary of corporate risks that links to the IPQR content and shows improvement or deterioration in the risk profile over time.
Board SBAR Template	It was noted that the template currently does not include explicit questions such as: Does this issue present a risk? Or Is there a specific risk related to this issue? Should we modify the template?
DATIX Risk Register Module	The module is not considered user friendly, rather clunky” and can be a barrier to effective risk management. As previously reported to the committee, and as stated in the SPRA, the intention is to upgrade our system; a business case will be taken forward in the next quarter.
Risk Description	There is support to use a standard structure for describing a risk in a way to effectively understand, manage and mitigate it. The description should contain three key elements: the risk, the cause, and the consequence. “There is a risk that If [insert cause here], [a certain event may happen], resulting in [describe impact if it manifests. This approach is notably used by the PMO. “The way the PMO set outs risks makes a difference, can we make this the standard?”
Risk Assessment	Assessment or scoring of risks was frequently raised. There is cognisance of the importance of determining the likelihood and consequence of a risk using standardised criteria to assign a score, and having related discussions to ensure risks are properly calibrated. This is important as these factors will allow us to understand and prioritise which risks to mitigate.
Risks & Opportunities Group	Setting up this group was enthusiastically received; many wish to join and feel it will: • provide a forum in which to have focused conversations about risk and opportunity; • consider risk in wider context including cross cutting risks; • help to foster a culture and climate in which candid, quality conversations can take place

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**18 May 2022**
Title:	**Update on the NHS Fife Board Assurance Framework**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Report Author:	**Pauline Cumming, Risk Manager**

1 Purpose

This is presented to the Audit & Risk Committee for:

- Assurance

This report relates to a:

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

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Board Assurance Framework (BAF) identifies risks to the delivery of NHS Fife's strategic objectives and priorities, including the NHS Fife Strategic Framework, the NHS Fife Clinical Strategy and the Fife Health & Social Care Integration Strategic Plan. The BAF integrates information on strategic risks, related operational risks, controls, assurances, mitigating actions and an assessment of current performance. This is an update to the Committee since the last report on 17 March 2022.

The previous report to the Committee summarised the updates on the BAF components that were to be reported to the governance committees in March 2022. Similarly, this report summarises the updates being reported to the committees during the April / May 2022 meeting cycle.

2.2 Background

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

2.3 Assessment

The current BAF risk levels and ratings are summarised in Table 1.

Table 1 - Risk Level and Rating over time

Risk ID	Risk Title	Initial Risk Level & Rating LxC	Likelihood (L)	Consequence (C)	Current Level & Rating Aug/ Sep 2021	Current Level & Rating Oct / Nov 2021	Current Level & Rating Jan / Feb 2022	Current Level & Rating Mar /Apr 2022
1671	**Financial Sustainability**	High 16	Likely 4	Major 4	16 (4x 4) High	16 (4x 4) High	9 (3x3) Mod	9 (3x3) Mod
1672	**Environmental Sustainability**	High 20	Likely 4	Extreme 5	20 (4x 5) High	20 (4x 5) High	20 (4x5) High	20 (4x5) High
1673	**Workforce Sustainability**	High 20	Almost certain 5	Major 4	16 (4x 4) High	16 (4x 4) High	16 (4x4) High	16 (4x4) High
1674	**Quality & Safety**	High 20	Likely 4	Extreme 5	15 (3x 5) High	15 (3x 5) High	15 (3x5) High	15 (3x5) High
1675	**Strategic Planning**	High 16	Likely 4	Major 4	16 (4 x 4) High	16 (4 x 4) High	12 (3x4) Mod	12 (3x4) Mod
1676	**Integration Joint Board**	High 16	Likely 4	Major 4	12 (3x4)) Mod	12 (3x4)) Mod	12 (3x4) Mod	12 (3x4) Mod
1677	**Digital and Information**	High 20	Likely 4	Extreme 5	15 (3x5) High	15 (3x5) High	15 (3x5) High	15 (3x5) High

Key points from updates to be provided to Committees

The BAF components are provided separately in Appendices 1-7.

Financial Sustainability BAF

The Director of Finance & Strategy reported on the financial sustainability component of the BAF to the Finance, Performance & Resources Committee (F, P&RC) on 15 March 2022, and will report on the current position to the Committee on 10 May 2022. Assurance will be provided to the committee that there is mitigation in place for risks associated with financial sustainability.

Since the last update, the BAF current risk level has been reviewed and it remains at **moderate.**

The score reflects the current position where, following the Quarter 3 reporting submission, and a follow up meeting with Scottish Government (SG), non-repayable funding support to allow the Board to break even this financial year has been received. In addition, full funding of COVID-19 costs has been received for this financial year. Although SG support for our financial gap is confirmed, our BAF risk remains at a moderate risk level reflecting the underlying financial gap the board has going into the financial year 2022/23.

In relation to financial sustainability, the organisation has launched a Financial Improvement / Sustainability (FIS) Programme. This programme will report through the Portfolio Board and aligns firmly with the strategic priority to "Drive Value and Sustainability". This is a key enabling programme to support the delivery of our 2022/23 corporate objectives and longer-term strategy development.

There are no changes to report in relation to linked risks.

Environmental Sustainability BAF

The Director of Property & Asset Management reported on the Environmental Sustainability component of the BAF to the Finance, Performance and Resource Committee (F, P & R C) on 15 March 2022 and will report on the current position to the Committee on 10 May 2022. Assurance will be provided to the committee that there is mitigation in place for risks associated with environmental sustainability.

Since the last update, the BAF current risk level has been reviewed and it remains at **high**.

The Internal Audit Internal Control Evaluation report (ICE B08/22) recommended that the risks to the delivery of the Property & Asset Management Strategy (PAMS) and the Capital Programme would benefit from having a BAF or operational risk to aid and support the delivery of the future Health and Wellbeing Strategy.

The Director of Property & Asset Management has discussed the recommendation with the NHS Fife Risk Manager and agreed to develop the risks as recommended. These have been drafted and are being consulted upon. The proposed risks will be presented for consideration to EDG in the first instance and a decision taken on the risk register on which they should be placed.

There are no changes to report in relation to linked risks.

Workforce Sustainability BAF

The Director of Workforce reported on the Workforce Sustainability component of the BAF to the Staff Governance (SG) Committee on 3 March 2022 and will report on the current position to the Committee on 12 May 2022. Assurance will be provided to the committee that there is mitigation in place for risks associated with workforce sustainability.

Since the last update, the BAF current risk level has been reviewed and it remains at **high**.

There have been minor changes to the BAF content in relation to controls and mitigations associated with workforce capacity. For ease, these are highlighted in Appendix 3.

There are no changes to report in relation to linked risks.

Quality & Safety BAF

The Medical Director reported on the Quality and Safety component of the BAF to the Clinical Governance Committee (CGC) on 10 March and on 29 April 2022. The committee was asked to take assurance that there is mitigation in place for risks associated with quality and safety.

At the CGC on 10 March, members approved the revised BAF risk description which is intended to better capture the risk to safe, quality and effective care. The new wording is.

“There is a risk that due to failure of clinical governance, performance and management systems (including information & information systems), NHS Fife may be unable to provide safe, effective, person centred care. Additionally, there is a risk that the effects of the COVID - 19 pandemic, including restricted capacity, reduced elective & non urgent services, and workforce pressures, will impact on the quality & safety of patient care and service delivery”.

This current iteration of the BAF reflects the updated description. See Appendix 4.

Linked Risk Changes

Since the last report to the committee, there have been several changes in linked risks, as summarised below.

Risks unlinked from the BAF

Risk 43: Vascular Access for Haematology/Oncology: Following discussion at the CGC in March 2022, and subsequently with the Director of Acute Services, this risk has been unlinked from the BAF. Management and oversight of the risk will be provided through the Acute Services Division governance structures.

Risk 1365: Cancer Waiting Times Access Standards: As previously reported, this risk had materialised, therefore it has been closed and unlinked from the BAF.

Risks newly linked to the BAF

- Risk 2297: Cancer Waiting Times Access Standards: This new risk associated with performance against the Cancer Waiting Times 62-day target replaces Risk 1365 above.

- Risk 2214: Nursing and Midwifery Staffing Levels: At the last time of reporting to the committee, this risk was linked to the Workforce Sustainability BAF. Following discussion at CGC in March 2022, in view of the risk to patient safety, it was agreed the risk should also be linked to the Quality & Safety BAF.

- Risk 1904: Coronavirus Disease 2019 (COVID -19): Following discussion at the CGC in March 2022 and subsequently with the Director of Public Health, it was agreed that this risk should be linked to the Quality & Safety BAF.

- Risk 1907: Public Health Oversight of COVID -19 in Care Homes: As above, following discussion at the CGC in March 2022 and subsequently with the Director of Public Health, it was agreed that this risk should be linked to the Quality & Safety BAF.

The CGC previously considered recommendations on risks that should be linked to the Quality & Safety BAF, including a risk around Unscheduled Care. A risk has been drafted and is being consulted upon, in the first instance through discussions with Senior Leadership Teams. In light of the decision to replace the BAF with a corporate risk register, the risk when agreed, will be considered for inclusion on that register.

Since the last report to the committee, the BAF risk level has been reviewed; the current risk level remains at **high**.

Strategic Planning BAF

The Director of Finance & Strategy reported on the Strategic Planning component of the BAF to the F, P&R C on 15 March 2022 and will report on the current position to the Committee on 10 May 2022. Assurance will be provided to the committee that there is mitigation in place for risks associated with strategic planning.

Since the last report to this committee, the BAF risk level has been reviewed; the current risk level remains at **moderate**.

It is expected, that as we progress through the milestones, plan activity in terms of the new strategy development and, as the recently recruited additional PMO capacity embeds, the risk level should reduce.

Of note, the updated version of this component of the BAF describes how:

- The Strategic Priorities form the focus of strategic planning direction going forward for NHS Fife.

- Work is progressing in the development of the Population Health and Wellbeing Strategy with revised timescales. The analysis from the public and staff survey will inform the production of a broader engagement proposal for consideration at the Portfolio Board and the Public Health and Wellbeing Committee in May 2022. Engagement planning is ongoing and will continue over the next few months. A Milestone plan to December 2022 has been produced.

- The process for SPRA for 2022/23 has concluded with the production of a transitional organisational 1-year plan and financial plan. Corporate objectives are due to be signed off by the Board in May 2022. The actions from SPRA will form the basis of the Annual Delivery Plan 2022/23.

- An update on RMP4 was submitted at the end of April for the year 2021/22. Any undelivered actions will be carried over to the Annual Delivery Plan 22/23.

The committee will be asked to note the current risk level against progress made in the development of the Population Health and Wellbeing Strategy and the robust planning through SPRA.

Integration Joint Board (IJB) BAF

The Director of Health and Social Care provides the following update to the committee.

The review of the Fife Integration Scheme concluded through NHS Fife and Fife Council governance structures in September 2021. Thereafter it was submitted to Scottish Government for approval. Approval was granted by Scottish Ministers in March 2022.

Following the approval of the revised Scheme, work is required to ensure governance arrangements for NHS Fife, Fife Council and the IJB clearly reflect the position set out in the Integration Scheme. Work has begun on a review of the IJB Governance Manual and a review of risk management arrangements within NHS Fife and the IJB is being progressed.

The BAF current risk level remains at **moderate.** Following Ministerial approval of the Scheme, the risk level will be revised.

Regular updates continue to be provided to the IJB and its Governance Committees, SLT and EDG.

Digital and Information BAF

The Medical Director reported on the Digital and Information component of the BAF to the CGC on 10 March 2022, and 29 April 2022. The committee was asked to take assurance

that there is mitigation in place for risks associated with digital and information.

Linked Risk Updates

Risk 1338 - NHS Fife at risk of increased cyber attack: Since the last report to the committee, this risk which was formerly assessed as a high level risk with a rating of 20 - Likelihood (5) almost certain x Consequence (4) major, has been raised to a high 25. This reflects an increase in the consequence rating to 5 - extreme - in accordance with the risk alert recently issued by the National Cyber Security Centre (NCSC). The elevation in consequence is due to geo-political activities related to the Russia / Ukraine conflict and an associated heightened risk of malicious cyber incidents.

The committee was assured that enhanced mitigations have been introduced at local and national levels; these include patching, verification of access controls, and reviews of resilience, communications, supply chain awareness, and monitoring of legacy systems.

Since the last update, the BAF current risk level has been reviewed and it remains at remains at **high**.

Next Steps

As previously reported, we are working towards making the transition from the BAF to a Corporate Risk Register (CRR).The work to identify the risks that will form the refreshed corporate risk register will be concluded by 31 May 2022.

As previously reported, risks will be categorised under the headings:

- Clinical Quality & Safety
- Workforce
- Property & Infrastructure (including Digital & Information D&I)
- Finance

Each risk category will be assigned to a governance committee; this will be noted on the risk register. Some risks may need to be assigned to more than one committee.

The proposed assigned risks will be presented to the respective governance committees in July 2022 for approval.

To ensure there is continuity in the transition process, it is proposed that the final reports on the components of the BAF will be submitted to the governance committees in July 2022.

It is proposed that formal reporting on corporate risks to the governance committees will commence during the September 2022 meeting cycle.

2.3.1 Quality/ Patient Care

Risks to quality and safety are detailed in Appendix 4.

2.3.2 Workforce

Risks to workforce sustainability are detailed in Appendix 3.

2.3.3 Financial

Risks to financial sustainability are detailed in Appendix 1.

2.3.4 Risk Assessment/Management

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

2.3.5 Equality and Diversity, including health inequalities

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

2.3.6 Other impact

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

2.3.7 Communication, involvement, engagement and consultation

This report reflects the engagement of Executive Directors, Non Executives, the Associate Director of Quality and Clinical Governance, and other key stakeholders.

2.3.8 Route to the Meeting

Via Margo McGurk, Director of Finance and Strategy on 9 May 2022

2.4 Recommendation

- Assurance

3 List of appendices

The following appendices are included with this report:

- Appendix 1, NHS Fife BAF Financial Sustainability for FP& RC on 100522
- Appendix 2, NHS Fife BAF Environmental Sustainability for FP& RC on 100522
- Appendix 3, NHS Fife BAF Workforce Sustainability for SGC on 120522
- Appendix 4, NHS Fife BAF Quality & Safety for CGC on 290422
- Appendix 5, NHS Fife BAF Strategic Planning for CGC on 100522
- Appendix 6, NHS Fife BAF Integration Joint Board (IJB) as at 160322
- Appendix 7, NHS Fife BAF Digital and Information for CGC on 290422

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

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Financial Sustainability																											
1671	Sustainable	30/03/2022	30 April 2022	There is a risk that the funding required to deliver the current and anticipated future service models, particularly in the context of the COVID 19 pandemic, will not match costs incurred. There is a risk that the organisation may not fully identify the level of savings required to achieve recurring financial balance. Thereafter there is a risk that failure to implement, monitor and review an effective financial planning, management and performance framework would result in the Board being unable to deliver on its required financial targets.	4 – Likely – Strong possibility this could occur	4 – Major	16	High Risk	3 – Possible – May occur occasionally – reasonable chance	3 – Moderate	9	Moderate Risk	SG have confirmed they will provide funding support to Breakeven in 2021/22 however a number of actions must be completed by the board including minimising the requirement for support as much as possible. Funding has been received from SG to enable to board to Breakeven at 31.03.2022 and the actions requested by SG have been completed. However underlying financial gap remains going into 2022/23	Margo McGurk Director of Finance and Strategy	Finance, Performance & Resources (F,P&R) Rona Laing	*Ongoing actions designed to mitigate the risk including:* 30 March 2022 Funding has been received from Scottish government to support Covid expenditure in 2021/2022 and to support the board deliver a break even position at the financial year end. Savings in excess of the original level of savings planned for 2021/22 have been achieved albeit a number on a non recurring basis. The actions requested by Scottish Government in November to support the provision of funding support are complete. The level of savings plans required to achieve recurring financial balance is reflected in the risk level remaining at moderate. 14 Feb 2022 We have submitted our Quarter 3 reporting to SG indicating our 21/22 Covid-19 funding requirements across HB retained and HSCP; and have signposted the level of financial support to deliver a break even RRL position for 21/22. Whilst formal funding notification has yet to be received, indications at our Q3 review meeting with SG suggest funding support, following our significant efforts reported each month, will be forthcoming. Hence the risk level is updated to moderate risk. 14 Jan 2022 Monthly reporting returns to SG indicate improvement in delivery of in year savings targets indicating the target will be achieved. Draft financial gap for 2022/23 and savings plans for 50% of the gap have been identified as per the instructions received from SG. Recruitment to PMO continues to enhance capacity within the team and the Portfolio board has been established including the Financial improvement and sustainability programme	Nil	1. Continue a relentless pursuit of all opportunities identified through the transformation programme in the context of sustainability & value. Responsible Person: Director of Finance / Director of Acute Services / Director of Health & Social Care Timescale: Ongoing 2. Continue to maintain an active overview of national funding streams to ensure all NHS Fife receives a share of all possible allocations. 3. Continue to scrutinise and review any potential financial flexibility. 4. Engage with H&SC / Council colleagues on the risk share methodology and in particular ensure that EDG, FP&R and the Board are appropriately advised on the options available to manage any overspend within the IJB prior to the application of the risk share arrangement Responsible Person: Director of Finance Timescale: Ongoing	1. Produce monthly reports capturing and monitoring progress against financial targets and efficiency savings for scrutiny by all responsible managers and those charged with governance and delivery. 2. Undertake regular monitoring of expenditure levels through managers, Executive Directors' Group (EDG), Finance, Performance & Resources (F,P&R) Committee and Board. As this will be done in parallel with the wider Integrated Performance Reporting approach, this will take cognisance of activity and operational performance against the financial performance.	1. Internal audit reviews on controls and process; including Departmental reviews. 2. External audit review of year end accounts and governance framework.	1. Enhanced reporting on various metrics in relation to supplementary staffing. 2. Confirmation via the Director of Health & Social Care on the social care forecasts and the likely outturn at year end.	SG has provided COVID 19 non recurring funding for finance year 2021/22 which includes funding required to support the board achieve a balanced position at 31.03.2022. SG has confirmed COVID-19 funding will be received in line with the LMP submissions. Current performance indicates the board is in line with the submission provided to SG at time of Quarter 2. This will be reviewed for Q3 before onward submission to SG Covid funding has been received following each of our quarterly returns in 2021/22; and we anticipate a further allocation following our Q3 return. Full funding is anticipated, although not yet confirmed. Whilst full Covid-19 funding was received for 2020/21 and we delivered a small underspend £0.340m subject to external audit review; funding for 2021/22 will be determined post formal quarter 1 review of Boards' financial performance.	3 – Possible – May occur occasionally – reasonable chance	3 – Moderate	9	Moderate Risk	Financial risks will always be prevalent within the NHS / public sector however it would be reasonable to aim for a position where these risks can be mitigated to an extent.

Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
522	Prescribing and Medicines Management - Prescribing Budget	Active Risk	High Risk	15	McKenna, Christopher

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
1357	Financial Planning, Management and Performance	Active Risk	Moderate	12	McGurk, Margo
1363	Health and Social Care Integration	Active Risk	Moderate	9	McGurk, Margo
1513	Financial and Economic impact of Brexit	Active Risk	Low Risk	6	McCormick, Neil
1846	Test and Protect/Covid Vaccination	Active Risk	Moderate	12	Connor, Nicky
1364	Efficiency Savings	Closed Risk	High Risk	16	McGurk, Margo
1784	Finance (Short Term/Immediate)	Closed Risk	Moderate	8	Connor, Nicky

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Environmental Sustainability																											
1672	Clinically Excellent, Sustainable	09/03/2022	31 March 2022	There is a risk that Environmental & Sustainability legislation is breached which impacts negatively on the safety and health of patients, staff and the public and the organisation's reputation.	4 – Likely – Strong possibility this could occur	5 - Extreme	20	1_HIGH	4 – Likely – Strong possibility this could occur	5 - Extreme	20	1_HIGH	Estates currently have significant high risks on the E&F risk register; until these have been eradicated this risk will remain. Action plans have been prepared and assuming capital is available these will be reduced in the near future.	Neil McCormick Director of Property & Asset Management	Finance, Performance & Resources (F,P&R). Rona Laing.	*Ongoing actions designed to mitigate the risk including:* 1. Operational Planned Preventative Maintenance (PPM) systems in place 2. Systems in place to comply with NHS Estates 3. Action plans have been prepared for the risks on the estates & facilities risk register. These are reviewed and updated at the monthly risk management meetings. The highest risks are prioritised and allocated the appropriate capital funding. 4. The SCART (Statutory Compliance Audit & Risk Tool) and EAMS (Estates Asset Management System) systems record and track estates & facilities compliance. 5. Sustainability Group manages environmental issues and Carbon Reduction Commitment(CRC) process is audited annually. 6. Externally appointed Authorising Engineers carry out audits for all of the major services i.e. water safety, electrical systems, pressure systems, decontamination and so on.	Nil	1. Capital funding is allocated depending on the E&F risks rating Responsible person: Director of Estates, Facilities & Capital Services Timescale: Ongoing as limited funding available 2. Increase number of site audits Responsible person: Estates Compliance Manager Timescale: Ongoing	1. Capital Investment delivered in line with budgets 2. Sustainability Group minutes. 3. Estates & Facilities risk registers. 4. SCART & EAMS. 5. Adverse Event reports..	1. Internal audits 2. External audits by Authorising Engineers 3. Peer reviews.	None.	High risks still exist until remedial works have been undertaken, but action plans and processes are in place to mitigate these risks.	1 – Remote – Can't believe this event would happen	5 - Extreme	5	3_LOW/	All estates & facilities risk can be eradicated with the appropriate resources but there will always be a potential for failure i.e. component failure or human error hence the target figure of 5..

Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
1007	Theatre Phase 2 Remedial work	Active Risk	High Risk	15	Cross, Murray
1252	Flexible PEX hoses in PHASE 3 VHK	Active Risk	High Risk	15	McCormick, Neil
1296	Emergency Evacuation, VHK Phase 2 Tower Block	Active Risk	High Risk	15	McCormick, Neil

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
1207	Water system Contamination STACH	Active Risk	Moderate Risk	10	McCormick, Neil
1275	South Labs Plantroom	Active Risk	Moderate Risk	8	Lowe, David
1306	Risk of pigeon guano on VHK Ph2 Tower Windows	Active Risk	Moderate Risk	12	Lowe, David
1316	Inadequate Compartmentation VHK Phase 1, Phase 2 floors B-1st	Active Risk	Moderate Risk	8	McCormick, Neil
1341	Oil Storage - Fuel Tanks - Central/NEF	Active Risk	Moderate Risk	10	Keatings, Gordon
1342	Oil Storage - Fuel Tanks - QMH/DWF	Active Risk	Moderate Risk	10	Wishart, James
735	Medical Equipment Register	Closed Risk	Moderate Risk	10	Lowe, David
749	836 - VHK Ph.2 Main Foul Drainage Tower Block	Closed Risk	High Risk	15	Lowe, David
1083	VHK CLO2 Generator (Legionella Control)	Closed Risk	High Risk	15	GRB
1312	Vertical Evacuation - VHK Phase 2 Tower Block	Closed Risk	Moderate Risk	10	Fairgrieve, Andrew
1314	Inadequate Compartmentation of Escape Stairs and Lift Enclosures	Closed Risk	Low Risk	6	Fairgrieve, Andrew
1315	Vertical Evacuation - VHK Phases 1 and 2 (excluding Tower Block)	Closed Risk	Moderate Risk	8	BAN
1335	FCON Fire alarm potential faiure	Closed Risk	High Risk	15	GRB
1352	Pinpoint malfunction	Closed Risk	High Risk	16	Pirie, Margaret
1384	Microbiologist Vacancy	Closed Risk	High Risk	20	JGARDN
1473	Stratheden Hospital Fire Alarm System	Closed Risk	High Risk	20	Keatings, Gordon

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Workforce Sustainability																											
1673	Exemplar Employer	11/03/2022	13 May 2022	There is a risk that failure to ensure the right composition of workforce, with the right skills and competencies will adversely affect the provision of services and quality patient care and impact on organisational capability to implement the new clinical and care models and service delivery set out in the Clinical Strategy and the future population Health & Wellbeing Strategy and the challenges and demands associated with the current COVID-19 pandemic.	5 – Almost Certain – Expected to occur frequently – more likely than not	4 – Major	20	1_HIGH	4 – Likely – Strong possibility this could occur	4 – Major	16	1_HIGH	Workforce failures may have consequences for patients' health outcomes. NHS Fife has an ageing workforce, with recruitment challenges in many disciplines. Failure to ensure the right composition of workforce with the right skills and competencies continues to give rise to a number of organisational risks including: reputational and financial risk; a potential adverse impact on the safety and quality of care provision; staff engagement, staff absence, staff attrition and morale. Failure may also adversely impact on the implementation of the current Clinical Strategy and the future NHS Fife Population Health & Wellbeing Strategy. The current scores reflect the existing controls and mitigating actions in place.	Linda Douglas Director of Workforce Staff Governance	Sinead Braiden	WORKFORCE – GENERAL • Implementation of the Workforce Strategy to support the Clinical Strategy and Strategic Framework; development of Workforce Strategy and Workforce Plans for 2022 to 2025. • Implementation of the Health & Social Care Workforce Strategy to support the Health & Social Care Strategic Plan for 2019 to 2022, the integration agenda and the development of the H&SCP Workforce Strategy and Workforce Plan for 2022 to 2025. • Implementation of the NHS Fife Board Strategic Objectives, particularly the "exemplar employer / employer of choice" and the associated values and behaviours. • Implementation of the NHS Fife / H&SCP Joint Interim Workforce Plan for 2021/2022. • Work towards implementation of the National Workforce Strategy for Health & Social Care. WORKFORCE CAPACITY • Current resourcing actions include: active local and international recruitment campaigns and continued expansion of bank and supplementary staffing resources, including recruitment of newly qualified nurse practitioners in all disciplines, Band 4 pre-registered nurses, additional Band 2 bank HCSWs, fast track process to support appointable candidates being appointed to other vacancies and admin support roles as part of a commitment to support Senior Charge Nurses and nursing teams. First International Nurse recruits will take up post in February 2022. • Planning and delivery of actions undertaken by respective COVID-19 and Workforce Groups at various levels, including inter alia local workforce groups, workstreams associated with new programmes of work, for example, Community Care and Treatment, Vaccination Transformation and Implementation of the General Medical Services contract. • Planning to meet future service needs, applying workforce planning and forecasting skills in support of service delivery, using the workforce modelling and abstraction techniques learned during the pandemic and managing staff availability to respond to escalation requirements. • Supporting service delivery through implementation and integration of systems and joint working with services on redesign of services to mitigate shortfalls in staff availability. • The first 14 young people will take up a paid placement on our Kickstart Programme at the end of March 2022. WORKFORCE CAPABILITY • eLearning and training offers aligned to current work modes • Continuation of fast track induction and related activity, including new welcome and orientation package. • Implementation of Practice Development initiatives to support changes in service delivery and preparation for further escalation requirements, for example training resources for non-clinical staff to support clinical service delivery. • Ensuring managers and staff are prepared for the implementation of and compliance with the Health & Care (Staffing) (Scotland) legislation within the clinical workforce. • Develop and deliver Phase 1 of the framework to improve leadership capability and embed talent management and succession planning. • To prioritise staff personal / professional development needs that have been delayed or restricted due to COVID-19 response as restrictions are eased, through Directorate development delivery plans. • To progress actions in support of the employability agenda. WORKFORCE ENGAGEMENT • Working in partnership with staff side and professional organisations across all sectors of NHS Fife to ensure staff engagement opportunities are maximised. • iMatter – supporting action planning and Board actions arising from the 2021 cycle of feedback and reporting. • Supporting staff through changes in ways of working and providing access to new and different career opportunities. • Realising the benefits of the Internal (Staff) Communication Strategy and ensuring that StaffLink and other mediums for example the weekly Team and Chief Executive Briefings, joint managerial / partnership walkabouts support organisational objectives. • Scoping a Staff Experience and Engagement Framework that sets out our key ambitions and commitments for improving staff experience, which will help to develop a culture that values and supports our workforce. WORKFORCE SUPPORT & WELLBEING • Provision of support and wellbeing initiatives which contribute to staff maintaining and enhancing their personal health and wellbeing at work and creating a great place to work. • Access to OH, H&S, Peer Support, Psychology, Spiritual Care and Staff Listening Services.	Nil	WORKFORCE – GENERAL • Implementation and review of workforce plans and strategies to ensure that these support service delivery and the provision of appropriate and safe care to the population of Fife. • Ensuring workforce preparedness for any further COVID-19 escalation requirements, working in partnership through the respective Workforce Groups and command structure. • Support for capacity building within and across the organisation to make sure we make the best use of the skills of all of our workforce and to foster an environment for staff development. WORKFORCE CAPACITY • Consideration of redesign of roles and services, for example: expansion of Health Care Support Worker and Nursing Associate roles, Advanced Practitioners, Pharmacy Technicians and Physicians Associates, combined with targetted ward administrative support, to enable clinical time to be released. • Consideration of alternative ways to attract and recruit staff, or redesign of job roles to support service delivery models and the future supply pool. • Realising the benefits of implementation of the regional recruitment model. • Harnessing the benefits of digital technology and automation to support service delivery and the commitments within the Recovery Plan / Clinical Strategy, for example within Laboratory Services, to compensate for shortfalls in current staff / future pipeline and complement recruitment and the introduction of advanced practice. • Create a pathway for young people with barriers to employment to gain paid work experience with us, with the aim of securing future employment via the Kickstart and Long Term Unemployed Programme. • Continue with plans to develop and implement an Apprenticeship programme to support the development and progression into high demand roles. WORKFORCE CAPABILITY • Consideration of and implementation of learning and development activities in support of skill mix and associated actions. • Contributing to NHS Scotland developments in Learning and Development. • Realising benefits from the implementation of and compliance with the Health & Care (Staffing) (Scotland) legislation within the clinical workforce. • Supporting managers to harness the benefits of Tableau, TURAS and other systems integration aligned to workforce planning. • Provision of workforce planning training and support for managers. • Develop and deliver further phases of the framework to improve leadership capability and embed talent management and succession planning. • Consideration of the functionality of TURAS Learn to support capture and to facilitate reporting and analysis of training and development data. WORKFORCE ENGAGEMENT • Continuation of active partnership working through APF and LPFs, with staff side colleagues key stakeholders in the development of the next Workforce Strategies and Action Plans. • Continue to promote NHS Fife as an employer to enhance our ability to recruit and retain staff, utilising positive Communication support and social media. • To develop mechanisms which enable everyone to feel more valued and involved on a collaborative basis throughout health and social care. WORKFORCE SUPPORT & WELLBEING • Review of Staff Health & Wellbeing Framework to take account of COVID-19 lessons learned and evaluation of activities to establish which are most appreciated by staff. • Provision of additional staff support and wellbeing initiatives which contribute to staff health and wellbeing, staff resilience and staff retention, showcasing NHS Fife as an exemplar employer in the local labour market.	1. Regular performance monitoring and reports to Executive Directors Group, Area Partnership Forum, Local Partnership Fora and Staff Governance Committee 2. Staff Governance activities are reported to EDG, APF, LPFs and Staff Governance Committee	1. Use of national data for comparative purposes 2. Internal Audit reports 3. Audit Scotland reports 4. Bench - marking against other NHS Boards	Full implementation and utilisation of eESS, Job Train, Tableau and TURAS will provide integrated workforce systems which, alongside access to national data via the NES Portal will capture and facilitate reporting, including all learning and development activity.	Overall NHS Fife has robust workforce planning, learning and development, governance and risk systems and processes in place. Continuation of the current controls and full implementation of mitigating actions, in particular the Workforce Strategy supporting the Clinical Strategy and the future Population Health and Wellbeing Strategy for Fife and full implementation and use of eESS, should provide appropriate levels of control.	2 – Unlikely – Not expected to happen – potential exists	4 – Major	8	2_MOD/	Continuing improvements in current controls, ongoing review and full implementation of mitigating actions will reduce both the likelihood and consequence of the risk to moderate, taking account of current and potential future workforce challenges.

													• Integration of Mindfulness, Good Conversations and Our Space support and Outdoor sessions for staff as part of Going Beyond Gold Programme, contributing to a culture of kindness and staff recovery. • Consistent application of NHS Fife and Once for Scotland employment policies • Provision of a healthy and safe working environment, including access to refreshments in the workplace and ongoing development of Staff Hubs, Pause Pods and rest areas. Management of leave and encouraging rest and recuperation.		• Continue to hold Gold HWL Award status and deliver on Health Promoting Health Service commitments. • Consideration of support for the ageing workforce and other disadvantaged groups and opportunities for job redesign. Responsible Person/s: Director of Workforce								

Linked Operational Risk(s)

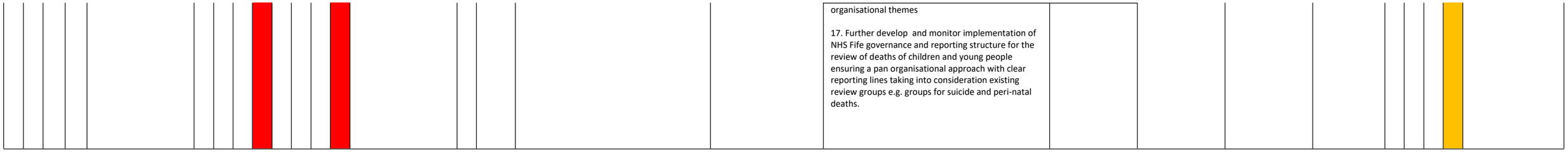
Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
2214	Nursing and Midwifery Staffing Levels	Active Risk	High Risk	20	Owens, Janette
90	National Shortage of Radiologists	Active Risk	High Risk	16	Dobson, Claire

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
1324	Medical staff recruitment and retention	Active Risk	Moderate Risk	12	Kennedy, John
1375	Breast Radiology Service	Active Risk	Moderate Risk	12	Cross, Murray
1420	Loss of consultants	Active Risk	High Risk	15	Bett, Heather
1652	Medical Capacity in Community Paediatric Service	Active Risk	Moderate Risk	12	Dobson, Claire
1846	Test and Protect/Covid Vaccination	Active Risk	Moderate Risk	12	Connor, Nicky
503	Diabetes	Closed Risk	Moderate Risk	9	CHE
1042	Staffing Levels	Closed Risk	Moderate Risk	12	Nolan, Karen
1349	Service Provision - GP locums may no longer wish to work for NHS Fife Salaried Practices	Closed Risk	Moderate Risk	8	Dobson, Claire
1353	Service Provision - Shortfall in GP Cover will limit service provision	Closed Risk	Moderate Risk	9	Dobson, Claire
1858	workload resulting from deterioration in mental health	Closed Risk	Moderate Risk	10	Torrens, Jillian

NHS Fife Board Assurance Framework (BAF)

Risk ID	Corporate Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Quality & Safety																											
1674	Clinically Excellent, Person Centred	10 March 2022	29 April 2022	There is a risk that due to failure of clinical governance, performance and management systems (incluing information and information systems), NHS Fife may be unable to provide safe,effective, person centred care. Additionally, there is a risk that the effects of the COVID - 19 pandemic, including restricted capacity, reduced elective & non urgent services, and workforce pressures, will impact on the quality & safety of patient care and service delivery.	4 – Likely – Strong possibility this could occur	5 - Extreme	20	High Risk	3 – Possible – May occur occasionally – reasonable chance	5 - Extreme	15	High Risk	Failure in this area could have a direct impact on patients' health, organisational reputation and exposure to legal action. While it is recognised that several adverse events ranging from minor to extreme harm can occur daily, the proportion of these in relation to overall patient activity is very small.	Christopher McKenna Medical Director	Clinical Governance Christina Cooper	*Ongoing actions designed to mitigate the risk including:* Oversight and monitoring of strategy / framework / policy and procedure implementation and impact including: 1. Strategic Framework 2. Clinical Strategy 3. Clinical Governance Structures and operational governance arrangements 4. Clinical & Care Governance Strategy 5. Participation & Engagement Strategy 6. Risk Management Framework 7. Governance arrangements established to support delivery of the UK Coronavirus (COVID-19) action plan 8. Processes established for reporting and escalation of COVID-19 related incidents & risks 9. Remobilisation plan 3/4 These are supported by the following: 10. Risk Registers 11. Integrated Performance and Quality Report (IPQR), Performance reports dashboard data 12. Performance Reviews 13. Adverse Events Policy 14. Scottish Patient Safety Programme 15. Implementation of SIGN and other evidence based guidance 16. Staff Learning & Development 17. System of governance arrangements for all clinical policies and procedures 18. Participation in relevant national and local audit 19. Complaints handling process 20. Using data to enhance quality control 21. HIS Quality of Care Approach & Framework, Sept 2018 22. Implementing Organisational Duty of Candour legislation 23. Adverse event management process 24. Sharing of learning summaries from adverse event reviews 25. Implementing Excellence in Care 26. Using Patient Opinion feedback 27. Acting on recommendations from internal & external agencies 28. Revalidation programmes for professional staff 29. Electronic dissemination of safety alerts 30.Organisational Learning Group established in August 2021	1.Reviewing together of patient experience, complaints, adverse events and risk information to provide an overview of good practice, themes, trends, and exceptions to the norm 2.Weaknesses in the process for recording completion of actions from adverse event reviews including evidence of steps taken to implement and share learning from actions. Adverse Event improvement Programme now underway. 3.Weaknesses in related oversight and monitoring processes at operational level 4. Risk Management Framework requires review, update & plan for implementation Risk Management Framework eview and improvement programme now underway. Review and update of Clinical and Care Governance Framework is now underway.	1. Give due consideration to how to balance the remobilisation of clinical services and manage staff and public expectations, while dealing with the ongoing COVID-19 pandemic 2. Continually review the Integrated Performance and Quality (IPQR) to ensure it provides an accurate, current picture of clinical quality / performance in priority areas 3. Refresh the extant Clinical Governance structures and arrangements to ensure these are current and fit for purpose 4..Review the coverage of mortality & morbidity meetings in line with national developments and HIS guidance 5. Review and refresh the current content and delivery models for key areas of training and development e.g. corporate induction, in house core, quality improvement, leadership development, clinical skills, interspecialty programmes, risk management, clinical effectiveness 6. Review annually, all technology & Digital & Information systems that support clinical governance e.g. Datix / Formic Fusion Pro./ Labs systems 7. Review our position against the Quality of Care Framework and understand our state of readiness for a review 8. Further develop the culture of a person centred approach to care 9. Executive commissioning of reviews as appropriate e.g. internal audit, external peer and 'deep dives' 10. Align the developing Clinical Governance Framework with the NHS Fife Corporate Objectives and the developing Population Health & Wellbeing Strategy 11.Identify improvements within the adverse events process taking into consideration communication, roles, use of DATIX and lines of reporting 12. Build a risk culture which ensures that there is engaged risk leadership and proactive measures with focus in place to address risks 13 .Build risk culture which links the identification of risk to organisational objectives and strategic priorities 14.Identify and implement an electronic system/ quality management system for managing policy and procedures to improve efficiency and assurance of document management 15. Use the Essentials of Safe Care framework as the basis of an organisational self assessment to understand status quo and support development of CG Framework 16..Ensure linkages with Patient Relations Team to allow for shared learning and identification of	1. Assurance statements from clinical & clinical & care governance groups and committees 2. Assurances obtained from all groups and committees that: i. they have a workplan ii. all elements of the work plan are addressed in year 3. Annual Assurance Statement 4. Annual NHS Fife CGC Self assessment 5. Reporting bi annually on adequacy of systems & processes to Audit & Risk Committee 6. External accreditation systems e.g.. Unicef - Accredited Baby Friendly Gold. UKAS Inspection for Labs 7. External agency reports e.g. GMC 8. Quality of Care review 9. Compliance and monitoring of policies & procedures to ensure these are up to date 9. Locally designed subject specific audits 10. National audits	1. Internal Audit reviews and reports on controls and process; including annual assurance and governance review / departmental reviews 2. External Audit reviews 3. HIS visits and reviews 4. Healthcare Environment Inspectorate (HEI) visits and reports 5. Health Protection Scotland (HPS) support and feedback 6. Health & Safety Executive visits and reports 7. Scottish Patient Safety Programme (SPSP) visits and reviews 8. Scottish Govt Organisational DoC Annual Report 9. Scottish Public Service Ombudsman (SPSO) reports 10. Patient Opinion 11. Specific National reporting 12. Mental Welfare Commission (MWC) reviews	1. Key performance indicators relating to corporate objectives e.g. person centred, clinically excellent, exemplar employer & sustainable 2. We require additional assurances that there is a system in place for oversight and monitoring of actions from a variety of sources e.g. audit, adverse events, SPSO, MWC reviews 3. We require additional assurances that there are systems in place for oversight of operational and strategic risks	Overall, NHS Fife has in place sound systems of clinical governance and risk management as evidenced by Internal Audit and External Audit reports and the Statement of Annual Assurance to the Board.	2 – Unlikely – Not expected to happen – potential exists	5 - Extreme	10	Moderate Risk	The organisation can identify the actions required to strengthen the systems and processes to reduce the risk level.



organisational themes 17. Further develop and monitor implementation of NHS Fife governance and reporting structure for the review of deaths of children and young people ensuring a pan organisational approach with clear reporting lines taking into consideration existing review groups e.g. groups for suicide and peri-natal deaths.	

Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
2214	Nursing and Midwifery Staffing Levels	Active Risk	High Risk	20	Owens, Janette
1904	Coronavirus Disease 2019 (COVID-19) Pandemic	Active Risk	High Risk	16	Tomlinson, Joy
2297	Cancer Waiting Times Access Standards	Active Risk	High Risk	15	Dobson, Claire
1296	Emergency Evacuation, VHK Phase 2 Tower Block	Active Risk	High Risk	15	McCormick, Neil
1907	Public Health Oversight of COVID-19 in Care Homes	Active Risk	High Risk	15	Tomlinson, Joy

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
43	Vascular access for haematology/Oncology	Active Risk	High Risk	16	Shirley - Anne Savage
528	Pandemic Flu Planning	Active Risk	Moderate Risk	12	Brown, George
637	SAB LDP standard	Active Risk	Moderate Risk	9	Cook, Julia
1652	Medical Capacity in Community Paediatric Service	Active Risk	Moderate Risk	12	Dobson, Claire
1670	Temperature within fluid storage room within critical care	Active Risk	Moderate Risk	12	Morgan, Belinda
356	Clinical Pharmacy Input	Closed Risk	High Risk	15	McKenna, Christopher
521	Capacity Planning	Closed Risk	Very Low Risk	1	Watts, Miriam
529	Information Security Risk	Closed Risk	High Risk	16	McGurk, Margo
1287	Overcapacity in AU1 Assessment Unit	Closed Risk	Very Low Risk	3	Shepherd, Angie
1297	Obsolete Equipment In Use – No Replacement Plan In Place (Graseby 3000 Series)	Closed Risk	Moderate Risk	10	Lowe, David
1366	T34 syringe drivers in the Acute Division	Closed Risk	Low Risk	6	Savage, Shirley-Anne
1502	3D Temperature Monitoring System (South Lab)	Closed Risk	Moderate Risk	12	Campbell, Ken
1514	Impact of the UK's withdrawal from the EU on the availability and cost of medicines and medical devices	Closed Risk	High Risk	15	Garden, Scott
1515	Impact of the UK's withdrawal from the EU on Nuclear Medicine and the ability to provide diagnostic and treatment service(s)	Closed Risk	High Risk	15	Anderson, Jane
1524	Oxygen Driven Suction	Closed Risk	High Risk	20	McKenna, Christopher
1667	Infusion pumps, volumisers and Syringe Divers in Paediatrics and Neonatal Units	Closed Risk	High Risk	25	Dobson, Claire

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Strategic Planning																											
1675	Clinically Excellent, Exemplar Employer, Person Centred, Sustainable	30/03/2022	25 May 2022	There is a risk that the development and the delivery of the new NHS Fife Population Health and Wellbeing strategy is not adequately supported by the required planning and programme management capacity, capability and governance arrangements. Key Risks from previous BAFs will remain until committees are content they are covered in renewed PHW Strategy. 1. Community/Mental Health redesign is the responsibility of the H&SCP/IJB 2. Governance remains between IJB and NHS Fife. 3. Regional Planning - risks around alignment with regional plans 4. Clinical Strategy does not reflect that the strategic direction of the organisation following the COVID-19 pandemic.	4 – Likely – Strong possibility this could occur	4 – Major	16	High Risk	3 – Possible – May occur occasionally – reasonable chance	4 – Major	12	3 – Moderate	Following period of COVID-19, portfolio management is being put in place. Programme management approach being refreshed through Strategic Planning Resource Allocation (SPRA) process.	Director of Finance and Strategy Margo McGurk	Clinical Governance. Christina Cooper.	*Ongoing actions designed to mitigate the risk including:* 30/03/22 1. PHW Portfolio Board meeting regularly and working well 2. Plan for delivery of PHW strategy to be agreed including analysis of Public and Staff Survey that will be used to inform strategy and public engagement work going forward. 3. SPRA 22/23 almost complete with draft Corporate Objectives for 22/23 still to be finalised	EDG Portfolio Board will provide the required leadership and executive support to enable strategy development - now in place.	PHW Portfolio Board is now meeting monthly. TOR signed off. Governance route will be Public Health and Wellbeing Committee Time period for Strategy has been amended to start from 23/24 rather than 22/23. Annual Delivery Plan for 22/23 providing interim strategic direction. Work will continue during 2022 to ensure delivery of Strategy for 23/24. Responsible Person: Director of Finance Timescale: 31/03/2022	1. Minutes of meetings record attendance, agenda and outcomes. 2. Reporting of key priorities to governance groups from the SPRA process. .	1. Internal Audit Report on Strategic Planning (no. B10/17) 2. Governance committee scrutiny and reporting. .	Governance of new arrangements will be agreed to deliver the required assurance. This gap have now been closed..	Corporate Objectives in draft for 22/23. SPRA 2022/23 will inform the Annual Delivery Plan due in July 22 and corporate objectives for 22/23. RMP4 Q3 update on deliverables was submitted in February 22 with Q4 update due in April 22.	2 – Unlikely – Not expected to happen – potential exists	4 – Major	8	3 – Moderate	Position is improving as Portfolio Board and Public Health and Wellbeing Committee is in place.

Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
	Nil currently identified				

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
	Nil applicable				

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Integration Joint Board																											
1676	Sustainable	11/03/2022	13 May 2022	There is a risk that the Fife Integration Scheme does not clearly define operational responsibilities of the Health Board, Council and Integration Joint Board (IJB) resulting in a lack of clarity on ownership for risk management, governance and assurance.	4 – Likely – Strong possibility this could occur	4 – Major	16	1_HIGH	3 – Possible – May occur occasionally – reasonable chance	4 – Major	12	2_MOD/	The level of risk has been actively reviewed and, following feedback from colleagues, as there is considerable work ongoing to support the conclusion of the review and this is being regularly monitored, the risk score has been maintained at a moderate level	Nicky Connor Director of HSCP	NHS Fife Board. Tricia Marwick.	*Ongoing actions designed to mitigate the risk including:* Mar 22 1. The partner bodies, NHS Fife and Fife Council, developed the Fife IJB Integration Scheme in 2015 and it received Scottish Ministers' approval in October of that year. 2. The Integration Scheme was reviewed in March 2018 to reflect the implementation of the Carers (Scotland) Act 2016 as required by the Scottish Government. 3. The Audit Scotland report, Health and Social Care Integration – Update on Progress, published on 15 November 2018, was the second in a series of three national performance audits following the introduction of the Public Bodies (Joint Working) (Scotland) Act, 2014. It examined the impact public bodies are having as they integrate health and social care services. The report set out six areas which needed to be addressed if integration is to make a meaningful difference to Scotland. 4. This report was followed by the Ministerial Strategic Group for Health and Community Care's report – Review of Progress with Integration of Health and Social Care published in February 2019 which set out a number of proposals in each of the six key areas and allocated a timescale for completion of these. These were reviewed by Fife IJB and its partners to ensure they were incorporated into the work that was ongoing within Fife and an action plan was produced to drive forward changes. This was submitted to the Scottish Government in August 2019. The action plan set out actions to improve governance arrangements including the need to provide further clarity on the Integration Scheme. 5. All Integration Schemes are scheduled to be reviewed every five years, however, Scottish Government have allowed additional time for the review to take cognisance of the disruption caused by the coronavirus outbreak. 6. The review of the Fife Integration Scheme concluded through NHS Fife and Fife Council governance structures in September 2021. Thereafter it was submitted to Scottish Government for approval which was received on 9 March 2022. The revised IS will now be submitted to NHS Fife, Fife Council and the IJB for formal sign off. 7. Following the approval of the revised Integration Scheme work has begun to ensure governance arrangements for NHS Fife, Fife Council and the IJB clearly reflect the position set out in the Integration Scheme. Work has begun on review of the IJB Governance Manual and review of risk management arrangements within NHS Fife and the IJB is being progressed.	Nil	Nothing more to be done than the ongoing actions set out. Responsible Person: Director of Health & Social Care	1. Through regular updates to SLT and EDG about the progress of the reviews. 2. Updates to Audit & Risk Committees, the Integration Joint Board (IJB) and NHS Fife. .	1. • The views of auditors will be the key independent assurance mechanism around this risk. We will involve them in the work to clarify governance arrangements as it progresses. 2. • Scottish Government will also provide useful advice and an independent perspective on the work to be carried out.	None.	The problem should be largely resolved with the action taken.	1 – Remote – Can't believe this event would happen	4 – Major	4	3_LOW/	Once resolved and given effect to in IJB integration scheme and NHS Fife corporate governance arrangements, the issue should largely be resolved. But given maturity of relationships and dynamics around regional approaches a remaining risk will remain..

Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
	Nil currently identified				

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
	Nil applicable				

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Digital & Information																											
1677	Clinically Excellent, Exemplar Employer, Person Centred, Sustainable	11/03/2022	20 May 2022	There is a risk that the organisation will fail to recognise and afford the financial investment necessary to deliver its D&I Strategy and current operational lifecycle commitment to enable transformation across Health and Social care to deliver sustainable and integrated services that are safe, secure and compliant with governance frameworks and associated legislation.	4 – Likely – Strong possibility this could occur	5 - Extreme	20	1_HIGH	3 – Possible – May occur occasionally – reasonable chance	5 - Extreme	15	1_HIGH	Failure in this area could have a direct impact on patients care, organisational reputation and exposure to legal action. While it is recognised that several adverse events ranging from minor to extreme can occur daily, the proportion of these in relation to overall activity is very small and reporting to competent authorities is minimal.	CMK Medical Director	Clinical Governance, Finance Performance & Resources (FP&R) Christina Cooper (CGC), Rona Laing (FP&R)	*Ongoing actions designed to mitigate the risk including:* 1. Consistent alignment of the D&I Strategy with the NHS Fife Corporate Objectives and developing Health & Wellbeing Strategy 2. Digital & Information Board Governance improvement with ongoing review 3. Information Governance & Security Governance improvement with assurance activity plans reviewed by Steering Group and Improvement measures agreed 4. Caldicott - register maintained and reviewed 5. Review of financial impact of D&I Strategy as part of annual deliver planning and areas of exposure quantified and presented via SPRA process 6. Operational governance lead through SLT focusing on operation controls (finance & resource), lifecycle management, policy/procedure implementation a workforce development 7. Risk management arrangements underpinned by: Policy & Process, Adverse event management, Asset Management Controls, Monitoring and Detection, Defence in Depth security measures and technology; all of which are receiving a higher percentage of budget allocation. 8. Directive on security of network and information systems (NIS) & Cyber Essentials Compliance – Action Plan developed prioritising a series of Cyber workshops informing technical controls and organisational response to Cyber attacks 9. Additional resilience planning and disaster recovery work underway to update alignment to current operating priorities 10. FOI, records management, DPA improvements being lead through IG&S Steering and Operational Groups 11. Senior Management Team consideration of policy and procedure impact and associated implementation 12. Monthly risk reviews with Operational Leads and escalation/reporting to Governance Groups as necessary 13. Performance Review 14. Participation in national and local audit e.g. NISD Audit 15. Commitment to ensure appropriate implementation of Cyber Defence Measures, including support of national centralised cyber incident reporting and coordination protocols. 16. Staff Learning & Development, both Digital staff and the wider organisation including leadership skills. 17. Business Case development to include costed resilience by design and ongoing support activities. 18. Enhancing monitoring of our digital systems.	Lack of formal quantification of the financial impact of the Digital Strategy, inline with the current baseline of D&I Operating Costs Lack of long term financial, lifecycle and workforce planning. Lack of evidence of assurance now that systems to maintain ongoing monitoring of compliance and control are established: GDPR/DPA 2018 - Improvements noted in IG&S Assurance Report (Target March 2022) Lack of consideration and commitment to unification of business process on strategic applications and the associated remove of duplicate or legacy systems Lack of training and education resource to ensure our staff and patients are digitally ready - Business Case in consideration Lack of resilience of key digital systems and technical recovery procedures and regular failover (DR) testing. - Plan to address agreed with EDG - April 2021- project now in initiation – Oct 2021 Governance and procedures do not fully follow ITIL professional standards - Internal Audit Findings responded to	1. Improving and maintaining strong governance, risk management and operating procedures following Information Technology Infrastructure Library (ITIL) professional standards within early adoption of continuous improvement assessment. (ITIL implementation - Phase 1 Agreed - Phase 2 underway) 2. Organisation to consider the gaps in current operating financial commitments and assessment of financial implementation of Digital Strategy presented through SPRA process. 3. Develop long term financial, lifecycle and workforce planning - plan to address is in development (Completed - October 2021) 4. Work to become fully compliant with GDPR, DPA 2018, NIS Directive, Information Security Policy Framework and thereafter maintain compliance. (Target completion February 2022)	Second line of Assurance: 1. Reporting to D&I SLT, D&I Board, Information Governance & Security Steering Group (IG&SG), EDG & Clinical Governance groups and committees. 2. Annual Assurance Statements for the D&I Board and IG&S Steering Group. 3. Locally designed subject specific audits. 4. Compliance and monitoring of policies & procedures to ensure these are up to date via D&I Senior Management Team. 5. Reporting bi annually on adequacy of risk management systems and processes to Audit & Risk Committee. 6. Monthly SIRO report 7. SGHSCD Annual review 8. SG Resilience Group Annual report on NIS & Cyber compliance 9. Quarterly performance report. 10. External Assurance on Delivery Plan by Scottish Government 12. Update to Assessment following June 2019- Digital Maturity Assessment 13 Periodic Benchmarking for areas of focus	Third line of Assurance : 1. Internal Audit reviews and reports on controls and process; including annual assurance and governance review / departmental reviews. 2. External Audit reviews. 3. Formal resilience testing / DR testing using an approved scope and measured success and mechanism for lessons learned and action plans. 4. Cyber Essentials/Plus Assessments. 5. NISD Audit Commissioned by the Competent Authority for Health. 6. Benchmarking with NHS Scotland's Boards	1. The D&I Strategy has not undergone a financial assessment against delivery. This work is now complete (October 2021) Findings presented via SPRA 2. Continual development of data assured performance is ongoing across all D&I Domains. Development of workplans aligned to risk continue to be developed. 3. Assurance reports are consistently provided to D&I SLT monthly and development of data/KPI reports to Governance Groups continue to be developed. These reports will ensure trend and analysis to highlight potential vulnerabilities and provide assurances (including assurances that confirm compliance with GDPR, DPA 2018, NIS Directive, the Information Security Policy Framework is being maintained). 4. Implementation of improvements as recommended in Internal and external Audit ongoing. Adverse Events review to be included 5. Improvements to SLA's (in line with 'affordable performance')is that output still awaited from 4 to provide assurance or otherwise 6. Assurance on patients' readiness/equality impact in the adopt ion of digital care provision 6. Assurance on organisational readiness for further Digital Adoption	Overall, NHS Fife Digital has in place a sound systems of 1. Governance - agreed ToR and reporting 2. Improving security defences and risk management as evidenced by Internal Audit and External Audit reports 3. Attainment of the ISO27001 standard in the recent past and the Statement of Annual Assurance to the Board. 4. Investment has been made to support NIS, GDPR and Cyber resilience and some tools which will improve visibility of the Network. 5. Clear articulation of digital aspiration via the Digital Strategy 2019-2024 5. Extended corporate governance including EDG attendance 6. Meeting visibility through provision of minutes and delivery plans to EDG/CGC	2 – Unlikely – Not expected to happen – potential exists	5 - Extreme	10	2_MOD/	1. Difficulty in securing investment in people, tools and maintaining systems that are resilient and always within support cycles. 2. Fully implementing resistance to attack through 'resilience by design', well practised response plans and recovery procedures. 3. Reduce the 'human factor' through ongoing 'user base education' and improving organisational digital readiness. 4. Enhanced controls and continuing improvements to systems and processes for improved usage, monitoring, reporting and learning are continually being put in place. Aim for Moderate Risk as target rather than Low Risk is due to the fact that likelihood whilst unlikely may still happen and consequence will be extreme due to level of fines that may be imposed, reputational damage and patient harm.

Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
1338	NHS Fife at increased cyber attack risk due to legacy systems / application versions	Active Risk	High Risk	25	Graham, Alistair
885	Digital & Information Financial Position	Active Risk	High Risk	20	Graham, Alistair
2192	Risk that Digital & Information Service Management activities are not aligned to ITIL	Active Risk	High Risk	20	Graham, Alistair
1422	Unable to meet NIS & Cyber Essentials compliance	Active Risk	High Risk	16	Graham, Alistair
1934	Loss of Cloud based Email & Collaboration Services	Active Risk	High Risk	16	Young, Allan
1996	Office 365 - Unknown Financial Consequence and so risk to licence availability	Active Risk	High Risk	16	Graham, Alistair
537	Failure of the Network causing widespread loss of access to IT systems	Active Risk	High Risk	15	Young, Allan

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
226	Security of data being transferred off/on site	Active Risk	High Risk	16	Graham, Alistair
1393	Patch Management Risk	Active Risk	Moderate Risk	12	Young, Allan
1504	Lack of a central IT location to store guidance documents	Active Risk	High Risk	20	McKenna, Christopher
1576	Risk of not meeting Software as a Medical Device full compliance	Active Risk	Moderate Risk	9	McKenna, Christopher
1746	O365 May Cause Disruptive Network Overhead	Active Risk	Moderate Risk	9	Young, Allan
1932	T4 - User error in use of O365 products (including those supporting system)	Active Risk	Moderate Risk	12	Fowles, Malcolm
529	Information Security Risk	Closed Risk	High Risk	16	McGurk, Margo
913	MIDIS replacement	Closed Risk	Moderate Risk	9	Donovan, Lesly
1424	End of support lifecycle for Microsoft Server Products	Closed Risk	High Risk	16	Young, Allan
1927	Deliberate unauthorised data access or misuse by insiders (staff, contractors etc.)	Closed Risk	Moderate Risk	12	Fowles, Malcolm
1928	T2 - Deliberate unauthorised access or misuse of O365 Email by outsiders (e.g. hackers)	Closed Risk	Moderate Risk	12	Young, Allan
1929	T7 - Inadequate or absent audit trail	Closed Risk	High Risk	25	Young, Allan

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**18 May 2022**
Title:	**Internal Audit Framework**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Kevin Booth, Head of Financial Services & Procurement / A Gaskin, Chief Internal Auditor**

1 Purpose

This is presented to the Audit & Risk Committee for:

- Decision

This report relates to a:

- Legal requirement
- Local policy

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

- Safe
- Effective

2 Report summary

2.1 Situation

Public Sector Internal Audit Standards require each organisation to agree an Audit Charter, that defines Internal Audits purpose authority and responsibility. Whilst also clarifying the functional reporting relationships and accessibility provisions. This Charter, part of the Internal Audit Framework is to be annually reviewed and updated following approval by the Board, in this case through the Audit and Risk Committee.

The Charter is complementary to the relevant provisions included in the Board's Standing Orders and Standing Financial Instructions and the Shared Service Agreement and Service Specification with FTF Audit.

2.2 Background

The Framework was presented to the March 2022 Audit and Risk Committee. However due to the meeting being inquorate, the Chief Internal Auditor suggested that this item be

deferred to the May 2022 Audit and Risk Committee for further consideration. The FTF Audit Charter and Specification for Internal Audit Services (Appendix 1) has also been updated to reflect NHS Fife.

Internal Audit is an independent, objective assurance and consulting function designed to add value and improve the operations of NHS Fife. Internal Audit supports NHS Fife to accomplish its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of governance, risk management and control processes.

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

FTF Audit provides the internal audit service as part of a shared service which is hosted by NHS Fife. A partnership Board comprising of the Directors of Finance for NHS Fife, Forth Valley and Tayside is chaired by the Director of Finance of NHS Tayside. The FTF Partnership board have the responsibility to approve the draft Internal Audit Framework prior to the presentation to the respective boards Audit and Risk committees for their final approval.

2.3 Assessment

The attached internal audit framework sets out the Audit Charter, Service Specification and Reporting Protocol that have been reviewed and provided to NHS Fife for 2022/23. The revised framework follows on from the 2021/22 internal audit framework which was previously approved at the meeting of the Audit and Risk Committee on 19th January 2021. There are no material changes but it is important that the Audit and Risk Committee is assured that the document has been reviewed and has the opportunity to comment..

The Internal Audit Framework has been approved by the FTF Partnership Board members and is now presented to the Audit & Risk Committee for its formal approval.

2.3.1 Quality/ Patient Care

Internal Audit's Mission statement provides that 'Internal Audit is an independent, objective assurance and consulting activity designed to add value and improve the organisations operations'.

2.3.2 Workforce

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

2.3.3 Financial

Any identified Financial Implications will be highlighted to the appropriate responsible individual within NHS Fife.

2.3.4 Risk Assessment/Management

Internal Audit assignments identify the key risks at the planning stage and the work is designed to evaluate whether appropriate control systems are in place and are operating effectively to mitigate the risks identified at the onset.

2.3.5 Equality and Diversity, including health inequalities

Any Internal Audit assignments which involve the review of policies and procedures will consider the way in which equality and diversity is incorporated into the Boards documentation.

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

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

2.3.8 Route to the Meeting

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

The Internal Audit Framework was approved by the FTF Partnership Board on 4th January 2022.

2.4 Recommendation

The Audit and Risk Committee is asked to:

- **Decision** – Approve the Internal Audit Framework for 2022/23

3 List of appendices

The following appendices are included with this report:

- Appendix No 1 – FTF Audit Charter and Specification for Internal Audit Services

Report Contact
Kevin Booth
Head of Financial Services & Procurement

Email kevin.booth@nhs.scot

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

Introduction

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

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

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

Purpose and responsibility

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

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

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

Independence and Objectivity

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

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

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

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

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

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

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

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

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

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

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

Authority and Accountability

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

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

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

The Audit and Risk Committee approves all Internal Audit plans and may review any aspect of its work. The Audit and Risk Committee also has regular private meetings with the Chief Internal Auditor and its remit requires it to '*To ensure that there is direct contact between the Audit and Risk Committee and Internal Audit and to meet with the Chief Internal Auditor at least once per year and as required, without the presence of Executive Directors'.*

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

Relationships

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

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

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

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

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

Standards, Ethics, and Performance

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

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

Scope

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

- Reviewing the reliability and integrity of financial and operating information and the means used to identify measure, classify, and report such information;
- Reviewing the systems established to ensure compliance with those policies, plans, procedures, laws, and regulations which could have a significant impact on operations, and reports on whether the organisation is in compliance;
- Reviewing the means of safeguarding assets and, as appropriate, verifying the existence of such assets;
- Reviewing and appraising the economy and efficiency with which resources are employed, this may include benchmarking and sharing of best practice;

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

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

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

Risk Management

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

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

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

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

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

Reporting arrangements including Key Performance Indicators

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

The Annual Audit Report should contain:

- *An opinion on whether:*
    - ✧ *Based on the work undertaken, there were adequate and effective internal controls in place throughout the year;*
    - ✧ *The Accountable Officer has implemented a governance framework in line with required guidance sufficient to discharge the responsibilities of this role;*
    - ✧ *The Internal Audit plan has been delivered in line with PSIAS*

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

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

Assurances provided to parties outside the organisation;

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

Approach

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

Access and Confidentiality

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

a) *Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature (in which case he shall have a duty to safeguard that confidentiality), within the confines of the data protection act.*
b) *Access at all reasonable times to any land, premises or employees of the Board;*
c) *The production or identification by any employee of any cash, stores or other property of the Board under an employee's control; and*
d) *Explanations concerning any matter under investigation.*

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

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

Irregularities, Fraud & Corruption

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

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

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

Quality Assurance

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

The Chief Internal Auditor has establish a quality assurance programme designed to give assurance through internal and external review that the work of Internal Audit is compliant with the Public Sector Internal Audit Standards and to achieve its objectives. A commentary on compliance against PSIAS and against agreed KPIs will be provided in the Annual Internal Audit Report. KPIs will also be reported to each Audit and Risk Committee meeting as part of the Internal audit Progress report.

Resolving Concerns

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

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

Review of the Internal Audit Charter

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

Date: May 2022

Date of next review: May 2023

Appendix 1

Mission and values

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

WORKING TOGETHER TO PROVIDE ASSURANCE AND ADD VALUE

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

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

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

APPENDIX 2

Specification for Internal Audit Services

APPENDIX 2

CONTENTS

Page

1. Introduction

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

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

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

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

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

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

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

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

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

2. Internal Audit Responsibilities

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

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

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

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

- ✧ the organisation's objectives are achieved
- ✧ there is economical and efficient use of resources
- ✧ risks are adequately and effectively identified, recorded and managed

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

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

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

3. Internal Audit Standards

3.1 Public Sector Internal Audit Standards (PSIAS)

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

4. Planning

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

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

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

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

Strategic Audit Plan

4.5 The Strategic Audit Plan should cover the period of appointment during which all major risks, systems and key areas of activity, identified by the planning process, will be audited. The plan should usually incorporate a rotation of audit emphasis to form a cyclical approach.

There are a number of areas within the audit universe which, because of their nature, need to be planned for outwith the Risk Assessment process. These may include:

- ✧ Core Financial systems where assurance is required by External Audit
- ✧ Reviews targeting high risk fraud/probity areas through proactive CFS liaison
- ✧ Management of significant projects
- ✧ Post-transaction Monitoring

The Strategic Plan should set out the audit areas categorised by type of activity, risk rating, frequency of audit, and an assessment of resources to be applied. It should be prepared in conjunction with Audit and Risk Committee members and management, and be presented by the Chief Internal Auditor for formal approval by the Audit and Risk Committee by 30 June. The Strategic Plan should be updated annually in order to inform the Annual Audit Plan.

Annual Audit Plan

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

Audit Assignment Plans

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

- ✧ Job number and title
- ✧ Relevant Corporate/operational risks
- ✧ Relevant Director and responding officer
- ✧ Audit staff
- ✧ Start date and planned number of audit days required
- ✧ Scope, control objectives and other instructions
- ✧ Target draft report date and target Audit & Risk Committee

5. Managing Audit Work

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

5.2 The Chief Internal Auditor will also be responsible for monitoring the contract and will therefore be the Agreement Control Officer performing the additional quality, performance measurement and liaison activities. The Chief Internal Auditor shall be available to meet with the Director of Finance and Strategy 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 and Strategy 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 and Strategy must endeavour to ensure management's perspective of internal audit is positive and that a participative approach is adopted. Therefore FTF will be expected to actively involve and keep auditees informed during all stages of audit assignments. This is particularly crucial during the testing and evaluation stages when it would be more appropriate to inform management of the emerging findings where these are significant rather than wait and produce the findings in a report at a later date. The circumstances where this approach would be appropriate would be:

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

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

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

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

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

6. Reporting

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

6.2 The aim of every internal report should be to:

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

6.3 In addition, Internal Audit should provide the Director of Finance and Strategy and Audit and Risk Committee with regular reports on progress (see 0 below)

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

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

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

Individual Audit Project Reporting

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

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

Annual Audit 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 January Audit and Risk Committee and the Annual Internal Audit Report needs be prepared in time for submission to the Audit and Risk Committee not later than the target date specified in Appendix I following the end of the audit period. The Annual Internal Audit Report should contain:

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

- ✧ The Accountable Officer has implemented a governance framework in line with required guidance sufficient to discharge the responsibilities of this role
- ✧ The Internal Audit plan has been delivered in line with PSIAS
- ✧ analysis of any changes in control requirements during the year
- ✧ comment on the key elements of the control environment
- ✧ summary of performance against this service specification
- ✧ progress in delivering the Quality Assurance Improvement Programme.

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

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

Progress reporting

6.9 The Director of Finance and Strategy will receive regular reports, together with the FTF Balanced Scorecard specific to the client, on dates specified by the Client, detailing progress against the agreed Annual Audit Plan together with notification of any significant breaches of the timescales within the approved reporting protocol.

For each individual assignment within the plan the following will be reported:

- ✧ Planned days
- ✧ Actual days to date
- ✧ Planned start date
- ✧ Date of each milestone
- ✧ Audit opinion (where applicable)

Progress reports will also be presented to each Audit & 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 and Strategy.

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

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

Client Satisfaction Survey

7.5 A questionnaire will be issued to key contacts at the end of each audit review in a format agreed with the Director of Finance and Strategy. The Chief Internal Auditor shall review these surveys, investigate any matters of concern and take appropriate remedial action where required. The results of the surveys should be reported annually to the Audit & 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 Strategy, and through the offer of availability for meetings with the Audit and Risk Committee Chair and Board Chair.

8. Liaison with External Audit

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

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

9. Best Value Reviews

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

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

10. Suspected Criminal Offences

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

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

10.3The audit universe shall include the arrangements for complying with relevant HDL/CELs, for responding to suspected criminal offences and for liaising with the CFS as appropriate.

11. Freedom of Information

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

11.2 As part of our duties under the Act, the Board may publish some of the information clients provide to us in its Freedom of Information publication scheme. The Board may disclose information to anyone who makes a request.

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

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

12. Staffing

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

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

12.3 FTF shall ensure that every person employed or contracted by FTF is at all times properly and sufficiently trained and instructed with regard to:

- ✧ the task or tasks that person has to perform
- ✧ all relevant provisions of this specification
- ✧ all relevant rules, procedures and standards of the organisation
- ✧ security
- ✧ patient confidentiality and relevant aspects of Information Governance

12.4 Training and development should be a planned and continuing process. The Chief Internal Auditor should co-ordinate and keep under review the training requirements of all staff engaged on the contract in compliance with national guidance and report on these as part of the Balanced Scorecard.

12.5 The Director of Finance and Strategy may instruct FTF to remove from work in or about the provision of the service, any person employed by FTF if, in the opinion of the Director of Finance and Strategy, such person is not providing the service or part thereof to a satisfactory level or is not conforming with client expectations of behaviour or professionalism. FTF shall immediately comply with such instructions and as soon as reasonably practical thereafter provide a replacement individual.

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

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

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

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

During each successive twelve month period of the Agreement, FTF shall maintain, in the performance of the services, the skill mix of staff outlined in Appendix IV. Actual performance against this specified skill mix should be reported within the Annual Internal Audit Report.

12.7 FTF shall be expected to limit the number of staff employed on the contract to ensure sufficient experience and continuity is gained. With regard to this limit FTF should comply with the parameters specified in Appendix IV.

12.8 FTF shall be required to keep detailed time ledger records detailing actual time spent on each audit and the name and qualification of staff. Only time spent working exclusively on the performance of the services and associated chargeable travelling time shall be chargeable. The Director of Finance and Strategy will have the right to make random spot checks of detailed time ledgers to verify the accuracy of time records.

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

- ✧ there are sufficient staff employed at the appropriate levels to fulfil the terms of the Shared Service Agreement
- ✧ staff do not smoke while on the organisation's premises
- ✧ staff do not introduce or consume any drug (including alcohol) on the organisation's premises
- ✧ staff who are under the influence of any drug (including alcohol) do not work or attempt to work on the organisation's premises
- ✧ staff are properly and presentably dressed while on the organisation's premises

Appendix I

INTERNAL AUDIT SPECIFICATION

PERFORMANCE MEASURES

The following performance measures shall be monitored by FTF, reported to the client Director of Finance and Strategy bi-annually and included within the Annual Internal Audit Report, with comparative figures for the previous year.

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

Appendix II

INTERNAL AUDIT SPECIFICATION

INTERNAL AUDIT REPORTING PROTOCOL & FLOWCHART

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

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

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

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

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

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

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

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

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

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

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

12. All final audit reports may be presented to the Executive Directors Group, relevant Standing Committee and, where appropriate, the Fife IJB Audit and Risk Committee.

Dispute resolution

13. In the event of a failure to receive a timely response from the Responsible Director in relation to a draft report or assignment plan, or to reach agreement on a fundamental recommendation, the matter will be referred to the Director of Finance and Strategy 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 and Strategy	
1	Assignment Plan agreed	Terms of reference for the assignment agreed with Responsible Director and / or Responding Officer.	Regional Audit Manager with Responding Officer/ Responsible Director.	within 2 weeks of issue
2	Fieldwork commenced	Audit team conduct audit assignment in accordance with Assignment Plan	Principal/Auditor with co-operation of operational staff	
3	Fieldwork completed	Audit findings evaluated and summary of findings discussed and agreed with appropriate staff, including the Responding Officer. If the audit findings relate to the work of any other department or have an impact on any other departments, an appropriate senior officer from within that area will be consulted on the summary of findings. Draft report prepared for review.	Principal/Auditor in discussion with operational staff prior to Audit Manager review	Within 1 week of fieldwork end
4	Draft report issued to Directorate	Audit report issued to Directorate in draft for review and consideration of action plans. If audit findings relate to the work of any other department or have an impact on any other departments, an appropriate senior officer from within that area should be consulted on the report content.	Regional Audit Manager with Principal/ Auditor to Responding Officer/ Responsible Director.	within 2 weeks of fieldwork end
5	Directorate response	Formal response required from Directorate to include completed time bound action plan matrix.	Responding Officer with agreement of Responsible Director	within 2 weeks of draft report release

Assignment Milestone	Stage	Processes involved	Responsibilities	Response time
6	Report issued to Director of Finance and Strategy	Audit report reviewed for clearance.	Regional Audit Manager	within 1 week of Directorate response
			Director of Finance and Strategy/ 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 and Strategy, Responding Officer & Chief Executive	within 1 week of Director of Finance and Strategy 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 and Strategy.	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 and Strategy for review, comment and approval.	For return within 1 Week
CE / Director of Finance Responses	The responses from the Director of Finance and Strategy will be incorporated into the report.	Within 1 Week
Report finalised and issued	The Office Manager will finalise and issue the report to the relevant Client Director and Officers.	By the end of the next day
Recom-mendations added to AFU	The recommendations will be added to the AFU System by the AFU Coordinator and progress reported to the Audit & Risk Committee.	On receipt of report

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

Appendix III

INTERNAL AUDIT SPECIFICATION

FOLLOW-UP OF AGREED INTERNAL AUDIT RECOMMENDATIONS

NHS FIFE

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

1. INTRODUCTION

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

2. MANAGEMENT FOLLOW-UP ON INTERNAL AUDIT REPORTS

- Internal Audit will follow up all agreed audit action points arising from Internal Audit reports. Internal audit will only review progress against external audit recommendations where relevant to internal audit fieldwork
- Once an action point falls due, the Responsible Officer (the officer noted in the Internal Audit Action Plan as responsible for implementing the agreed action) will provide Internal Audit with an update on the current status of the action point, indicating whether it has been completed or not and, if not completed, provide a reason for the outstanding element, together with a revised due date for completion of the entire action point.
- Actions classified by Responsible Officers as no longer relevant, or where an extension of the due date is requested, will require evidence to support to request. . Internal audit will conclude on whether these are reasonable.
- The Responding Officer will also provide supporting evidence to demonstrate that the required action has been taken and that it has been effective. Internal Audit will review in detail any responses which do not appear adequate to address the control weakness identified in the original report, or where the evidence does not fully support the conclusion drawn.
- Where significant inaction by a Responsible Officer is apparent and intervention is required, the internal audit will discuss this with the relevant Director/Senior Manager. Where the matter cannot be resolved in this way, it will be escalated to the Director of Finance and Strategy and, ultimately, the Chief Executive.
- After each Audit and Risk Committee meeting where an Audit Follow Up report has been presented, the report will also be taken to the Executive Directors Group to allow consideration of any long outstanding responses, repeated

extensions to due by dates, actions not completed and those which did not fully address the identified control weakness, either because of the content or the accuracy of the response.

- Internal Audit will be responsible for presenting regular reports on follow-up to each Audit and Risk Committee. These reports will contain a graphical representation of progress towards implementation of all internal audit recommendations, detail progress on all outstanding recommendations.
- The report will detail the most recent position on summary of progress, detailed action status by report, reasons for extensions granted, outstanding recommendations and Internal Audit validation.

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

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

3. FOLLOW-UP OF EXTERNAL AUDIT REPORTS

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

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

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

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

Appendix IV

INTERNAL AUDIT SPECIFICATION
AUDIT SERVICE

STAFFING SKILL MIX

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

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

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

Appendix V

INTERNAL AUDIT SPECIFICATION
AUDIT SERVICE

PUBLIC SECTOR INTERNAL AUDIT STANDARDS

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

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**18 May 2022**
Title:	**Internal Audit Progress Report 2021/2022**
Responsible Executive/Non-Executive:	**M McGurk, Director of Finance & Strategy**
Report Author:	**B Hudson – Regional Audit Manager**

1 Purpose

This is presented to the Audit and Risk Committee for:

- Assurance
- Discussion

This report relates to a:

- Local policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this report is to:

- Provide the Audit and Risk Committee with comprehensive assurance on the progress of the 2021/22 Internal Audit Plan and the commencement of the 2022/23 plan.

2.2 Background

The Internal Audit year runs from May to April. The Internal Audit team is progressing the 2021/22 Annual Internal Audit Plan under the supervision of the Chief Internal Auditor. Audit work completed allows the Chief Internal Auditor to provide the necessary assurances prior to the signing of the annual accounts.

A large element of our year-end assurance has already been provided through the Internal Control Evaluation report presented to the last Audit and Risk Committee.

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

2.3 Assessment

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

Appendix A shows:

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

Improvement Activities

Development of the FTF website is complete. The requirement for an FTF Internal Audit webpage was considered as good practice to enhance compliance with the Public Sector Internal Audit Standards. The web pages can be accessed as follows:-

https://www.nhsfife.org/about-us/accountability/internal-audit/

The FTF self assessment against the Public Sector Internal Audit Standards has been completed and, following approval by the FTF Partnership Board, it will be presented to the June 2022 Audit and Risk Committee.

Advice and input

In addition to formal audit reviews which result in a report to the Audit and Risk Committee, Internal Audit have continued to provide advice and assistance to officers and Board members since the last Audit and Risk Committee meeting.
The Assurance mapping Group continues to meet and have recently updated the Committee Assurance Principles. The Board Secretary is working with Standing Committee's Chairs to ensure they are embedded within the Board's formal assurance processes and Internal Audit continue to liaise with management on the application of the principles across a range of risks. Given the impending update of the Risk Register, there is no benefit in a detailed review of the Quality and Safety BAF, as originally intended, although Internal Audit have liaised with the Associate Director of Quality and Clinical Governance throughout the year and will provide a year-end summary report .

2.3.1 Quality/ Patient Care

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

2.3.2 Workforce

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

2.3.3 Financial

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

2.3.4 Risk Assessment/Management

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

2.3.5 Equality and Diversity, including health inequalities

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

2.3.6 Other impacts

N/A

2.3.7 Communication, involvement, engagement and consultation

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

2.3.8 Route to the Meeting

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

2.4 Recommendation

The Audit and Risk Committee is asked to:

- **DISCUSS** and **NOTE** the progress on the delivery of the Internal Audit Plan

3 List of appendices

The following appendices are included with this report:

- Appendix A – Internal Audit Progress Report

Internal Audit Progress Report

Introduction

This report presents the progress of internal audit activity up to 6 May 2022.

Internal Audit Activity

NHS Fife Completed Audit Work

The following audit products, with the audit opinion shown, have been issued since the last Audit and Risk Committee meeting on 17 March 2022. Each review completed has been categorised within one of the five strands of corporate governance. A summary of each report is included for information within the 'Summary of Audit findings' section.

Audit 2021/22	Opinion on Assurance	Recommendations	Draft issued	Finalised
Corporate Governance				
B09/22 – Audit Follow Up	N/A	N/A	28 April 2022	Report provided to each Audit and Risk Committee and year end summary to May 2022 Audit and Risk Committee
B10/22 – Attendance at meetings/ Ad-hoc Advice provided by Chief Internal Auditor, Audit Manager and Principal Auditors	N/A	N/A	28 April 2022	6 May 2022 – Year end summary
B11/22 – Assurance Framework	N/A	N/A	28 April 2022	6 May 2022 – Year end summary
B15/22 – Health and Social Care Integration	N/A	N/A	4 May 2021	6 May 2022 – Year end summary
B16/22 Medicine Management – Prescription Stationery	N/A	Three Moderate	11 March 2022	5 May 2022

Security				
B18/22 - Procurement	Reasonable Assurance	Four Moderate; One Merit Attention	23 March 2022	9 May 2022
B20/22 Financial Process Compliance	N/A	One Moderate	29 April 2022	9 May 2022
B23/22 Resilience – Interim Report	N/A	One Significant	9 March 2022	19 April 2022

NHS Fife Draft Reports Issued

Audit 2020/21	Draft issued
B13/22 Strategic Planning	13 May 2022

NHS Fife Work in Progress and Planned:

Audit 2020/21		Status	Target Audit and Risk Committee
B12/22	Risk Management [1]	Fieldwork	September 2022
B17/22	Workforce Planning	Fieldwork	September 2022

[1] Within the Internal Audit Annual Report for 2021-22, Internal Audit will conclude on the risk management arrangements. NHSF are currently developing a new approach to Risk Management which will involve fundamental review of the structure and content of the high level risk register. Internal audit will provide comment on both the process and output, ensuring that Assurance mapping principles are embedded throughout. The timing of the Internal Audit input will be dependent on the progress made to the new risk management process with the work possibly undertaken in the 2022-23 audit plan.

Summary of Audit Findings

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

1. B09/22 Audit Follow Up (AFU)

Throughout 2021/22, Internal Audit have provided a comprehensive Audit Follow Up (AFU) report to each Audit and Risk Committee. Enhancements to the reporting have been made during the year and the Executive Directors Group has monitored the action taken in year for the outstanding recommendations. Internal Audit have reviewed historical audit recommendations, many have been updated within "current" audit reports or been removed as they are no longer applicable. The outcomes from these updates are reported within the AFU reports to the May 2021 and December 2021 Audit and Risk Committee meetings.

2. B10/22 – Attendance at meetings/ Ad-hoc Advice provided by Chief Internal Auditor, Audit Manager and Principal Auditors

Internal Audit have provided advice and assistance to officers and Board members on the following areas during 2021-22, including:

- Assurance mapping and risk advice, in particular Digital and Information risks
- Advice on the revised Terms of Reference for the Digital Information Board, Information Governance and Security Steering and Operational Groups and attendance at their meetings.
- Suggested amendments to the draft Integration Scheme
- Assurance reporting regarding Whistleblowing (quarterly and annual)
- Commenting on Terms of Reference for the Quality Management Assurance Group.
- Internal Audit have facilitated the work of the Assurance Mapping group and liaised with the Board Secretary to consider how the agreed principles can be adapted to the specific needs of NHS Fife.
- Commenting on the development of the Financial Operating Procedures.

3. B11/22 – Assurance Framework

The Assurance mapping Group continues to meet and have recently updated the Committee Assurance Principles. The Board Secretary is working with Standing Committee's Chairs to ensure they are embedded within the Board's formal assurance processes and Internal Audit continue to liaise with management on the application of the principles across a range of risks. Given the impending update of the Risk Register, there is no benefit in a detailed review of the Quality and Safety BAF, as originally intended, although Internal Audit have liaised with the Associate Director of Quality and Clinical

Governance throughout the year and will provide a year-end summary report .

4. B15/22 – Health and Social Care Integration

For 2021/22, FTF have provided the input to and delivered the IJB Audit Plan, led by the Chief Internal Auditor.

5. B16/22 - Medicine Management – Prescription Stationery Security

Internal audit evaluated the design and operation of the controls in place to ensure the security of prescription stationery at seven locations and specifically considered whether the controls to secure prescription stationery outlined in NSS Prescription Stationery Guidance, the SSUMPP and relevant Standard Operating Procedures are followed. This included the controls for:

- Storing prescription stationery
- Issuing prescription stationery to prescribers
- Maintaining records of the receipt and issue of prescription stationery
- Monitoring the receipt, storage, and issue of prescription stationery.

Our testing at acute dispensaries at Victoria and Queen Margaret Hospitals and the Primary Care Store at Cameron and at a sample of wards and departments at Victoria and Queen Margaret Hospitals found that processes in place for the receipt, storage and issue of prescription stationery were broadly in line with NSS Prescription Stationery Guidance, the SSUMPP and relevant Standard Operating Procedures with issues identified that management have agreed to rectify.

6. B18/22 - Procurement Governance Board

Internal Audit reviewed the arrangements of the Procurement Governance Board (PGB) including the scope and operation of its remit. We also considered whether the Procurement Governance Board has appropriate oversight and monitoring over the Procurement Strategy; the procurement work plan; risk management and performance monitoring mechanisms.

Executive summary: The ever increasing challenges of the COVID environment has impacted the operation of the PGB and we have identified improvements and recommendations to enhance the current Procurement Governance arrangements within the following areas:

- the frequency of the PGB meetings;
- the Terms of Reference of the PGB;
- the assurances to the Finance, Performance and Resources Committee;
- the reporting of KPIs and the inclusion of further data, where possible, within the Procurement Annual Report around the progress on

Procurement Strategic objectives.

7. B20/22 Financial Process Compliance

The Internal Audit strategic planning process recognises that not all systems are subject to full review every financial year. Where full audits are not carried out, high level financial process compliance (FPC) audits are carried out in order to provide assurance on the operation of key financial systems.

The scope of this review was to provide assurance that, for a sample of key financial systems, processes and procedures are established and meet the requirements of the Financial Operating Procedures (FOPs) and the relevant parts of the Standing Financial Instructions. This exercise tested outputs from and certain procedures within the accounts payable and budgetary control systems.

From our high level review of the budgetary control system we concluded that:

- Budget holders signed for their respective budgets at the beginning of the financial year
- We are satisfied that monthly reports are provided to budget managers using a standard format and that appropriate support to budget managers is provided by the Management Accounts Team
- A timetable is in place for the production and distribution of standard reports with appropriate review undertaken by senior management.

From our review and sample testing of the Accounts Payable system we concluded that key controls for the system were in place and operating effectively and BACS payment runs were in line with the Financial Operating Procedures. Invoices examined were correctly coded, appropriately authorised and invoices were passed to the Accounts Payable Department in a timely manner.

We reviewed the Invoice Register weekly report as at 7 of March 2022, a report which shows a cumulative record of unpaid invoices and the dispute code with reasons why these cannot be processed for payment. Overall at the time of our review the financial value of 6,874 invoices was approximately £18.6m and the most common reasons recorded were 'Awaiting Authorisation' - 26% and 'Awaiting Receipt' – 19%. Internal Audit have recommended that further analysis with clear actions to resolve the number of disputed invoices is undertaken by NHS Fife and are advised that an initial report has been distributed to Executive Directors for dissemination to address the issue.

8. B23/22 Resilience – Interim Report

We have not provided an audit opinion as a full review has not been undertaken. Our initial work undertaken during planning highlighted that due to management staffing vacancies, key controls have not been functioning as required, initiating this interim report to highlight immediate concerns over governance and internal control arrangements for resilience. These include:

- Reporting of resilience planning arrangements has not been made to the CGC, with no annual assurance being provided to it. There has been no formal oversight and monitoring of NHS Fife's business continuity planning arrangements so far during 2021/22
- The revised Major Incident Plan, which is currently a working document, has never been formally approved and it has not been confirmed if the related action cards have been fully updated to compliment it
- Due to staff vacancies, there has been no oversight of business continuity planning arrangements since January 2021, but arrangements have now

been concluded to appoint a Head of Resilience with the appointee having started in March 2022

- It is not clear that any person or group involved appears to have noticed the cessation in reporting to the CGC and indeed, activity on resilience or the issues in relation to the MIP, although Covid may well have focused attention elsewhere.

The Director of Public Health has provided a detailed management response to these areas of concern, and Internal Audit will be undertaking a further review later in the year as part of the 2022/23 Internal Audit Plan.

Key Performance Indicators
2021/22

Performance against service specification as at 6 May 2022 :

	Planning	Target	9 December 2021	17 March 2022	16 May 2022
1	Audit assignment plans for planned audits issued to the responsible Director at least 2 weeks before commencement of audit	75%	100%	100%	100%
2	Draft reports issued by target date	75%	67%	60%	75%
3	Responses received from client within timescale defined in reporting protocol	75%	100%	100%	100%
4	Final reports presented to target Audit Committee	75%	100%	75%	75%
5	Number of days delivered against plan	100% at year-end	-	349 days – 77%	420 days – 92%
6	Number of audits delivered to planned number of days (within 10%)	75%	-	67%	67%

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**18 May 2022**
Title:	**Draft Annual Internal Audit Plan – 2022/2023**
Responsible Executive:	**Margo McGurk – Director of Finance and Strategy**
Report Author:	**Tony Gaskin – Chief Internal Auditor**

1 Purpose

This is presented to the Audit and Risk Committee for:

- Assurance

This report relates to a:

- Legal requirement

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

Public Sector Internal Audit Standards (PSIAS) require the Chief Internal Auditor to produce a risk based plan, which takes into account NHS Fife's risk management framework, strategic objectives and priorities.

This paper provides an update on the approach for the development of the Internal Audit plan for 2022/23. Given the impending changes to the Risk Register and the fluidity of strategic risks, the draft Internal Audit Operational Plan 2022/23 has not been mapped to the extant BAFs but does take into account issues identified in recent Internal Audit reports.

A Risk Management Improvement Programme was approved by NHSF Board in March 2022. NHS Fife is in the process of revisiting the risk profile and introducing a Corporate Risk Register (CRR), with completion due June 2022.

We have engaged initially with the Director of Finance and Strategy and then with the wider Executive Directors Group to identify areas where a review would add value.

Appendix A shows days already allocated for areas such as audit management, completion of prior year audits, risk assessed reviews from 2021-22, ICE themes, executive requests, audits required for year-end assurance or to comply with legislation and guidance.

A full internal audit operational plan, incorporating any comments from this meeting, will be presented to the Audit and Risk Committee once the Strategic Priorities and Corporate Risk Register are completed in June 2022.

Over the last two years, Internal Audit work has largely focused on key strategic responses to Covid and related issues and whilst some audit review of Strategy development is still incorporated within the draft 2022/23 annual plan, we intend to focus more on operational aspects this year, including any areas where the operation of key controls has changed as a result of revised working arrangements or any other impacts of Covid-19.

2.2 Background

> ***"Internal auditing is an independent, objective assurance and consulting activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, internal control and governance processes."***
>
> Public Sector Internal Audit Standards (PSIAS) – Section 3, Definition of Internal Auditing

The Operational Plan 2022/23 will be developed in accordance with Public Sector Internal Audit Standard 2010 – Planning, to enable the Chief Internal Auditor to meet the following key objectives:

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

The internal audit service will be delivered in accordance with the Internal Audit Charter.

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

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

2.3 Assessment

Standard process – Previous Years

Our Strategic Internal Audit planning process is normally structured around an audit universe based on a 5 year cycle which links to the Strategic Risk Register and objectives. The process overtly demonstrates cyclical coverage of all strategic risks and

is designed to allow Executive Directors and the Audit and Risk Committee to contribute their views on areas for inclusion. The resultant operational plan is again overtly linked to the relevant strategic risk, which will still be the focus of our work, together with any key governance or assurance elements required in order to provide a view on the overall adequacy and effectiveness of internal controls.

Current year process – 2022/23

As was the case for 2021/22, due to the significant and ongoing impact of Covid-19 on the risk profile of the organisation, a planning process which relied on a relatively static risk environment and change generally occurring in the medium to long term was no longer viable. As such, our view is very much that the plan will need to be flexible, responsive to the requirements of senior management and non executive directors and, to a certain extent, emergent as the risk profile changes.

We have asked for the views of Directors with greater emphasis on the organisations current rather than cyclical needs, focusing on emergent risks and those with most immediacy, as the basis for a first draft plan.

However, we know that the organisational risk profile is changing rapidly, as is organisational understanding of those risks and we may present an updated plan later in the audit year.

Environmental and change risks

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

- Corporate Strategy & Plans/ Recovery and Remobilisation Plans / local plans
- Themes / risks emerging from our Internal Control Evaluation work
- Previous internal audit reports
- External audit reports and plans
- Board website, internal policies and procedures
- Our NHS knowledge and experience
- Discussions with the EDG and the Audit and Risk Committee
- Changes to the risk profile due to Covid-19
- Identification of any areas where the operation of key controls has changed as a result of revised working arrangements due to Covid-19.

Assurance mapping

Internal Audit continues to work with the Board to develop a process and timetable for the development of a holistic Assurance Mapping process to identify key sources of assurance and any gaps in independent assurance, which will then be taken into account in the formation of future Internal Audit plans and audit scopes. The Assurance Principles have recently been updated and the Board Secretary is working with Standing Committees Chairs to ensure they are embedded within the Board's formal assurance processes.

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 the IJB, with IJB Plans agreed with the IJB Chief Officers and Chief Finance Officers and approved by the IJB Audit Committee. The IJB Chief Officer was provided with the opportunity to influence the Health Board Plan as a member of the EDG and there is a sharing protocol that allows for Health Board and Council Internal Audit Plans to be shared with the IJB and vice-versa.

We will consult on the plan with our External Audit colleagues and we will ensure that work which will be relied upon by External Audit and that which provides assurance on the highest risk areas is prioritised.

2.3.1 Quality/ Patient Care

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

2.3.2 Workforce

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

2.3.3 Financial

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

2.3.4 Risk Assessment/Management

Whilst a detailed mapping has not been undertaken this year, the plan is cognisant of NHS Fife's risk profile as identified through the BAF and through our detailed ICE review. Individual internal audit assignments identify the key risks at the planning stage and our work is designed to evaluate whether appropriate systems are in place and operating effectively to mitigate the risks identified. Legal requirements are a core consideration in planning all internal audit reviews.

2.3.5 Equality and Diversity, including health inequalities

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

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

See timetable above.

2.3.8 Route to the Meeting

Executive Directors Group – 21 April 2022

2.4 Recommendation

The Audit and Risk Committee are asked to:

- Decision – approve the partial audit plan for 2022/23 (Appendix A) and support the approach to further developing the Internal Audit Plan for 2022/23 once the Strategic Priorities and Corporate Risk Register are formalised.
- provide suggestions for inclusion in the annual internal audit plan for 2022/23.

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

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

Appendix A – Draft Operational Internal Audit Plan 2022-23

Audit Process	Scope	Days
AUDIT MANAGEMENT		***55***
Audit Risk Assessment & Planning	Audit Risk Assessment & Operational Planning	8
Audit Management & Liaison with Directors	Audit Management, liaison with Director of Finance and other officers	15
Liaison with External Auditors	Liaison and co-ordination with External Audit	4
Audit Committee	Briefing, preparation of papers, attendance and action points	18
Clearance of Prior Year	Provision for clearance and reporting of 2020/21 audit reports	10
CORPORATE GOVERNANCE		
Accountability and Assurance		***105***
Annual Internal Audit Report	CIA annual assurance to Audit Committee	15
Governance Statement	Preparation of portfolio of evidence to support	15
Interim Control Evaluation	Mid-year assurance for Audit and Risk Committee on specific agreed governance areas	35
Audit Follow Up	Undertaking the follow up of audit action points and provision of related reports to the Audit and Risk Committee	40
Control Environment		***10***
Board, Operational Committees and Accountable	Attendance and input / provision of advice at Standing Committees and other Groups.	5

Audit Process	Scope	Days
Officer		
Assurance Framework	Continuation of assurance mapping work across FTF Clients – CIA leading	5
Risk Management		***30***
Risk Management Strategy, Standards and Operations	Yearly review of strategy and supporting structures in order to conclude on risk maturity. This review is a requirement of the Public Sector Internal Audit Standards.	15
Resilience and Business Continuity	Further review of Resilience following on from Interim Report T29/21	15
Health Planning		***50***
Strategic Planning	TBC	15
Health & Social Care Integration	Deliver Fife IJB Internal Audit Plans.	35
CLINICAL GOVERNANCE		***10***
Medicines Management	Follow-up audit of the Transportation of Medicines audit (B21/20) – Request from Director of Pharmacy (previous)	10
STAFF GOVERNANCE		***35***
Workforce Planning	TBC	25
Whistle blowing	Compliance with Whistle blowing Standards – Request from Kirstie MacDonald, Non Executive	10
FINANCIAL GOVERNANCE		

Audit Process	Scope	Days
Capital Investment		***15***
Property Transaction Monitoring	Post transaction monitoring	15
Transaction Systems		***35***
Financial Process Compliance	To be selected from: Central, payroll, travel, accounts payable, accounts receivable, banking arrangements.	15
Patients Funds/Endowments	Focus on the ward controls – Request from Kevin Booth	20
Total Days Allocated		***345***
Unallocated – approx 6 reviews		***118***
Total Days for 2022/23 Internal Audit Plan		***463***

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**18 May 2022**
Title:	**Patients' Private Funds – Audit Planning Memorandum**
Responsible Executive:	**Margo McGurk, Director of Finance**
Report Author:	**Kevin Booth, Head of Financial Services**

1 Purpose

This is presented to the Audit & Risk Committee for:

- Assurance

This report relates to a:

- Legal requirement for the annual statutory audit

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

- Effective

2 Report summary

2.1 Situation

The Committee is asked to consider the Audit Planning Memorandum in respect of the external audit of the Patients' Private Funds Abstract of Receipts and Payments for 2021/22.

2.2 Background

International Standard on Auditing 260 requires auditors to communicate by effective means, matters concerning an entity's audit to those charged with the governance of that organisation. The purpose of the report is to provide the Committee with information regarding:

- the planned audit approach to be adopted by Thomson Cooper
- the proposed means and modes of communication throughout the audit assignment; and
- to provide the opportunity to discuss the assignment and the audit approach, agreeing any changes as necessary.

2.3 Assessment

As part of the audit planning process the auditors have provided their Audit Planning Memorandum for the statutory audit of Patients' Private Funds Abstract of receipts and Payments and this is attached at the Appendix.

Although this is part of the Exchequer Annual Accounts process, it relates to private funds held on trust and is therefore audited separately by Thomson Cooper at the same time as they carry out the Endowment Fund audit. The main issue for the auditors in carrying out this audit during the ongoing COVID-19 pandemic is the restrictions that are currently in place regarding access to wards in NHS Hospitals which may result in a limitation of scope*.

* A limitation of scope may result in the auditor not being in a position to give an opinion on the validity of the financial statements or the controls operating within an organisation or it may mean that they can only give an opinion on part. It is likely to mean that the Committee cannot be comprehensively assured in respect of the subject of the audit.

2.4 Recommendation

The Committee is asked to take assurance from the Audit Planning Memorandum attached at the Appendix and to agree any requirements they may have with regard to this audit.

2 List of appendices

The following appendices are included with this report:

- Fife NHS Board Patients' Private Funds Audit Planning Memorandum 2021/22.

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

Fife Health Board Patients' Private Funds Audit Planning Memorandum

To the Board

Audit of Accounts

Year Ended 31 March 2022

Introduction

Purpose and Scope

International Standard on Auditing 260 requires auditors to communicate by effective means, matters concerning an entity's audit to those charged with the governance of that organisation.

The purpose of this report is to provide the Board (as those charged with the governance of Fife Health Board Patients Private Funds) with information regarding:

- the planned audit approach;
- the proposed means and modes of communication throughout the audit assignment; and
- to provide the Board with the opportunity to discuss the assignment and the audit approach prior to the commencement of audit field work.

Over recent years there have been a number of developments in the auditing and financial reporting framework. We have provided details of these developments in the Audit Planning Memorandum for the Fife Health Charity.

This report is addressed to the Board of Fife Health Board Patients' Private Funds and is intended for internal use only for the purpose of planning and discussing the audit of the financial statements for the year ended 31 March 2022. This report may not be reproduced in whole or in part without the prior, written consent of Thomson Cooper.

Background to Appointment

General

As part of our quality control procedures, we review and update our Letters of Engagement on a regular basis. As there has been a change of the Director of Finance, we have issued an updated Engagement Letter. An electronic copy of this Engagement Letter is shown at Appendix 1. As detailed in our Engagement Letter, it remains effective until it is replaced.

Independence

We can confirm that Thomson Cooper are independent within the context of relevant regulatory and professional requirements and that there are no circumstances of which the firm is aware which might lead to impairment in the objectivity of either the audit engagement partners or audit staff.

Staff Independence

All our Staff must adhere to strict regulatory, professional and internal independence requirements related to investments or business relationships with clients. All staff and partners must certify their compliance with independence rules on an annual basis. Thomson Cooper is authorised by ICAS to carry out statutory audits. Members of ICAS and other Accounting Bodies are bound by the Ethical Code which covers, objectivity, independence, confidentiality and integrity.

Money Laundering Regulations

All our staff are briefed in the current Money Laundering Regulations. As part of these regulations, and determining the risk to our audit, we consider the nature of your business, where you operate, your products and services and the appropriateness of your internal controls.

Quality

Independent quality reviews of our audit work are performed throughout the year. The reviews include testing of the effectiveness and quality of our audit work and we maintain a continuous improvement programme to ensure that our standards are maintained and improved. In addition, external reviews are also carried out periodically by the Institute of Chartered Accountants of Scotland (ICAS).

We are members of Accelerate, a community of relationship-focused, technology-driven, value-based accounting firms. Accelerate is a Business Associate of Crowe Global, meaning we can access accounting firms in more than 130 countries throughout the world. As part of that membership we receive visits every two years to review our audit approach and to discuss current auditing issues. Accelerate also provides technical courses and material on auditing throughout the year.

All Audit Staff undertake ongoing Continuous Professional Development via attendance at internal and external training courses and seminars.

Background to Appointment (continued)

Ethical Standards

Part 5 of the Ethical Standard issued by the Financial Reporting Council limits the range of services auditors can provide. At present, we assist in the preparation of the Statutory Accounts as required. There is no need to disclose this in the financial statements if the company has "informed management". Based on the knowledge and experience of the Trustees, we are satisfied that Fife Health Board Patients' Private Funds has "informed management" and therefore no disclosures will be required in the financial statements.

Thomson Cooper Audit Approach

General

Thomson Cooper adopts a risk-based approach to audit assignments.

The starting point for each assignment is to identify the key issues and risks facing the organisation including a review of internal control strengths and weaknesses. This involves close liaison with clients in order to obtain a good understanding of the client's business before detailed audit work commences.

Following this initial assessment, the audit work to be undertaken can be fully planned.

Effective planning facilitates:

- concentration of audit effort in areas of high risk;
- maximisation of overall efficiencies in audit work; and
- the drawing of suitable conclusions concerning the truth and fairness of the financial statements.

Detailed Audit Procedures

The extent of testing undertaken on the detailed records depends upon the continued adequacy of key internal accounting and operational controls, the materiality of the item involved, and the information and support provided by management.

Detailed audit testing will be performed to test the reliability of the accounting system in operation and to provide additional audit assurance.

Relationship with Internal Audit

Introduction

NHS Fife has an internal audit service which conducts periodic reviews of the Patients' Private Funds.

International Standard on Auditing 610 (ISA 610) entitled "Considering the Work of Internal Audit" establishes standards and provides guidance to external auditors in considering the work of internal audit. The standard requires external auditors to "consider the activities of internal auditing and their affect, if any, on external audit procedures".

The following sets out our audit approach for the current year and our relationship with NHS Fife internal audit function.

International Standard on Auditing 610

As stated above, the standard requires the auditor to consider the activities of internal audit. Section 5 of the standard indicates that internal audit normally has specific regard to the following:-

1. Monitoring of internal control.
2. Examination of financial and operating information.
3. Review of the efficiency and effectiveness of operations including non financial controls.
4. Review of compliance with laws and regulations.

The role of internal audit is set by management and clearly its objectives will differ from the external auditor whose appointment is to report independently on the annual financial statements. The standard recognises, however, that some of the means of achieving the respective objectives are similar and therefore certain aspect of internal audit work may be useful in determining the nature, timing and extent of external audit procedures. It follows therefore that we are obliged to obtain a sufficient understanding of the work carried out by internal audit to enable us to identify and assess the risks of material misstatements of the financial statements and accordingly to design and perform further audit procedures.

Based on our review of the work carried out by NHS Internal Audit Service in previous years, the principal area upon which we can place reliance on the work of internal audit function, has been in relation to the overall control environment within which the Patients' Private Funds operates.

The process of communication between external and internal auditors is two way and we will ensure that any instances of non compliance with the Financial Operating Procedures detected during our external audit work are brought to the attention of internal audit. The Board are asked to note and confirm their approval with the way in which we intend working with internal audit.

Staffing

Partner in Charge of Assignment

The current lead partner is Alan Mitchell. The audit of the financial statements for the year ended 31 March 2022 will be Alan's ninth year as lead partner following the rotation of the audit engagement partner from Andrew Croxford to Alan Mitchell.

Support Partners

Andrew Croxford will be called upon to undertake concurring reviews where required and will be available to discuss any issues which may arise throughout the audit.

Other Staff

In order to maximise efficiency and minimise disruption to the company, the firm, as far as possible will try to maintain continuity in the other staff deployed on the assignment.

Staff members involved in the audit have previous experience of the assignment and are suitably qualified and trained.

The senior staff member this year is Billy Leitch, a qualified Accountant. He will be assisted by Sophie Wilkinson who is a trainee Accountant.

Audit Risks

Introduction

Audit risk comprises three elements:

- Inherent risk
- Control risk
- Detection risk

Thomson Cooper aim to plan and perform sufficient audit work so as to ensure that detection risk is minimised, and that the conclusion drawn regarding the truth and fairness of Fife Health Board Patients Private Fund's accounts is valid.

This involves Thomson Cooper in a wide evaluation of risk areas (per ISA 300 - Planning, ISA 250A – Consideration of Laws and Regulations and ISA 330 - Auditor's Response to Assessed Risks) and also a detailed evaluation, at the level of account class, of the risk of material misstatement.

The areas detailed below have been limited to those, based on previous audit experience, which carry the highest risk of material misstatement either because the balances are so significant in the overall context of Fife Health Board Patients Private Fund's accounts or the account class is subject to a degree of estimation or relies upon the work of an expert.

The list is not exhaustive and has been prepared based upon our previous experience prior to the commencement of the detailed planning work for the audit for the year ended 31 March 2022.

The Board remain ultimately responsible for the integrity of the financial statements and risk management in the widest context. Thomson Cooper, as external auditor, are responsible for providing the Board of Fife Health Board Patients' Private Funds reasonable assurance that the accounts are free from material misstatement and that the accounts give a true and fair view of the state of the affairs of Fife Health Board Patients' Private Funds at 31 March 2022. While the audit work performed may involve consideration of such issues as the impact of failure of IT equipment for example, the work performed will be limited to considering the extent to which the breach might impact upon the financial statements. Hence risks of this nature have been excluded from those listed below.

Audit Risks (continued)

Security of Patients Funds

Due to the nature of the fund's assets i.e. cash, there is an increased susceptibility of the assets to loss through theft or misappropriation. A key focus of our audit will be the testing of the adequacy of the controls in place governing the security of patient funds on the wards.

Compliance with Agreed Operating Procedures

The Board has in place a series of control and authorisation procedures for patient funds which are documented in the Board's Financial Operating Procedure. This report details the various forms which should be used by staff in order to adequately record and control patient funds on the wards and is a key source of internal control. Our audit will include tests to assess the extent to which members of staff have adhered to the documented procedures, including visiting various hospital wards on a rotational basis (see Appendix 2).

We shall also consider any areas of potential non-compliance with procedures that were identified and communicated to the Board in the previous year's audit and follow up with regard to how each item has been subsequently dealt with. In addition, where considered relevant, we will seek to re-visit any wards attended in the previous year where issues were identified to perform updated tests to re-assess the extent to which staff have been advised of the issues and have acted upon the recommendations.

Management Override

In every organisation, senior management may be in a position to override the routine day-to-day financial controls. For all of our audits, we consider this risk and adapt our audit procedures accordingly.

Fraud

The auditor's responsibility to consider the audit risk of fraud is laid down in ISA 240 "The auditor's responsibility to consider fraud in an audit of financial statements".

In accordance with ISA 200, 'the auditor shall maintain professional scepticism throughout the audit, recognising the possibility that a material misstatement due to fraud could exist, notwithstanding the auditor's past experience of the honesty and integrity of the entity's management and those charged with governance'.

Audit Risks (continued)

Fraud (continued)

As part of the planning process, we are obliged to make enquiries of management and those charged with governance regarding:

a) Management's assessment of the risk that the financial statements may be materially misstated due to fraud, including the nature, extent and frequency of such assessments;
b) Management's process for identifying and responding to the risks of fraud in the entity, including any specific risks of fraud that management has identified or that have been brought to its attention, or classes of transactions, account balances, or disclosures for which a risk of fraud is likely to exist;
c) Management's communication, if any, to those charged with governance regarding its processes for identifying and responding to the risks of fraud in the entity;
d) Management's communication, if any, to employees regarding its views on business practices and ethical behaviour; and
e) Whether Management have knowledge of any actual, suspected or alleged fraud affecting the entity.

We can confirm that if we identify any fraud or obtain information that indicates that a fraud may exist, we will communicate this to the appropriate level of management as soon as practicable. If the fraud involves management, employees who have significant roles in internal control or where the fraud results in a material misstatement in the financial statements, we will communicate these matters to the Board as soon as practicable.

At the conclusion of our audit work, we will request written confirmation in our letter of representation that the Board acknowledge their responsibility for the design and implementation of internal control to prevent and detect fraud and that it has disclosed to ourselves the results of its risk assessment and disclosed any instances or allegations of fraud which have arisen.

Materiality

Concept and definition

The concept of materiality is fundamental to the preparation of the financial statements and the audit process and applies not only to monetary misstatements but also to disclosure requirements and adherence to appropriate accounting principles and statutory requirements.

- According to International Standard on Auditing 320 Audit Materiality, 'misstatements, including omissions, are considered to be material if they, individually or in aggregate, could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements; and judgements about materiality are made in light of surrounding circumstances, and are affected by the size or nature of a misstatement, or a combination of both'.

  The Clarified ISA 320 on Audit Materiality establishes the concept of 'performance materiality'. Performance materiality means the amounts set by the auditor at less than materiality for the financial statements as a whole to reduce to an appropriately low level the probability that the aggregate of uncorrected and undetected misstatements exceeds materiality for the financial statements as a whole.

An item may also be considered material for reasons other than size, if for example, it had an impact on:

- trends;
- compliance with loan covenants; or
- instances when greater precision is required.

Calculation and determination

We have determined materiality based on professional judgement in the context of our knowledge of Fife Health Board Patients' Private Funds, including consideration of factors such as member expectations, industry developments, financial stability and reporting requirements for the financial statements.

We determine materiality in order to:

- estimate the tolerable level of misstatement in the financial statements;
- assist in establishing the scope of our audit engagement and audit tests;
- calculate sample sizes; and
- assist in evaluating the effect of known and likely misstatements on the financial statements.

We will finalise our materiality figure prior to the commencement of our audit.

Materiality (continued)

If, in the specific circumstances of Fife Health Board Patients' Private Funds, we believe there are particular transactions, account balances or disclosures where misstatement of less than materiality for the financial statements as a whole could be expected to influence the decisions of the users, we shall also determine the performance materiality level to be applied to those particular transactions.

Reassessment of materiality

We will reconsider materiality if, during the course of our audit engagement, we become aware of facts and circumstances that would have caused us to make a different determination of planning materiality if we had been aware of those facts and circumstances when we made our initial determination.

Further, when we have performed all our substantive tests and are ready to evaluate the results of those tests, including any misstatements we detected, we will reconsider whether materiality, in combination with the nature, timing and extent of our auditing procedures, provided a sufficient audit scope. If we conclude that our audit scope was sufficient, we will use materiality to evaluate whether uncorrected misstatements, individually or in aggregate, are material.

Unadjusted errors

In accordance with auditing standards, we will communicate to the Board all unadjusted items identified during our audit, other than those which we believe are "clearly trivial".

Clearly trivial is defined as matters which will be of a wholly different (smaller) order of magnitude than the materiality thresholds used in the audit, and will be matters that are clearly inconsequential, whether taken individually or in aggregate.

Auditing standards do not place numeric limits on the meaning of 'clearly trivial', however, we consider the 'clearly trivial' limit to be less than 1% of materiality.

We will obtain written representations from the Board confirming that after considering all these unadjusted items, both individually and in aggregate, no adjustments are required.

There are a number of areas where we would strongly recommend or request any misstatements identified during the audit process being adjusted. These include:

- misstatements that we believe were intentionally made to achieve targeted earnings or similar goals;
- clear cut-off errors whose correction would cause non-compliance with loan covenants, management compensation agreements, other contractual obligations or governmental regulations that we consider are significant; and
- other misstatements that we believe are material or clearly wrong.

Reporting of Audit Findings

Communication

As external auditor, we have direct access to the Board should the need arise. Audit findings will be communicated orally at the meeting of the Board at which the annual accounts are reviewed.

In addition, on completion of the audit field work an Audit Completion Memorandum will be prepared summarising the main audit findings which will be addressed to the Board for their responses.

Audit Adjustments

Any misstatements identified as a result of the audit work performed, which have not already been adjusted, will be reported to the Board. If, after discussion, there remain any material unadjusted misstatements written representation from the Board may be sought setting out the reasons for non-adjustment.

Misstatements which have been found, but adjusted, will only be brought to the attention of the Board where it is believed that an awareness is required for the Board to be able to fulfil their governance responsibilities or where adjustments indicate significant weaknesses in the system of internal controls.

Timetable

	Date
Issue Bank Confirmation Letter	18 March 2022
Audit Planning Meeting with Client	11 March 2022
Issue Audit Planning Memorandum	25 March 2022
Audit Staff Planning Meeting	2 May 2022
Audit Fieldwork Commences	3 May 2022
Audit Clearance Meeting	20 May 2022
Provide Completion Documents	1 June 2022
Board Papers Issued	1 June 2022
Audit Committee Meeting	7 June 2022
Board Meeting	28 July 2022

Proposed Fees

	Proposed 2022	Actual 2021
	£	£
On completion of audit fieldwork	1,800	1,650
On signing of accounts	900	900
	2,700	2,550

Should we anticipate that our costs will exceed our budget due to additional work that we may require to undertake, we shall notify you immediately in order that we may agree what action, if any, is required by you and to agree the basis for any additional charges.

The above fees are exclusive of VAT and expenses.

Appendix 1 – Engagement Letter

An electronic copy of our newly issued Engagement Letter is as follows:

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24 March 2021

The Trustees
Fife Health Board Patients' Private Fund
Evans Business Centre
Mitchelston Industrial Estate
Mitchelston Drive
Kirkcaldy
Fife
KY1 3NB

Dear Trustees

We are pleased to continue the instruction to act as your advisers and are writing to confirm the terms of our appointment.

The purpose of this letter together with the attached terms and conditions is to set out our terms for carrying out the work and to clarify our respective responsibilities.

We are bound by the ethical guidelines of the Institute of Chartered Accountants Scotland and accept instructions to act for you on the basis that we will act in accordance with those guidelines.

1. Engagement letter

1.1 Thank you for engaging us as your advisers. Alan Mitchell will be your main point of contact and will have primary responsibility for this assignment. This letter and the attached schedule(s) of services together with this firm's standard terms and conditions set out the basis on which we will act.

2. Who we are acting for

2.1 For the avoidance of doubt Margo McGurk is acting as nominated first point of contact. Any change to the nominated person should be notified to us in writing and will not be effective until acknowledged by us in writing.

3. Period of engagement

3.1 This engagement will start from the date this letter is signed. It replaces all previous engagements that we have had with you.

4. Our responsibility to you

4.1 We have set out the agreed scope and objectives of your instructions within this letter of engagement. Any subsequent changes will be discussed with you and where appropriate a new letter of engagement will be agreed. We shall proceed on the basis of the instructions we have received from you and will rely on you to tell us as soon as possible if anything occurs which renders any information previously given to us as incorrect or inaccurate. We shall not be responsible for any failure to advise or comment on any matter which falls outside the specific scope of your instructions. We cannot accept any responsibility for any event, loss or situation unless it is one against which it is the expressed purpose of these instructions to provide protection.

5. Your responsibility to us

5.1 The advice that we give can only be as good as the information upon which it is based. Insofar as that information is provided by you, or by third parties with your permission, your responsibility arises as soon as possible if any circumstances or facts alter as any alteration may have a significant impact on the advice given. If the circumstances change therefore or your needs alter, advise us of the alteration as soon as possible in writing.

6. Services

6.1 Attached is the schedule of services listed below which records the work we are instructed to carry out. This also states your and our responsibilities in relation to the work to be carried out.

Schedules

Unincorporated Charity Audit (April 2015 version 2)

6.2 You may request that we provide other services from time to time. We will issue a separate schedule of service or, if necessary, a new letter of engagement and scope of work to be performed accordingly.

6.3 Because rules and regulations frequently change you must ask us to confirm any advice already given if a transaction is delayed or a similar transaction is to be undertaken.

7. Fees

7.1 Our fees will be charged in accordance with our standard terms and conditions. Please review these to ensure you understand the basis of our charges and our payment terms.

8. Limitation of liability

8.1 You have agreed that our liability as auditors to the company will be limited in accordance with sections 532 to 538 of the Companies Act 2006. The terms of this agreement are in our standard terms and conditions which are attached to this engagement letter.

8.2 We specifically draw your attention to paragraph 23 of our standard terms and conditions which sets out the basis on which we limit our liability to you and to others. You should read this in conjunction with paragraph 11 of our standard terms and conditions which excludes liability to third parties.

8.3 There are no Third Parties that we have agreed should be entitled to rely on the work done pursuant to this engagement letter.

9. Your agreement

9.1 Once it has been agreed, this letter will remain effective until it is replaced.

9.2 We shall be grateful if you could confirm your agreement to the terms of this letter, the schedule of services and the standard terms and conditions by signing the enclosed copy and returning it to us immediately.

9.3 If this letter and schedule of services is not in accordance with your understanding of the scope of our engagement or your circumstances have changed, please let us know.

Yours sincerely

Thomson Cooper

Acceptance

We confirm that we have read and understood the contents of this letter, schedules and related terms and conditions and agree that it accurately reflects our fair understanding of the services that we require you to undertake.

Signed ..... Date .....

For and on behalf of
Fife Health Board Patients' Private Fund

SCHEDULE OF SERVICES

This schedule should be read in conjunction with the engagement letter and the standard terms and conditions.

UNINCORPORATED CHARITY AUDIT

1. Your responsibilities as trustees of the charity

1.1 In agreeing to these engagement terms, you acknowledge your responsibilities and confirm that you understand them.

1.2 As trustees of the charity you are responsible for:

a) ensuring that adequate accounting records are maintained which disclose the charity's financial position with reasonable accuracy at any time;

b) preparing financial statements for each financial year that:

i) give a true and fair view of the charity's state of affairs at the end of the financial year and of its incoming resources and application of resources for that year; and

ii) are in accordance with the Charities and Trustee Investment (Scotland) Act 2005 and regulations thereunder;

c) preparing an annual report on the activities of the charity during the year that complies with the requirements of the relevant regulations.

1.3 In preparing the financial statements (or arranging for them to be prepared) you are required to:

a) select suitable accounting policies and then apply them consistently;

b) make judgements and estimates that are reasonable and prudent;

c) prepare the financial statements on the going concern basis unless it is inappropriate to assume that the charity will continue in business; and

d) have regard to applicable accounting standards and the relevant statement of recommended practice.

1.4 You are responsible for such internal controls as you consider necessary to enable the preparation of the financial statements that are free from material misstatement, whether due to fraud or error.

1.5 Under the Charities Accounts (Scotland) Regulations 2006 (as amended) and the Charities SORP you are required to report as to whether you have given consideration to the major risks to which the charity is exposed, and to the systems designed to manage those risks. We are not required to audit this statement, or to form an opinion on the effectiveness of the risk management and control procedures.

1.6 You are responsible for safeguarding the assets of the charity and to ensure their proper application, and hence for taking reasonable steps to prevent and detect fraud and other irregularities.

1.7 You are responsible for ensuring that the charity complies with laws and regulations that apply to its activities, and for preventing non-compliance and detecting any that occurs.

1.8 You undertake to make available to us, as and when required, all the charity's accounting records and related financial information, including minutes of management and members' meetings that we need to do our work. You will disclose to us all relevant information in full. In particular, you agree to provide:

a) access to all information of which management is aware that is relevant to the preparation of the financial statements such as records, documentation and other matters;

b) additional information that we may request from management for the purpose of the audit; and

c) unrestricted access to persons within the entity from whom we determine it necessary to obtain audit evidence.

1.9 If audited financial information is published, which includes a report by us or is otherwise connected to us, on the charity's website or by other electronic means, you must inform us of the electronic publication and obtain our consent before it occurs and ensure that it presents the financial information and auditor's report properly. We have the right to withhold consent to the electronic publication of our report or the financial statements if they are to be published in an inappropriate manner.

1.10 You must set up controls to prevent or detect quickly any changes to electronically published information. We are not responsible for reviewing these controls nor for keeping the information under review after it is first published. You are responsible for the maintenance and integrity of electronically published information and we accept no responsibility for changes made to audited information after it is first posted.

1.11 You are responsible for establishing and controlling any process for electronically distributing Annual Reports and other financial information to members and/or supporters of the charity and to the Office of the Scottish Charity Regulator (OSCR).

1.12 You are responsible for filing the charity's financial statements and an annual report for the financial year complying in its form and content, as well as other relevant documentation, with OSCR in accordance with their requirements, unless otherwise agreed.

1.13 The audited financial statements and annual report are required to be delivered to OSCR within nine months of the end of the charity's financial year end and it is the trustees' responsibility to ensure that this deadline is met.

2. Our responsibilities as auditor

2.1 We have a statutory responsibility to report to you whether, in our opinion, the financial statements give a true and fair view of the state of affairs of the charity at the end of the financial year and of its incoming resources and application of resources in that year and whether they have been properly prepared in accordance with the Charities and Trustee Investment (Scotland) Act 2005 and regulations thereunder. In deciding this, we must consider the following matters, and report on any that we are not satisfied with:

a) whether the charity has kept proper accounting records;

b) whether the charity's balance sheet and statement of financial activities are in agreement with the accounting records and returns;

c) whether we have obtained all the information and explanations which we consider necessary for the purposes of our audit; and

d) whether the information given in the annual report of the charity trustees is not consistent with that contained in the audited financial statements.

2.2 We may also need to deal with certain other matters, according to the circumstances, in our report such as any material concerns we may have relating to the financial effects of any non-compliance with relevant laws and regulations.

2.3 We have a professional responsibility to report if the financial statements do not significantly comply with applicable financial reporting standards or the relevant statement of recommended practice unless, in our opinion, the departure is justified in the circumstances. In deciding whether or not this is the case we consider:

a) whether the non-compliance is necessary for the financial statements to give a true and fair view; and

b) whether the non-compliance has been clearly disclosed.

2.4 Our professional responsibilities also include:

a) describing in our audit report the trustees' responsibilities for the financial statements if the financial statements or accompanying information do not include this information; and

b) considering whether other information in documents containing the audited financial statements is consistent with those financial statements.

2.5 In respect of the expected form and content of our report, we refer you to the most recent bulletin on auditor's reports published by the Auditing Practices Board at http://www.frc.org.uk/apb. The form and content of our report may need to be amended in the light of our findings.

2.6 We have a statutory duty to report to OSCR such matters (concerning the activities or affairs of the charity or any connected institution or body corporate) of which we become aware during the course of our audit which are (or are likely to be) of material significance to OSCR in the exercise of the powers of inquiry into, or acting for the protection of, charities. It is envisaged that the need to make such a report will arise only very rarely, in accordance with the guidance set out in International Standards on Auditing (UK & Ireland) 250 Section B "The Auditor's Right and Duty to Report to Regulators in the Financial Sector".

2.7 We will report solely to the charity's trustees, as a body. Our audit work will be undertaken so that we might state to the trustees those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the trustees, as a body, for our audit work, for this report, or for the opinion we have formed.

2.8 You should be aware that the charity's annual financial statements are for the specific purpose of reporting to the trustees [as well as to the members] at a particular point in time. They may therefore not be suitable for other purposes such as such as making decisions regarding borrowing or investing by you as trustees or by any other party.

3. Scope of audit

3.1 We will carry out our audit in accordance with the International Standards on Auditing (UK and Ireland) issued by the Auditing Practices Board. The audit will include such tests of transactions and of the existence, ownership and valuation of assets and liabilities as we consider necessary.

3.2 We shall obtain an understanding of the accounting and internal control systems to ensure they are adequate as a basis for the preparation of the financial statements and to establish whether the charity has kept proper accounting records. We will gather enough evidence to enable us to reach a reasonable conclusion.

3.3 You are responsible for safeguarding the charity's assets and for preventing and detecting fraud, error and non-compliance with law or regulations. We will plan our audit so that we can reasonably expect to detect significant misstatements in the financial statements or accounting records (including those resulting from fraud, error or non-compliance with law or regulations), but you cannot rely on us finding all such errors.

3.4 We shall not be treated as having notice, for the purposes of our audit responsibilities, of information provided to members of our firm other than those engaged on the audit.

3.5 Once we have issued our audit report we have no further responsibility in relation to the financial statements for that financial year.

3.6 We would appreciate receiving notice of and invitations to attend the meeting of the trustees at which the annual report and financial statements are to be approved.

3.7 To ensure that there is effective two-way communication between us and to comply with the requirements of Auditing Standards we will:

a) contact you prior to the audit to discuss any relevant matters and to agree any required action; and

b) contact you to discuss any matters arising from the audit and to confirm any agreed action.

4. Reporting to the Trustees and Management

4.1 The nature and extent of our procedures will vary according to our assessment of the charity's accounting system and, where we wish to place reliance on it, the internal control system, and may cover any aspect of the charity's operations that we consider appropriate. Our audit is not designed to identify all significant weaknesses in the charity's systems but, if such weaknesses come to our notice during the course of our audit which we think should be brought to your attention, we shall report them to you. Any such report may not be provided to third parties without our prior written consent. Such consent will be granted only on the basis that such reports are not prepared with the interests of anyone other than the charity in mind and that we accept no duty or responsibility to any other party as concerns the reports.

5. Representations by management/trustees

5.1 As part of our normal audit procedures, we may request written confirmation of oral representations which we have received during the course of the audit on matters having a material effect on the financial statements.

6. Documents issued with the financial statements

6.1 In order to assist us with the examination of your financial statements, we shall request sight of all documents or statements, including the trustees' report, which are due to be issued with the financial statements. If it is proposed that any documents or statement which refer to our name, other than the audited financial statements, are to be circulated to third parties, please consult us before they are issued.

7. Irregularities, including fraud

7.1 The responsibility for the prevention and detection of fraud, error and non-compliance with law or regulations rests with yourselves. However, we shall endeavour to plan our audit so that we have a reasonable expectation of detecting material misstatements in the financial statements or accounting records (including those resulting from fraud, error or non-compliance with law or regulations), but our examination should not be relied upon to disclose all such material misstatements or frauds, errors or instances of non-compliance as may exist.

8. Provision of Service Regulations

8.1 Details of our audit registration can be viewed at www.auditregister.org.uk under reference number 0538.

24 March 2021

Thomson Cooper

Appendix 2 – Hospitals Visited

Hospital	Gross Receipts	2015	2016	2017	2018	2019	2020	2021	Proposed 2022
Adamson	-								
Levenmouth	1,269	✓				✓	✓		
Lynebank	106,372		✓		✓	✓		✓	✓
Queen Margaret *	6,981		✓					✓	
St Andrews	-								
Stratheden	104,103	✓		✓	✓		✓		✓
Whyteman's Brae	8,595			✓					

* Excludes "QM Acute" of £25,902

Gross Receipts are based on the figures from the accounts for the year ended 31 March 2021.

Note : Queen Margaret will also be visited to review and test the art catalogue