NHS Fife Audit & Risk Committee

Wed 13 December 2023, 13:30 - 14:40

MS Teams

Agenda

13:30 - 13:30
0 min

1. Apologies for Absence

Alastair Grant

13:30 - 13:30
0 min

2. Declaration of Members' Interests

Alastair Grant

13:30 - 13:30
0 min

3. Minutes of Previous Meeting held on Thursday 31 August 2023

Enclosed *Alastair Grant*

Item 3 - Audit & Risk Committee Minutes (unconfirmed) 20230831.pdf (5 pages)

13:30 - 13:35
5 min

4. Matters Arising / Action List

Enclosed *Alastair Grant*

Item 4 - Audit & Risk Committee Action List 20231214.pdf (2 pages)

13:35 - 13:55
20 min

5. RISK

5.1. October 2023 Development Session Outputs

Enclosed *Margo McGurk*

Item 5.1 - SBAR October 2023 Development Session Outputs.pdf (4 pages)

5.2. Corporate Risk Register

Enclosed *Margo McGurk*

Item 5.2 - SBAR Corporate Risk Register.pdf (6 pages)
Item 5.2 - Appendix 1 NHS Fife Corporate Risk Register.pdf (17 pages)
Item 5.2 - Appendix 2 Assurance Principles.pdf (1 pages)

5.3. Risk & Opportunities Group Progress Report

Enclosed *Pauline Cumming / Alistair Graham*

Item 5.3 - SBAR Risk & Opportunities Group Progress Report.pdf (7 pages)

5.4. Risk Management Policy Update

Enclosed *Pauline Cumming*

Item 5.4 - SBAR Risk Management Policy Update.pdf (3 pages)
Item 5.4 - Appendix 1 Revised Draft Risk Management Framework 2023-25.pdf (35 pages)

13:55 - 14:15
20 min

6. INTERNAL AUDIT

6.1. Delivering Excellence in Internal Audit

Presentation *Jocelyn Lyall*

6.2. Internal Audit Progress Report

Enclosed *Barry Hudson*

- Item 6.2 - SBAR Internal Audit Progress Report.pdf (3 pages)
- Item 6.2 - Appendix 1 Internal Audit Progress Report.pdf (6 pages)

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

Enclosed *Barry Hudson*

- Item 6.3 - SBAR Follow Up Report on Audit Recommendations 2022-23 + appendices.pdf (17 pages)

6.4. Internal Controls Evaluation Report 2023/24

Enclosed *Jocelyn Lyall*

- Item 6.4 - SBAR Internal Controls Evaluation Report 2023-24.pdf (3 pages)
- Item 6.4 - Appendix 1 - Internal Control Evaluation Report.pdf (36 pages)

14:15 - 14:20
5 min

7. EXTERNAL AUDIT

7.1. Annual Audit Plan 2023/24

Enclosed *Chris Brown*

- Item 7.1 - External Audit Plan 2023-24.pdf (37 pages)

14:20 - 14:35
15 min

8. GOVERNANCE MATTERS

8.1. National Fraud Initiative Assignment 2023 Participation

Enclosed *Kevin Booth*

- Item 8.1 - SBAR National Fraud Initiative Assignment 2023 Participation.pdf (4 pages)

8.2. Losses & Special Payments Quarter 2

Enclosed *Kevin Booth*

- Item 8.2 - SBAR Losses & Special Payments Quarter 2.pdf (3 pages)
- Item 8.2 - Appendix 1 Summary of Losses and Special Payments 010723 – 300923.pdf (1 pages)

8.3. Procurement Tender Waivers Quarter 2

Enclosed *Kevin Booth*

- Item 8.3 - SBAR Procurement Tender Waivers Quarter 2.pdf (3 pages)

8.4. Financial Operating Procedures Review 2023

Enclosed *Kevin Booth*

- Item 8.4 - SBAR Financial Operating Procedures Review 2023.pdf (3 pages)

8.5. Review of Draft Annual Workplan 2024/25

Enclosed *Margo McGurk*

Item 8.5 - Review of Draft Annual Workplan 2024-25.pdf (4 pages)

14:35 - 14:40
5 min

9. FOR ASSURANCE

9.1. Audit Scotland Technical Bulletin 2023/3

Enclosed *Kevin Booth*

Item 9.1 - SBAR Audit Scotland Technical Bulletin 2023-3.pdf (3 pages)
Item 9.1 - Appendix 1 Audit Scotland Technical Bulletin 2023-3.pdf (22 pages)

9.2. Delivery of Annual Workplan 2023/24

Enclosed *Margo McGurk*

Item 9.2 - Delivery of Annual Workplan 2023-24.pdf (4 pages)

14:40 - 14:40
0 min

10. ESCALATION OF ISSUES TO NHS FIFE BOARD

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

Verbal *Alastair Grant*

14:40 - 14:40
0 min

11. ANY OTHER BUSINESS

14:40 - 14:40
0 min

12. DATE OF NEXT MEETING - THURSDAY 14 MARCH 2024 FROM 2PM - 4.30PM VIA MS TEAMS

Fife NHS Board

Unconfirmed

MINUTE OF THE AUDIT & RISK COMMITTEE MEETING HELD ON THURSDAY 31 AUGUST 2023 AT 2PM VIA MS TEAMS

Present:
Alastair Grant, Non-Executive Member (Chair)
Aileen Lawrie, Non-Executive Member
Anne Haston, Non-Executive Member
Kirstie MacDonald, Non-Executive Member

In Attendance:
Kevin Booth, Head of Financial Services & Procurement
Andy Brown, Principal Auditor (deputising for Jocelyn Lyall)
Chris Brown, Head of Public Sector Audit (UK), Azets *(from item 8)*
Pauline Cumming, Risk Manager
Tony Gaskin, Chief Internal Auditor
Dr Gillian MacIntosh, Head of Corporate Governance & Board Secretary
Margo McGurk, Director of Finance & Strategy
Carol Potter, Chief Executive
Hazel Thomson, Board Committee Support Officer (Minutes)

Chair's Opening Remarks

The Chair welcomed everyone to the meeting.

The NHS Fife MS Teams Meeting Protocol was set out and a reminder given that the notes are being recorded with the Echo Pen to aid production of the minutes.

1. Apologies for Absence

Apologies were received from attendees Barry Hudson, Regional Audit Manager, and Jocelyn Lyall, Chief Internal Auditor.

2. Declaration of Members' Interests

There were no declarations of interest made by members.

3. Minute of the last Meeting held on 23 June 2023

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

4. Action List / Matters Arising

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

5. GOVERNANCE – INTERNAL AUDIT

5.1 Internal Audit Progress Report

The Principal Auditor explained that there had been a slight delay in finalising the audits from the previous year, which are now expected to be completed by December 2023.

It was reported that the evidence in relation to the implementation of actions from the Internal Audit Annual Report 2023/24 has been distributed to the relevant Directors.

It was also reported that the vacancy for the Regional Audit Manager for NHS Tayside and NHS Forth Valley has been advertised, and interviews will be held in September 2023.

The Principal Auditor thanked Tony Gaskin for his service and support and wished him well for his retirement.

The Committee **discussed** and took **assurance** on the progress of the delivery of the Internal Audit Plan.

5.2 Internal Audit – Follow Up Report on Audit Recommendations 2022/23

The Principal Auditor spoke to the report and advised that there are currently 11 remaining actions from past report recommendations that have remained open longer than one year. A focus will be on those actions, and it was advised that review dates have been extended and agreed by the appropriate officer. It was noted that it is expected that all 11 actions will be implemented by the revised review dates, including 3 which are flagged with an amber status.

The Principal Auditor highlighted the changes to the revised Audit Follow up Protocol, at appendix G, and advised that the main change is to the authorisation required for extensions, to link these more explicitly to the risk assessment of the findings and recommendations of the original report.

To provide greater assurance to the Committee, it was agreed a discussion around the timings of Internal Audit reports going first to the Executive Directors' Group and then the Committee would be arranged between the Chief Executive, Director of Finance & Strategy, Principal Auditor and Chief Internal Auditor. This would help with oversight over outstanding action points.

Action: Principal Auditor

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

6. GOVERNANCE MATTERS

6.1 Losses & Special Payments Quarter 1

The Head of Financial Services & Procurement spoke to the report and advised that there had been a significant decrease in losses compared to quarter 4 of the previous

financial year, however he noted that quarter 4 2022/23 was an outlier as a result of a number of Year End entries. It was advised that the Treasury team carried out their quarterly analytical review to provide additional assurance, and that their findings were highlighted in the paper and will be carried forward into quarter 2 to assist with the identification of any developing trends.

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

6.2 Procurement, Waiver of Competitive Tenders Q1

The Head of Financial Services & Procurement provided background detail to the Procurement Waiver of Competitive Tenders process and highlighted that approval is signed off by the Head of Procurement and then countersigned by both the Director of Finance & Strategy and the Chief Executive. The required, restricted criteria, in order for the Procurement Department to issue a Waiver of Competitive Tender in place of following the required Procurement Journey as stipulated by the Scottish Government, as detailed within the paper, was outlined.

The quarter 1 position was provided, and the sole Waiver of Competitive Tender which following approval the Procurement Department implemented in the quarter, was summarised to the committee.

The Committee took **assurance** that the Procurement process for the Waiver of Competitive Tenders was correctly applied in the period.

7. RISK

7.1 Corporate Risk Register

The Director of Finance & Strategy informed the Committee that the version of the Corporate Risk Register presented reflects the change to the review cycle process. Moving forward not all corporate risks will continue to be formally reviewed and reported upon every two months and have moved to a triannual reporting schedule. It was advised that any significant changes to those risks would be escalated through the responsible Director.

The Director of Finance & Strategy advised that the report details the latest position in relation to the operation of the risk management process, and an overview on that position was provided.

The Director of Finance & Strategy provided an update on risk 13 - delivery of a balanced in-year financial position - and reported that a formal quarter 1 review of the financial position has concluded, which has been submitted to the Scottish Government. A detailed paper will be presented to the Finance, Performance & Resources Committee at their meeting on 19 September 2023. It was noted that there was no change to the risk rating, however, there will be a change to the detail provided on mitigation actions.

The Risk Manager provided an update to risk 17 - cyber resilience - and advised that an audit has been carried out and a final report will be available from 1 September 2023. In terms of risk 18 - digital & information - it was advised that the mitigations for that risk

will include a reference to workforce planning. The register will be updated for the next iteration.

Action: Risk Manager

The Chief Internal Auditor made positive comments on the progress of the Corporate Risk Register, and the Risk Manager reminded members that there is an Audit & Risk Committee Development Session on Thursday 12 October 2023 to review the effectiveness of the new Corporate Risk Register process.

It was agreed levels of assurance, for those risks within our control, will be added to the next iteration of the Corporate Risk Register.

Action: Risk Manager

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

7.2 Risks & Opportunities Group and Progress Report

The Risk Manager provided a verbal update and advised that the focus of the Risk & Opportunities Group has been acknowledging feedback from the Governance Committees and taking forward considerations and recommendations. The groups have also been focussing on the risk matrix and descriptors, which is a work-in-progress at present.

The Risk Manager reported that the group will also be considering opportunities, and that a session has been arranged in October 2023 to discuss opportunities, and risks, within the Population Health & Wellbeing Strategy.

The Board Secretary highlighted the positive discussions at recent meetings of the Risks & Opportunities Group and provided assurance that the group is working well.

It was reported that work is ongoing around enhancing the risk guidance for Governance Committee papers and SBAR template, to strengthen the content of the risk assessment & risk management sections.

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

7.3 Risk Management Framework Update

The Director of Finance & Strategy provided an overview on the main points from the document, and highlighted the work that has been undertaken in relation to the risk improvement programme. She also highlighted the risk appetite and governance structure that underpins the framework, and responsibility and accountability arrangements.

The Committee took **assurance** from and endorsed the updated framework for Board approval.

8. FOR ASSURANCE

8.1 Audit Scotland Technical Bulletin 2023/2

The Head of Financial Services & Procurement advised that the main focus for the report is predominately around the Annual Accounts process, in particular the Good Practice Note that was issued in relation to the remuneration report.

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

8.2 Corporate Calendar – Proposed Audit & Risk Committee Dates 2024/25

The Board Secretary presented the paper and advised that the full Corporate Calendar will go to the Board at the September 2023 meeting for approval, and diary invites will follow. It was noted the date for the Annual Accounts meeting in June 2024 is subject to change depending on the issue of the new financial year guidance.

The Committee **agreed** the proposed dates for 2024/25.

8.3 Delivery of Annual Workplan 2023/24

The Committee took **assurance** from the tracked workplan.

9. ESCALATION OF ISSUES TO NHS FIFE BOARD

There were no issues to highlight to the Board.

10. ANY OTHER BUSINESS

10.1 Chief Internal Auditor Retirement

The Director of Finance & Strategy paid warm tribute to the Chief Internal Auditor, for whom this was his last working day before his retiral. The Committee thanked the Chief Internal Auditor for all his invaluable support and service over the years and wished him well for his retirement.

11. DATE OF NEXT MEETING

The next meeting will take place on **Thursday 14 December 2023** from 2pm – 4.30pm via MS Teams.

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

AUDIT & RISK COMMITTEE – ACTION LIST
Meeting Date: Wednesday 13 December 2023

NHS Fife

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	TIMESCALE	COMMENTS / PROGRESS	RAG
1.	31/08/23	**National Risk Management System**	Exploratory discussions are ongoing at a national level around procurement of risk management systems. Currently, the local preference is for Datix Cloud IQ. The outcome of national discussions is awaited.	**PC**	An update will be brought back to the Committee on developments as the business case is finalised.	17/03/22 - A business case is being developed in April 2022 for NHS Fife, and the preferred upgrade package is Datix Cloud IQ. A verbal update was provided at the September 2022 meeting.	In progress/ on hold
2.	31/08/23	**Internal Audit – Follow Up Report on Audit Recommendations 2022/23**	A discussion around the timings of Internal Audit reports going first to the Executive Directors' Group and then the Committee to be arranged between the Chief Executive, Director of Finance & Strategy, Principal Auditor and Chief Internal Auditor.	**AB**	September/ October 2023	AB has confirmed timings.	Closed
3.	31/08/23	**Corporate Risk Register**	The mitigations for risk 18 - digital & information, to include a reference to workforce planning within the next iteration.	**PC**	December 2023	The associated wording on the mitigations was further developed for the 3 November 2023 Clinical Governance Committee. The version of the Corporate Risk Register to be presented to the Committee on 13 December 2023 will reflect the latest update.	Closed

4.	31/08/23		Levels of assurance, for those risks within our control, to be added to the next iteration.	**PC**	December 2023	An explicit statement using the following core text was introduced to the recommendation section of the SBAR 'Update on Corporate Risks Aligned to xx Committee' reports to the November 2023 committees: *"The report details the latest position in relation to the management of corporate risks linked to this Committee. The Committee is asked to take a "reasonable" level of assurance that all actions, within the control of the organisation, are being taken to mitigate these risks as far as is possible to do so".*	Closed

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**13 December 2023**
Title:	**October 2023 Development Session Outputs**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Report Author:	**Pauline Cumming, Risk Manager**

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Local Policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

An Audit and Risk Committee Development session took place on 12 October 2023. The topic considered was "Reviewing Progress and Effectiveness of Risk Management Arrangements and Reporting". This paper summarises the outputs of the session.

2.2 Background

In December 2021, the Committee and the Board considered some fundamental questions about the effectiveness of our risk management arrangements, including:

- Does the BAF contain strategic/corporate risks or have operational risks been included?
- Do we spend enough time considering the BAF and Risk Management?
- Do we actively prioritise risks which require attention?
- Do we have evidence of active scrutiny for risks which have been around for a long time?
- Do we correctly describe risks or are they issues?
- Does the current BAF approach fulfil the Board requirements in terms of active governance of risk?
- Is the Board Strategic Risk Profile visible?

This session provided the opportunity to reflect on the origins of the Risk Management Improvement Programme which emerged from the above questions, determine if developments that have taken place since then, have enhanced risk management in Fife, and consider further improvements.

The session also offered the Committee the chance to consider the evidence to support delivery of its responsibilities as set out in the Risk Management Framework 2023-2025.

2.3 Assessment

The session considered the following 3 key areas of significance to the Committee.

1. Risk Management Improvement Programme

Discussion centred on:

- Had the improvements to the Corporate Risk Register/Deep Dive Process led to more effective presentation and constructive scrutiny on corporate risks?
- Do our conversations on risk influence decision making?
- What further improvements should we consider?

There was consensus that the revised arrangements for reporting on corporate risks have been positive. The transition from the BAF to a corporate risk register has resulted in a clearer presentation of the corporate risks and more succinct risk descriptions, which over time, have encouraged sharper focus on the risks, their relevance and specificity, as well as the proportionality and reliability of mitigations. One indicator of improved scrutiny of the corporate risks can be found within the minutes of the committees to which the risks are aligned. Increasingly, these capture more detailed and nuanced discussions about risks, their implications, and the level of assurance derived from reports, requests for additional information, and matters for escalation.

The introduction of Deep Dive reviews in November 2022 was also considered to have added depth and rigour to the scrutiny process overall. Members agreed that deep dives can contribute to greater understanding of a risk, its strategic context, root causes and consequences, risk scores and rationales, and relationship to risk appetite.

A discussion took place on the role of the 'Deep Dive' within the lifecycle of a corporate risk. It was agreed that the Risks and Opportunities Group (ROG) should undertake further work and make recommendations on the role of a deep dive and triggers for reviews. This element is considered in more depth in the ROG update paper provided separately to the Committee.

In terms of improvements, it is recognised there is scope to improve the reviews e.g.

- Identify key controls and provide overt assurance and conclusions on their effectiveness;
- Demonstrate clearly which management actions will impact on the target score; and
- Assess the proportionality and sufficiency of proposed actions to achieve target score

The ROG will consider these elements and required template changes going forward.

Conversations arising both from discussions on corporate risks and deep dive reviews. have influenced decision making in a number of ways. These include revisions of risk descriptions to more accurately reflect the consequences of a risk in terms of scope and gravity, the commissioning of future deep dive reviews, escalation of matters of concern to the Board, and the identification of topics for Board Development Sessions.

2. Responsibilities of the Audit & Risk Committee

This aspect of the session focused on the Committee's responsibility to provide the Board with assurance on the effectiveness of risk management arrangements and confirm that a sound system of internal control is maintained.

Discussion took place on the extent to which there is evidence to support delivery of these responsibilities through the Committee, and consideration of possible areas of focus for improvement. It was agreed there is scope for the Committee to consider how it might further support delivery of its responsibilities by exercising greater scrutiny and challenge on the range of reports it receives. It was also mooted that consideration could be given to critiquing, the risk assurances provided by other standing committees. For example, to explore the potential of requiring those committees, to provide periodic assurance reports on their activities to the Audit & Risk Committee. These would be subject to assessment against the Assurance Principles to determine the validity of the assurance given and taken, and in turn, provide enhanced assurance to the Accountable Officer and the Board.

3. Role of the Risks & Opportunities Group

Discussion covered how the Group is supporting risk management across the organisation, including continuing to support a consistent approach to the management of Operational Risk, as well as the ongoing consideration of enhancements to the Corporate Risk approach.

The main focus of this part of the session was a demonstration of a new Risk Summary Dashboard. This had been created by placing a reporting tool (MicroStrategy), over the data in the Datix Risk Register to maximise the value to be derived from the information.

The presentation and the Dashboard's potential were enthusiastically received by the Committee. It was agreed that the ROG should take forward related developments.

A live demonstration of the Dashboard arrangement was subsequently shown to EDG on 2 November 2023 with a recommendation from the ROG that the Dashboard is made available and its use promoted to support and enhance our operational risk management approach. Further detail on the output from this part of the discussion is provided in the ROG update paper mentioned above.

2.3.1 Quality, Patient and Value-Based Health & Care

Effective management of risks to quality and patient care will support delivery of all strategic priorities.

2.3.2 Workforce

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

2.3.3 Financial

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

2.3.4 Risk Assessment / Management

Subject of the paper.

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

No specific Equality Impact Assessment has been conducted.

2.3.6 Climate Emergency & Sustainability Impact

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

2.3.7 Communication, involvement, engagement, and consultation

This paper reflects communication and feedback received from governance committees, and the considerations of the Risks and Opportunities Group.

2.3.8 Route to the Meeting

Margo McGurk, Director of Finance & Strategy, 4 December 2023.

2.4 Recommendation

Members are asked to take **assurance** from this note of the development session.

3 List of appendices

None.

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

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**13 December 2023**
Title:	**Corporate Risk Register**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy, NHS Fife**
Report Author:	**Pauline Cumming, Risk Manager, NHS Fife**

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Annual Delivery Plan
- Emerging issue
- Local policy
- NHS Board / IJB Strategy or Direction / Plan for Fife

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This paper provides the Committee with an update on the Corporate Risk Register since the last report on 31 August 2023. The content reflects the corporate risks reported to the Governance Committees in November 2023. Due to the timing of Committee meetings and reporting requirements, an earlier version of this paper was reported to the Board on 28 November 2023.

The Committee is invited to:

- review the corporate risks as at 2 November 2023 set out at Appendix No.1;
- consider the information against the Assurance Principles at Appendix No.2;
- conclude and comment on the assurance derived from the report.

2.2 Background

The Corporate Risk Register aligns to the 4 strategic priorities. The format is intended to prompt scrutiny and discussion around the level of assurance provided on the risks and their management, including the effectiveness of mitigations in terms of:

- relevance
- proportionality
- reliability
- sufficiency

2.3 Assessment

Since the last report:

- The strategic risk profile is unchanged. 18 risks - 13 high and 5 moderate level
- No risks have been closed
- Two potential new corporate risks have been identified relating to:
  - Preparation for the Implementation of the Health and Care (Staffing) (Scotland) Act 2019;
  - Future Biological Threats including Pandemics

NHS Fife Strategic Risk Profile

Strategic Priori	Total Risks	Current Strategic Risk Profile				Risk Movement	Risk Appetite
To improve health and wellbeing	5	2	3	-	-	◄►	High
To improve the quality of health and care services	5	5	-	-	-	◄►	Moderate
To improve staff experience and wellbeing	2	2	-	-	-	◄►	Moderate
To deliver value and sustainability	6	4	2	-	-	◄►	Moderate
Total	18	13	5	0	0		

Summary Statement on Risk Profile

The current assessment indicates that delivery against 3 of the 4 strategic priorities continues to face a risk profile in excess of risk appetite.

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

Assessment of corporate risk performance and improvement trajectory remains in place.

Risk Key		Movement Key	
High Risk	15 - 25	▲	Improved - Risk Decreased
Moderate Risk	8 - 12	◄►	No Change
Low Risk	4 - 6	▼	Deteriorated - Risk Increased
Very Low Risk	1 - 3		

Corporate Risks Update

Risk 3 - COVID 19
Consideration continues to be given to de-escalate as a corporate risk. Further discussions have taken place at the Executive Directors' Group (EDG), the Public Health Assurance Committee (PHAC) where the risk is regularly reviewed, and the Clinical Governance Committee (CGC) to which the risk is aligned for assurance. There is CGC support for closing the risk and moving to develop one that addresses the wider biohazard threat. The PHAC will review the risk at its meeting on 6 December 2023. Thereafter, a recommendation will be made to EDG and then CGC on 12 January 2024, to retain or close as a corporate risk.

Risk 4 - Optimal Clinical Outcomes
Following a deep dive review in May 2023, this risk was the focus of a CGC Development Session on 23 October 2023. An update on the risk will be provided to the Committee in January 2024 following feedback at that session.

Risk 7 - Access to outpatient, diagnostic and treatment services
It is still not possible to provide a definitive target risk level or date for this risk given the uncertainty over funding levels.

Risk 9 - Quality & Safety
Following a deep dive review in July 2023, the CGC requested that the risk score be reviewed, as the likelihood score was very high, in spite of the governance arrangements in place, and the number of completed mitigating actions. A review was carried out, which indicated the potential to reduce the risk score and bring the risk to within appetite. This exercise was undertaken in the aftermath of the Countess of Chester Hospital Inquiry, and the Board's response to the Cabinet Secretary's letter of 26 August 2023 relating. Given the issues raised by the Inquiry, the Chief Executive commissioned a review of governance arrangements around the triangulation of data associated with quality and safety. The risk level is to remain at high pending the outcome of the review.

Risk 13 - Delivery of a balanced in-year financial position
The financial position materially deteriorated in Q2, with very limited progress against the in-year cost reduction target. This position was forensically reviewed to determine actions which can be taken to reduce the level of forecast overspend. Despite ongoing attempts to reduce costs and a commitment to avoid any additional investment in our services, it is highly likely that the Board will require significant financial brokerage to break- even.

Risk 16 - Off-Site Area Sterilisation and Disinfection Unit Service
The CGC received a deep dive of this risk on 8 September 2023. While members were assured around patient safety, and that all actions were being taken to prevent the cancellation of the elective and emergency programme, there was concern that the mitigations in place cannot address all the issues being experienced with our Sterile Services provider. The risk was therefore escalated to the Board on 26 September 2023. The Board discussed the risk, noting the difficulties, including the national position and

scarcity of capital funding. It was agreed to consider the risk at a future Board Development Session on the prioritisation of capital resources more generally.

Risk 17- Cyber Resilience
The Network Information System Directive (NISD) and Cyber Resilience Framework Audit, in July 2023, showed an increase in compliance from 76% in 2022 to 87%. The Associate Director of Digital & Information advises there will be a further review of this risk and others related, which will indicate if the risk rating and / or level can be reduced.

Potential New Risks

Preparation for the Implementation of the Health and Care (Staffing) (Scotland) Act 2019 - for approval
Following discussions at the EDG, wording for the above risk was drafted. The Director of Workforce then requested approval for the risk wording at the Staff Governance Committee (SGC) on 9 November 2023, with a view to presenting to the Board for inclusion in the Corporate Risk Register. The Committee agreed that the risk should be highlighted to the Board, given the requirements for compliance. It was noted that this risk reflects a national direction of travel and further guidance from the Scottish Government is still to be issued. The risk is detailed in Appendix No, 1.

Future Biological Threats including Pandemics - risk in development
The Director of Public Health will present a draft risk and an initial deep dive, to the PHAC on 6 December 2023, EDG later in the month, and CGC on 12 January 2024.If agreed to pose a corporate risk, it will be proposed for Board approval in January 2024.

Deep Dive Reviews
Deep dives continue to form an important component of our risk assurance arrangements.13 of the 18 Corporate Risks have now undergone at least one deep dive, with reviews also commissioned into risks otherwise associated with a committee's remit.

Based on our experience and learning over the last year, and following discussion at the Audit and Risk Committee Development Session held on 12 October 2023, the Risks and Opportunities Group (ROG) made recommendations to EDG on 2 November 2023 on the role of the 'deep dive' and triggers for reviews during the life - cycle of a corporate risk. These recommendations form part of a separate ROG update paper to the Committee.

Risk Assurance Levels
As discussed at the Committee on 31 August, there was recognition of the need to be clearer on the 'level' of assurance we ask the Committees to take from the corporate risk reports. It was proposed that in addition to inclusion in deep dive reviews, an explicit statement should be added to the Recommendation section of the reports. The following example text was suggested:

*"The report details the latest position in relation to the management of corporate risks linked to this Committee. The Committee is asked to take a "**reasonable**" level of*

assurance that all actions, within the control of the organisation, are being taken to mitigate these risks as far as is possible to do so".

Following agreement on this proposal, this text was incorporated in reports to the governance committees in November 2023.

Next Steps

The ROG will continue to deliver its role in considering emergent risks and opportunities in order to recommend changes or additions to the corporate risks. Further detail is contained in the ROG update paper referenced above.

2.3.1 Quality, Patient and Value-Based Health & Care

Effective management of risks to quality, patient and value-based health & care will support delivery of our strategic priorities, to improve health and wellbeing and the quality of health and care services. Active consideration of the principles of realistic medicine demands a more co- ordinated and holistic focus on patients' needs, and the outcomes and experiences that matter to them, and their families and carers. This will ultimately support delivery of care that is more sustainable and reduces harm and waste.

2.3.2 Workforce

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

2.3.3 Financial

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

2.3.4 Risk Assessment / Management

The management of the corporate risks continues to be maintained, with risk reporting provided regularly to the relevant groups and committees. The majority of risks, remain outwith risk appetite, which reflects the level of delivery challenge across the services.

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

An Equality Impact Assessment (Stage 1) was carried out to identify if any items of significance need to be highlighted to EDG. The outcome of that assessment concluded that no further action was required.

2.3.6 Climate Emergency & Sustainability Impact

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

2.3.7 Communication, involvement, engagement and consultation

This paper reflects engagement with Executive and Non - Executive Directors, and discussions within the Risks and Opportunities Group.

2.3.8 Route to the Meeting

- Margo McGurk, Director of Finance & Strategy on 28 November 2023
- Risks & Opportunities Group on 5 December 2023

2.4 Recommendation

This report provides the latest position in relation to the management of corporate risks.

Members are asked to take **a "reasonable" level of assurance** that, all actions, within the control of the organisation, are being taken to mitigate the risks as far as is possible to do so.

3 List of appendices

Appendix 1 - NHS Fife Corporate Risk Register as at 2 November 2023

Appendix 2 - Assurance Principles

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

Updated NHS Fife Corporate Risk Register as at 02/11/23

No	Strategic Priority	Risk	Mitigation	Risk Appetite	Current Risk Level/ Rating	Target Risk level & rating by dd/mm/yy	Current Risk Level Trend	Risk Owner	Primary Committee
1		**Population Health and Wellbeing Strategy** There is a risk that the ambitions and delivery of the new organisational Strategy do not deliver the most effective health and wellbeing and clinical services for the population of Fife.	The strategy was approved by the NHS Fife Board in March 2023. The focus now will be on developing and delivering against an agreed set of outcomes for 2023/24. This is in the context that the management of this specific risk will span a number of financial years. We are now preparing the 3-year Medium Term Plan which flows from our strategy for submission to Scottish Government in July 2023. An update on the deep dive review was provided to the PHWC in Sept 2023 which reported that structures and processes are being put in place to allow ongoing assessment on delivery of the strategy. A mid - year review is underway; this will be reported to the Board on 28/11/23.	Below	Mod 12	Mod12 by 31/03/24	◄►	Chief Executive	Public Health & Wellbeing (PHWC)
2		**Health Inequalities** There is a risk that if NHS Fife does not develop and implement an effective strategic approach to contribute to reducing health inequalities and their causes, health and wellbeing outcomes will continue to be poorer, and lives cut short in the most deprived areas of Fife compared to the least deprived areas, representing huge disparities in health and wellbeing between Fife communities.	Public Health and Wellbeing Committee established, with the aim of providing assurance that NHS Fife is fully engaged in supporting wider population health and wellbeing for the local population. The Population Health and Wellbeing Strategy will identify actions which will contribute to reducing health inequalities; these will be set out in the delivery plan for the strategy. Consideration of Health Inequalities within all Board and Committee papers.	Within	High 20	Mod 10 by 31/03/24	◄►	Director of Public Health	Public Health & Wellbeing (PHWC)

			Leadership and partnership working to influence policies to 'undo' the causes of health inequalities in Fife. A risk update will be provided to the PHWC meeting in November 2023.						
3		**COVID 19 Pandemic** There is an ongoing risk to the health of the population, particularly the clinically vulnerable, the elderly and those living in care homes, that if we are unable to protect people through vaccination and other public health control measures to break the chain of transmission or to respond to a new variant, this will result in mild-to-moderate illness in the majority of the population, but complications requiring hospital care and severe disease ,including death in a minority of the population.	A range of indicators together provide an assessment that overall numbers of people affected by COVID19 in Scotland remain low. Treatments are available for individuals at higher risk of adverse outcomes. National surveillance continues and there are no variants currently under investigation. Tailored support continues to be provided to Care Homes with positive staff or resident cases. The Coronavirus (COVID 19) guidance for extended use of masks and face coverings across health and social care was withdrawn on 16th May. The risk is regularly reviewed by the Public Health Assurance Committee (PHAC). An update on the deep dive review presented to CGC on 03/03/23 will be provided to the PHAC in December 2023 and to the CGC in January 2024.	Below	Mod 9	Mod 12 by October 2023	◄►	Director of Public Health	Clinical Governance (CGC)
4		**Policy obligations in relation to environmental management and climate change** There is a risk that if we do not put in place robust management arrangements and the necessary resources, we will not meet the requirements of the 'Policy for NHS	Robust governance arrangements remain in place including an Executive Lead and a Board Champion. Regional working group and representation on the National Board ongoing. Active participation in Plan 4 Fife	Below	Mod 12	Mod 10 by 01/04/2025	◄►	Director of Property & Asset Management	Public Health & Wellbeing (PHWC)

		Scotland on the Global Climate Emergency and Sustainable Development, Nov 2021.'	continues. The NHS Fife Climate Emergency Report and Action Plan have been developed. These form part of the Annual Delivery Plan (ADP). The Action Plan includes mechanics and timescales. The board report which was required by the end of January 2023, as per policy DL38, has been completed and published on the NHS Fife website, via EDG, and PHWC, and sent to Scottish Government (SG). Resource in the sustainability team has increased by 1 FTE via external funding for 12 months. A Head of Sustainability has been seconded from the Estates Service for at least 18 months to drive delivery of the Climate Emergency Action Plan. The deliverables associated with climate change, will be monitored through the Annual Delivery Plan.						
5		**Optimal Clinical Outcomes** There is a risk that recovering from the legacy impact of the ongoing pandemic, combined with the impact of the cost-of-living crisis on citizens, will increase the level of challenge in meeting the health and care needs of the population both in the immediate and medium-term.	The Board has agreed a suite of local improvement programmes, as detailed in the diagram below to frame and plan our approach to meeting the challenges associated with this risk. The governance arrangements supporting this work will inform the level of risk associated with delivering against these key programmes and reduce the level of risk over time.	Within	High 15	Mod 10 by 31/03/24	◄►	Medical Director	Clinical Governance (CGC)

			 This risk was the focus of a CGC Development Session on 23/11/23. Based on discussions at the session, an update on the deep dive review of May 2023 is being prepared for the Committee in January 2024.						
6		**Whole System Capacity** There is a risk that significant and sustained admission activity to acute services, combined with challenges in achieving timely discharge to downstream wards and/or provision of social care packages, that the management of Acute hospital capacity and flow will be severely compromised.	The combination of application of our OPEL process on a daily basis and the improvement work through our Integrated Unscheduled Integrated Care and Planned Care programmes provides the operational and strategic response to the challenges posed through this risk. 	Above	High 20	Mod 9 by 30/04/24	◄►	Director of Acute Services	Finance, Performance & Resources (F,P&RC)

7		**Access to outpatient, diagnostic and treatment services** There is a risk that due to demand exceeding capacity, compounded by unscheduled care pressures, NHS Fife will see deterioration in achieving waiting time standards. This time delay **will** impact clinical outcomes for the population of Fife.	Planning for 2023/24 has been completed in line with planning guidance letter received on 06/02/23. Confirmed funding 20% less than committed staff costs. Agreement by EDG to continue with original plan acknowledging the gap in funding. Planned capacity for OP is 96% and for IP/DC is 99% of that delivered in 2019/20. Reduction is due in the main to clinical staff vacancies. Demand for OP and IP Imaging both is increasing year on year. Capacity is not meeting current demand for OP/IP/DC or Diagnostics. The Integrated Planned Care Programme Board is overseeing the productive opportunities work and this along with ongoing waiting list validation seeks to maximise available capacity. Speciality level plans in place outlining local actions to mitigate the most significant areas of risk. Focus remains on urgent and urgent suspicious of cancer patients however routine long waiting times will increase. The governance arrangements supporting this work will inform the level of risk associated with delivering against these key programmes and mitigate the level of risk over time. Discussions continue with Scottish Government around the need for additional funding to help reduce the waiting times for long waiting routine patients.	Above	High 20	It is still not possible to unable to provide a target risk and date given the uncertainty over level of funding	◄►	Director of Acute Services	Finance, Performance & Resources (F,P&RC)

8		**Cancer Waiting Times (CWT)** There is a risk that due to increasing patient referrals and complex cancer pathways, NHS Fife will see further deterioration of Cancer Waiting Times 62-day performance, and 31 day performance, resulting in poor patient experience, impact on clinical outcomes and failure to achieve the Cancer Waiting Times Standards.	The prostate project group continues with actions identified to improve steps in the pathway. The nurse-led model went live in August 23. A deep dive into urology performance challenges is being undertaken. The initiation of the lung pathway has been improved to reduce waits between steps in the pathway including integration with the Single Point of Contact Hub. Weekly meetings with Scottish Government (SG) and quarterly monitoring of the Effective Cancer Management Framework continue. The Effective Cancer Management Framework has been updated and actions have been identified for 2023-24. 65% of the actions have been completed An action plan has been developed and is progressing well to implement the Effective Breach Analysis Standard Operating Procedure in to NHS Fife. Work has commenced to take forward the Re-grading Framework which has now been published. An action plan has been developed based on the recommendations. A 6 month review of the Single Point of Contact Hub confirms there has been a reduction in DNAs. Further evaluation will be commenced September 2023. Patient and staff evaluation questionnaires have been sent out and an exercise to assess reduction in patient calls to CNS and feedback from staff users of the service.	Above	High 15	Mod 12 by 30/04/24	◄►	Director of Acute Services	Finance, Performance & Resources (F,P&RC)

			The Cancer Framework and delivery plan has been launched and priorities are currently being agreed for 2023-24. The governance arrangements supporting this work will inform the level of risk associated with delivering against these key programmes and reduce the level of risk over time.						
9		**Quality & Safety** There is a risk that if our governance, arrangements are ineffective, we may be unable to recognise a risk to the quality of services provided, thereby being unable to provide adequate assurance and possible impact to the quality of care delivered to the population of Fife.	Effective governance is in place and operating through the clinical Governance Oversight Group (CGOG) providing the mechanism for assurance and escalation of clinical governance (CG) issues to Clinical Governance Committee (CGC). This is further supported by the Organisational Learning Group to ensure that learning is used to optimise patient safety, outcomes and experience, and to enhance staff wellbeing and job satisfaction. There are also effective systems & processes to ensure oversight and monitoring of national & local strategy / framework / policy /audit implementation and impact. Following the deep dive review of this risk presented to the CGC in July 2023, members requested that the risk and the risk scores be reviewed. This was given that the likelihood of occurrence was scored very high, despite the governance arrangements in place, and the number of completed mitigating actions. A review of the risk scores has been carried out which indicates the potential to reduce the current and target risk ratings and levels. This would bring the	Above	High 15 (L5 x C3) 15	Mod 10 by 31/03/24	◄►	Medical Director	Clinical Governance (CGC)

			risk within its risk appetite. This exercise has been undertaken during a period in which the Board is considering its response to events at the Countess of Chester Hospital. This includes the NHS Fife Board Chief Executive, commissioning a review of our governance arrangements, including systems for organisational learning. The review will allow an objective opinion to be formed on the adequacy and effectiveness of our systems and processes, provide evidence of positive assurance, and where indicated, recommend improvement actions. The extant risk scores are to be retained pending the outcome of the review.						

10		**Primary Care Services** There is a risk that due to a combination of unmet need across health and social care as a result of the pandemic, increasing demand on services, workforce availability, funding challenges, adequate sufficient premises and overall resourcing of Primary Care services, it may not be possible to deliver sustainable quality services to the population of Fife for the short, medium and longer term.	A Primary Care Governance and Strategy Oversight Group is in place. The group, co-chaired by the Medical Director and the Director of Health and Social Care, brings together both the transformation and sustainability initiatives for all four of the independent primary care contractors, whilst also overseeing any critical aspects of governance. It provides assurance to NHS Fife Board and the Integration Joint Board (IJB) through the appropriate sub committees. This group allows governance and scrutiny of all aspects of primary care delivery and provides a focus for improving patient care for the population of Fife. A Primary Care Strategy was developed following a strategic needs analysis and wide stakeholder engagement. This was approved at IJB in July 2023 and is now moving to implementation. This is a 3 year strategy focused on recovery, quality and sustainability. Development of a Performance and Assurance Framework covering qualitative and quantitative performance will provide robust reporting, monitoring and oversight of implementation and impact of the Primary Care Strategy to committees quarterly. This is due by end of October 2023. Following approval of the Performance and Assurance Framework an annual report will be presented to Committee / IJB. A Primary Care Improvement Plan (PCIP) is in place; subject to regular	Above	High 16	Mod 12 (3 x4) by 31/03/24	◄►	Director of Health & Social Care	Public Health & Wellbeing (PHWC)

			monitoring and reporting to General Medical Services (GMS) Board, Quality & Communities (Q&C) Committee, IJB and Scottish Government. A workshop took place in January 2023 to review and refresh the current PCIP to ensure it is contemporary and based on current position and known risks to ensure a realistic and feasible PCIP. This will be progressed via committees for approval by November 2023. Work to progress extant PCIP does however continue to be overseen by the GMS Implementation Group. A second workshop on the refreshed PCIP will be held by end of Winter 2023. Further guidance from SG in April 2023 means risk remains high. Discussion is ongoing to support clarity of responsibilities and local negotiations are now in place to agree transitionary payment process in line with Memorandum of Understanding (MOU2) and priorities still to be fully delivered. As part of these negotiations further clarity will be laid out to ensure patient safety and quality service delivery at this time of transition. These will be completed with plan agreed via governance structure October 2023. Remodelling and recruitment of workforce action plan resulting from earlier Committee report will be progressed as part of the refreshed						

			PCIP. The review of leadership, management and governance structure which has been jointly commissioned by Deputy Medical Director (DMD) and Head of Service (HOS) for Primary & Preventative Care (P&PC) will be completed by October 2023 rather than the previous timescale of July 2023. Memorandum of Understanding 2 (MOU2) - in line with the direction of MOU2, the focus for the PCIP remains to be delivery of a complete CTAC and Pharmacotherapy, This programme of work will be underpinned by the PCIP 2023-2024 with regular monitoring and oversight by the GMS groups and the governance structures of the IJB. This will be reviewed - April 2024. The PCIP 2023-2024 will focus on consistency, continuity of service and communication to develop a 52 week model of service delivery for the priorities of MOU2 and continue to sustain service delivery in line with the priorities of MOU including MSK, mental health practitioners, urgent care in hours and community link workers - March 2024. Pharmacotherapy and CTAC models for care continue to be shaped and developed. The anticipated date for completion is April 2024.						
11		**Workforce Planning and Delivery** There is a risk that if we do not implement effective strategic and operational workforce planning, we will not deliver the capacity and	Continued development of the workforce elements of the Annual Delivery Plan, Population Health & Wellbeing Strategy and Strategic Framework; alongside the Workforce Plan for 2022 to 2025 and aligned	Above	High 16	Mod 8 by 31/03/25	◀▶	Director of Workforce	Staff Governance (SGC)

		capability required to effectively deliver services.	service based workforce plans. Implementation of the Health & Social Care Workforce Strategy and Plan for 2022 to 2025 to support the Health & Social Care Strategic Plan for 2023 to 2026 and the integration agenda. Implementation of the NHS Fife Board Strategic and Corporate Objectives, particularly the “exemplar employer / employer of choice” and the associated values and behaviours and aligned to the ambitions of an anchor institution. Harvesting and analysis of SPRA data is underway, so that Directorate and Service based workforce plans can be completed by the end of Quarter 2 of 2023/2024, allowing mapping of Corporate priorities to the SPRA submissions, identifying impacts on the future shape of the staffing complement, and highlight any sustainability pressures. An update on NHS Fife Workforce Planning actions and serviced based workforce plans will be provided at the September 2023 Staff Governance Committee, alongside an update on the HSCP Year 2 Action Plan. Progression of Bank and Agency Programme of Work and Nursing & Midwifery Workforce actions to improve workforce sustainability. A successful mass recruitment event held on 1 June 2023, to support workforce sustainability, attracted over 350 applicants, with over 100 offers of employment made to date. Candidates are currently undergoing pre employment checks with start dates being confirmed and allocated to						

			services based on priority of need and skills mixed required. Commencement of local guidance chapter testing to support the implementation of the Health and Care Staffing Act (2019) within NHS Fife. Local HCSA Reference Group well established, with multi disciplinary, Board wide representation informing preparatory work for Act implementation in April 2024.						
12		**Staff Health and Wellbeing** There is a risk that if due to a limited workforce supply and system pressure, we are unable to maintain the health and wellbeing of our existing staff we will fail to retain and develop a skilled and sustainable workforce to deliver services now and in the future.	Working in partnership with staff side and professional organisations across all sectors of NHS Fife to ensure staff health and wellbeing opportunities are maximised, to support attraction, development and retention of staff. The Staff Health & Wellbeing Framework for 2022 to 2025, setting out NHS Fife's ambitions, approaches and commitments to staff health and wellbeing, was published in December 2022. Consideration of staff support priorities for 2022-2025 being progressed via Staff Health & Wellbeing Group and other fora, to develop complementary Action Plan. Work progressing on promoting Attendance improvement actions to support reductions in staff absence and wellbeing.	Above	High 16	Mod 8 by 31/03/25	◀▶	Director of Workforce	Staff Governance (SGC)
13		**Delivery of a balanced in-year financial position** There is a risk that due to the ongoing impact of the pandemic combined with the very challenging financial	The EDG considered the outcome of the Q1&Q2 Financial Performance and Forecast report and has concluded the there is a need to explore further areas for efficiency savings and productive	Above	High 16	Mod 12 by 31/03/24	◀▶	Director of Finance & Strategy	Finance, Performance & Resources (F,P&RC)

		context both locally and nationally, the Board will not achieve its statutory financial revenue budget target in 2023/24 without further planned brokerage from Scottish Government.	opportunities in light of the current challenge in delivering against the 3 planned areas of focus. A range of potential schemes has been identified which EDG has committed to exploring and recommending action on over the coming months. The financial position has materially deteriorated in Q2 with very limited progress against the in-year cost reduction target. This position has been forensically reviewed to determine actions which can be taken to reduce the level of forecast overspend. Despite ongoing attempts to reduce costs and a commitment to avoid any additional investment in our services, it is highly likely that the Board will require significant financial brokerage to break-even.						
14		**Delivery of recurring financial balance over the medium-term** There is a risk that NHS Fife will not deliver the financial improvement and sustainability programme actions required to ensure sustainable financial balance over the medium-term.	Strategic Planning and Resource Allocation process will continue to operate and support financial planning. The FIS Programme will focus on medium-term productive opportunities and cash releasing savings. The Board will maintain its focus on reaching the full National Resource Allocation (NRAC) allocation over the medium- term. Scottish Government have received and supported our 5-year medium-term financial plan which includes significant cost savings across all 5 years, ongoing brokerage and commencement of repayment in the latter years of the plan. On 23 October we received a 3-year financial plan commission from Scottish Government. Work is underway to review financial planning assumptions to support completion of this work which	Above	High 16	Mod 12 by 31/03/24	◄►	Director of Finance & Strategy	Finance, Performance & Resources (F,P&RC)

			requires to be submitted by mid-January 2024.						
15		**Prioritisation & Management of Capital funding** There is a risk that lack of prioritisation and control around the utilisation of limited capital and staffing resources will affect our ability to deliver the PAMS and to support the developing Population Health and Wellbeing Strategy.	Infrastructure developments prioritised and funded through the NHS Board capital plan. Annual Property and Asset Management Strategy (PAMS) report submitted to F, P&R, NHS Board and Government. A further iteration will be presented to the Board in September 2023. Fife Capital Investment Group (FCIG) reviewed the 2022/23 position which showed full utilisation of significant capital allocation and agreed initial allocations for 2023/24 with agreement of all stakeholders.	Within	Mod 12	Mod 8 (by 01/04/26 at next SG funding review)	◄►	Director of Property & Asset Management	Finance, Performance & Resources (F,P&RC)
16		**Off-Site Area Sterilisation and Disinfection Unit Service** There is a risk that by continuing to use a single off-site service Area Sterilisation Disinfection Unit (ASDU), our ability to control the supply and standard of equipment required to deliver a safe and effective service will deteriorate.	Monitoring and review continues through the NHS Fife Decontamination Group. Establishment of local SSD for robotics is progressing. Health Facilities Scotland (HFS) have agreed the design and the unit at St Andrews Community Hospital (SACH) should be operational by December 2023. An option appraisal for delivery of the service is being explored. A briefing paper on the challenges and issues faced was prepared for the Private Session of NHS Fife Board, on 26/09/23 to provide full oversight of the potential risks at Board level. Following presentation of a Deep Dive	Within	Mod 12	Low 6 (by 01/04/2026 at next SG funding review)	◄►	Director of Property & Asset Management	Clinical Governance (CGC)

			review on 08/09/23, the risk owner is reviewing the likelihood score for the management actions as requested by the Committee. This will be considered by the NHS Fife Decontamination Group on 10/11/23.						
17		**Cyber Resilience** There is a risk that NHS Fife will be overcome by a targeted and sustained cyber attack that may impact the availability and / or integrity of digital and information required to operate a full health service.	Considerable focus continues in 2023 with heightened threat level to improve our resilience to attack and ability to recover quickly. The Network Information System Directive (NISD) and now Cyber Resilience Framework Audit has concluded. The compliance rate has increased to 87%, up from 76% from the previous year. The action plan for improvement will be assured by the Information Governance and Security Steering Group.	Above	High 16	Mod12 (4x3) by Sept 2024	◄►	Medical Director	Clinical Governance (CGC)
18		**Digital & Information** There is a risk that the organisation maybe unable to sustain the financial investment necessary to deliver its D&I Strategy and as a result this will affect our ability to enable transformation across Health and Social Care and adversely impact on the availability of systems that support clinical services, in their treatment and management of patients.	Consistent alignment of the D&I Strategy with the NHS Fife Corporate Objectives and the Population Health & Wellbeing Strategy. Active review of the Strategy deliverables against current strategic objectives is underway as part of the refresh of the Digital Strategy for 2024. The revised strategy will include financial and workforce planning, to support the mitigation of this risk. Digital & Information Board Governance established and supporting prioritisation with ongoing review. A second deep dive risk review risk has been prepared and will be considered by the CGC on 03/11/23.An initial deep dive was presented to the committee in January 2023.	Above	High 15	Mod 8 (4x2) by April 2025	◄►	Medical Director	Clinical Governance (CGC)

19		**PROPOSED NEW RISK** **Implementation of Health and Care (Staffing) (Scotland) Act 2019 [HCSA]** Taking account of ongoing preparatory work, there is a risk that the current supply and availability of trained workforce nationally, will influence the level of compliance with HCSA requirements. While the consequences of not meeting full compliance have not been specified, this could result in additional Board monitoring / measures.	NHS Fife Local HCSA Reference Group, chaired by Deputy Director of Workforce formed in 2022 with Fife wide, multi-disciplinary and staff side representation. Frequency of meetings increased to monthly from September 2023. NHS Fife participating in nationally led chapter guidance testing and monthly national Chapter Testing Group meetings. Fortnightly HIS / SG monitoring meetings in place with Head of Workforce & N&M Workforce Lead. N&M Workforce Lead in post since March 2021, with Scottish Government funding provided. HCSA resources shared widely within NHS Fife. Quarterly progress returns submitted to SG. Regular updates provided to APF, EDG and SGC. Planning underway for Board wide engagement event with NHS Fife/ Scottish Government /Healthcare Improvement Scotland on 30 November 2023.	Within	Moderate 12 (L4x C3)	Moderate 9 (L3xC3)	**NEW**	Director of Workforce	**Staff Governance Committee (SGC)**

Risk Movement Key

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

Assurance Principles

Risk Assurance Principles:

Board

- Ensuring efficient, effective and accountable governance

Standing Committees of the Board

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

Committee Agenda

- Agenda Items should relate to risk (where relevant)

Seek Assurance of Effectiveness of Risk Mitigation

- Relevance
- Proportionality
- Reliable
- Sufficient

Chairs Assurance Report

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

Year End Report

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

General Questions:

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

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

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

Level of Assurance:

Substantial Assurance	Reasonable Assurance	Limited Assurance	No Assurance
			

Document developed from diagram produced by NHS Lanarkshire based on principles compiled by the Assurance Mapping Group of members of Boards covered by the FTF Internal Audit Service, 2022

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**13 December 2023**
Title:	**Risks and Opportunities Group Progress Report**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Report Author:	**Pauline Cumming, Risk Manager**
	Alistair Graham, Associate Director of Digital and Information

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Local Policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Risks and Opportunities Group (ROG) meet to continue the development and evidencing of our effective risk management framework. Work has continued to support the continued development of an effective and consistent approach to the management of Operational Risk as well as the ongoing consideration of enhancements to the Corporate Risk approach.

The ROG's annual work plan allows the group to split its time between the Corporate Risk Register and in supporting operational risk management practice.

This paper provides a new set of recommendations associated with the role of the Deep Dive and updates on emerging thinking.

The paper is provided for assurance.

2.2 Background

The Datix system provides a consistent and well utilised management tool for the individual management of risk, as well as incidents, complaints, claims, safety alerts, and most recently an ability to profile business continuity.

While excellent in supporting these activities, we have sought to enhance the value derived from the data in Datix by placing a reporting tool (MicroStrategy) over the data source which has enabled the creation of a Risk Summary Dashboard; this is thought likely to be helpful for the collective management of risk. This was previously shown to the Committee at the October 2023 development session.

A live demonstration of the dashboard arrangement was also shown to EDG on 2 November 2023.

In the Corporate Risk area, we are seeking to confirm the role of the Deep Dive during the lifecycle of the risk and a recommendation agreed by EDG is enclosed in this report for the Committee's assurance.

2.3 Assessment

Operational Risk Management

EDG endorsed the recommendation to support the implementation of the Risk Summary Dashboard through the remit of the ROG.

The ROG provided a recommendation that the Risk Summary Dashboard is made available and its use promoted to support and enhance our operational risk management approach and maintain alignment to the principles outlined within the Risk Management Framework,

The dashboard seeks to support the risk owners and handlers to move through a series of activities which are detailed within a developing Operational Guidance document. Examples of these activities are outlined in Table 1 below.

Table 1 - Operational Risk Guidance

Overview	• The overview page provides the summary status of key measures for the risks shown (based on filter selection) and provides the basis for an individual or team to conduct a 'deeper dive' and promote action. • The overview page totals current number of "Active Risks" and the number of these "Active Risks" that have an "Overdue Risk" review – an obvious target for action. • The overview page also outlines the total of "Overdue Risks" based on their "Current Risk Rating" as summarised by High, Moderate, Low and Very Low. This, where time is limited, allows for a focus on the highest rated risks. • A summary of all risks shown (based on filter selection) is shown along the "Current Risk Rating" continuum. This support focus on mitigation of higher rated risks, but also potential consideration of "risk closure" where risks have reached lower ratings for extended periods of time. • For all selections on this page the summary details of the risk appear in the bottom panel for action allocation.

Risks due for Review	• This page offers the opportunity to keep up to date with the risk review requirements by presenting the risks shown (based on filter selection) by the month associated with the "next review date" contained within Datix. • The page also outlines "Area of Responsibility" based on the risk handler's location. • This not only shows risks that are overdue and so need action, but also prompts some planning for future review based on the volumes of risks being managed. • Some areas may choose to review all risks based on a certain cycle i.e., every 3 months, others may look to spread the risk review workload over coming months. • The active risks are also shown on their risk rating to support active management of high risk and consideration of closure for lower rated risks.
Risk Rating	• For all risk management activities, we are trying to ensure the current "risk rating", based on "likelihood" x "consequence" is mitigated to the "target risk rating", this page charts the progress to achieving this. • The panel shows the "current risk rating" minus the "target risk rating" with a positive number showing further mitigation management and review is required. • The panel also shows an equal and negative figure from the calculation, identifying risks that have reached their target and so have the potential to be monitored or closed. • For all selections on this page the summary details of the risk appear in the bottom panel for action allocation.
Risk History – Risks by Year and Quarter opened	• The duration that a risk exists for can offer insight into the effectiveness of management and categorisation of risks. • As a principle, a risk (i.e. something uncertain, unknown, a potential problem), that becomes an issue (i.e.an obstacle or challenge that's already present) should result in the risk being closed and an issue being raised and addressed. If on handling the issue a risk remains, a new risk should be created and this risk can be link to the original risk that became an issue to evidence continuity. • The duration that a risk has been opened for, can be an indicator that the "likelihood" of the risk materialising should be reviewed. • Risks that have been in existence, without becoming an issue, for 5 years or more should have a likelihood score of "unlikely" or "remote". • This screen helps to identify risks that may have a likelihood score that can be adjusted based on the length of time the risk has existed. • The risk history is also a helpful indicator when new risk owners take responsibility for risk, as an active review of historic risks may result in risks being reframed to match the current operational challenges rather than those of 5 years or more.
Risk Type	• A summary of types of risk is included in this page. • The summary allows us to see and understand, based on numbers of risk, where challenges may lie. • By considering and tackling the root cause of the risks in the prominent category, then a greater improvement may be achieved through mitigations to that group of risks.

The Committee are asked to note the specific recommendation, within the Risk History section, on the manner for handling a risk that has become an issue and the associated definition.

The guidance also seeks to provide a recommended set of KPIs associated with Operational risk. These will continue to be revised but are considered as:-

Demonstration of Active Risk Management and particular focus on High Risk

- 90% of all Active Risks should have a future review date.
- 90% of all Active and High Risks should have a future review date that is less than 3 months in the future.
- 100% of all Active and High Risks should have a future review date that is less than 6 months in the future.
- 0% of all Active and High Risks should have a review date that is greater than 3 months in the past.
- 99% of all Active Risks have a different Risk Owner and Risk Handler

Demonstration of Successful Risk Mitigations

- 1% of risks that have reached or surpassed their "target risk rating" should exist.
- 80% of all Active Risks should be less than 10 years old.

Role of the Deep Dive

Deep dive reviews have formed a component of our risk assurance arrangements since establishing a Corporate Risk Register in September 2022.A key objective of their introduction was to improve the scrutiny and assurance on the corporate risks.

We recognise that assurance should be based on credible evidence that risks are being adequately managed with key controls and mitigations identified, implemented and working effectively in terms of relevance, proportionality, reliability and sufficiency.

The role of a 'deep dive' review is to allow us to gain a detailed understanding of a risk; in particular, its strategic context, root causes and consequences, risk scores and rationales, and relationship to risk appetite. Critically, it should focus on the performance of controls and mitigating actions towards achieving the risk target. In this way a deep dive can test assumptions, highlight gaps and identify the need for additional information and / or areas for improvement.

One characteristic of a deep dive is that it should be carried out **at specific points in time.**

The first cycle of reporting to the governance committees on the corporate risks, including deep dive reviews, took place in November and December 2022.

Initially it was intended that deep dives would be commissioned for deteriorating or static risks, risks identified by Committees, risks identified by EDG, Executives, or by recommendation from the ROG. Each committee was asked to consider and select the corporate risk(s) for a deep dive to be presented at the subsequent meeting. In practice, some took this approach; others scheduled deep dives for all aligned corporate risks on their work- plan.

Our approach has also provided the flexibility for deep dives into risks which are not corporate, but relate to priority areas or concerns aligned to a committee's remit.

As we enter the second year of reporting on corporate risks, we are reflecting on our learning and committee feedback over the last year. Having considered questions posed, for example, around the frequency or need for 'repeat deep dives' in proximity to an initial review, we recognise the need to recommend a practical approach to the future commissioning of reviews, specifically to:

- clarify the role of a deep dive during the life cycle of a corporate risk; and
- define criteria for reviews

RECOMMENDED TRIGGERS FOR CORPORATE RISK DEEP DIVE REVIEWS

Risk Deep Dive Reviews should be carried out in the following circumstances, with consideration of key points:

Proposed New Corporate Risk:
A potential risk is identified to the delivery of strategic priorities:

- Describe the risk including the relevant strategic priority
- Risk appetite
- Clearly identify root causes and consequences
- Provide an assessment of likelihood and consequence
- Cite current controls and mitigations and expected impact on the risk

Deteriorating Corporate Risk:
A risk has deteriorated i.e. current risk level increased from when initially identified/ risk level causes risk to exceed risk appetite:

- How far away are we from achieving the target?
- Is the target realistic?
- What plans are in place to reduce the risk level?
- Are they on target and reducing the risk level?
- If not, not what are the delivery challenges?
- What more needs to be done?
- Are we prepared if the risk were to materialise?

Static Risk:
There is stasis in a corporate risk beyond the target date for achieving the target risk rating:

- Compare current risk score and target risk score
- How far away are we from achieving the target?
- Is the target realistic?
- What plans are in place to reduce the risk rating /level?
- If not reducing the risk rating / level, what are the delivery challenges?
- What more needs to be done?
- Are we prepared if the risk were to materialise?

Proposed De- escalation or Closure of Corporate Risk:
A risk has achieved or surpassed its planned risk target:

- Evidence of sustained improvement in controls and actions
- Positive impact on likelihood and/ or consequence
- Consensus that risk is no longer a threat to delivery of strategic priority based on assurances - factual, reliable, relevant from various sources

In all cases, the Risk Owner must complete the Deep Dive Review template and provide a supporting standard SBAR report. These will be submitted initially for EDG consideration, prior to making recommendations to the relevant Committee.

In all other circumstances, unless by exception, it is proposed that corporate risk reports and Committee updates, should be presented in a standard SBAR. It is suggested this provides scope to more fully discuss the risk, including work which is in development, and to set out longer term ambitions to measure and monitor risks.

2.3.1 Quality, Patient and Value-Based Health & Care

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

2.3.2 Workforce

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

2.3.3 Financial

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

2.3.4 Risk Assessment / Management

Subject of the paper.

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

No specific Equality Impact Assessment has been conducted.

2.3.6 Climate Emergency & Sustainability Impact

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

2.3.7 Communication, involvement, engagement, and consultation

This paper reflects communication and feedback received from governance committees, and the considerations of the Risks and Opportunities Group.

2.3.8 Route to the Meeting

The consideration and recommendations have been considered by:-

- Risks and Opportunities Group – 3 October 2023
- Audit and Risk Committee – 12 October 2023 – Risk Summary Dashboard
- EDG – 2 November 2023

2.4 Recommendation

Members are asked to take **assurance** from the update and recommendations provided.

Members are also asked to note the recommendation made on the role of the Deep Dive and indications for use, and that the ROG will continue to:

- Develop and implementation approach for the Risk Summary Dashboard
- Include the recommended approach for handling risks that become an issue
- Continue to refine the associated KPIs

3 List of appendices

None.

Report Contact
Alistair Graham
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NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**13 December 2023**
Title:	**Risk Management Policy Update**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy, NHS Fife**
Report Author:	**Pauline Cumming, Risk Manager, NHS Fife**

1 Purpose

This report is presented for:

- Assurance
- Approval

This report relates to:

- Local policy/ framework

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The NHS Fife Risk Register / Risk Assessment Policy GP/R7 (hereafter to be referred to as 'the Policy', required to be updated to complement the NHS Risk Management Framework approved by the Board in September 2023. It was intended that the Policy would set out the updated operational arrangements to support implementation of the Framework.

Having reflected and carefully considered this requirement, and following consultation with key stakeholders, this paper proposes an alternative approach which the Committee is invited to consider.

The paper is provided for assurance and approval.

2.2 Background

A key deliverable of the risk management improvement programme agreed in 2022, was to update the Framework and Policy. These were considered necessary to provide assurance to the Board that there is an effective risk management process in place to support delivery of the strategic priorities and mature our risk management approach i.e.

- further embed a systematic process that supports effective decision-making by ensuring appropriate risk governance arrangements are in place across NHS Fife;
- ensure risks are identified, assessed, recorded and managed consistently across the organisation to enhance reporting and business intelligence;
- apply risk management as a driver for performance improvement through existing strategic and operational group infrastructure;
- further develop the contribution of risk management processes to support NHS Fife in addressing strategic risks and opportunities;
- further embed the risk appetite of NHS Fife and consistently apply it to the organisation

2.3 Assessment

A revised Policy was drafted. On review, it became clear that despite best efforts, there was considerable duplication and overlap with the content of the Framework. While some crossover of material might be expected, we reflected that an alternative approach might be preferable. We therefore initially sought and obtained the views of the Internal Audit (IA) team on whether a Policy is needed when we have a detailed Framework, and if it would be acceptable to combine.

IA feedback indicated that it was not necessary to have a separate policy if the information is already included in the Framework. Their review of the extant Policy against the Framework indicated that most of the policy content was contained in the latter. Of note, the glossary and risk register content were not covered.

The view from IA was that if the decision is made not to have a separate Policy, the Framework should be updated to remove references to it and add content such as the glossary and key risk register elements. It was suggested that concise training materials which direct managers and other users to the Framework would be more useful rather than a policy that is duplicative.

These suggestions were mooted at the Risks and Opportunities Group (ROG) meeting on 5 December 2023 where they received strong support.

It is therefore proposed that we:

- expand the Framework document to capture essential content from the Policy; this will be subject to further refinement and iteration;
- prioritise the development of resources to meet staff learning needs; align/ baseline with existing resources such as the Board Induction pack, Datix Guides and the developing ‘Operational guidance for Risk Management - Working with the Datix Risk Summary Dashboard’;
- explore with the Communications Team the potential to develop video materials

2.3.1 Quality, Patient and Value-Based Health & Care

Effective management of risks to quality, patient and value-based health & care will support delivery of our all strategic priorities.

2.3.2 Workforce

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

2.3.3 Financial

Issues related to financial impacts, are not directly relevant to this report.

2.3.4 Risk Assessment / Management

The report provides summarises progress to update key risk management documents.

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

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 Climate Emergency & Sustainability Impact

Climate emergency and sustainability impact are not directly relevant to this report. .

2.3.7 Communication, involvement, engagement and consultation

Engagement included the Director of Finance and Strategy, the Associate Director of Digital & Information, the Associate Director of Quality and Clinical Governance, and the ROG.

2.3.8 Route to the Meeting

Margo McGurk, Director of Finance & Strategy on 6 December 2023

2.4 Recommendation

Members are asked to take **assurance** from the update and **approve** the proposals within.

3 List of appendices

Appendix 1 - Draft revised Risk Management Framework 2023-25.

Report Contact
Pauline Cumming
Risk Manager, NHS Fife
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Draft Revised

Risk Management Framework

2023 – 2025

1. Executive Introduction

The delivery of healthcare is complex and we operate in a context that inevitably requires the daily management of emerging and inherent risk. It is not always possible or necessary to eliminate all risks. There are occasions where we need to tolerate or take risks in order to develop and improve our care and services and the environment in which we work.

This Framework sets out our ambition, to create a culture which supports each of us, whatever our role, to manage risk in our daily work. In this way, Risk Management is Everyone's Business.

Carol Potter
Chief Executive NHS Fife

2. Purpose

2.1 The purpose of this Risk Management Framework is to promote awareness of risk, and set out the approach, objectives, responsibilities and operational arrangements for risk management in NHS Fife.

2.2 The Framework affirms our commitment to risk management and to integrating this more fully within the culture, practice, and values of the organisation.

2.3 The Board has a legal duty under the Health and Safety at Work Act 1974, to ensure, as far as is reasonably practicable, the health, safety and welfare of all employees. Compliance with the legislation includes duties towards patients, members of the public, contractors, and other people who use hospital premises. These duties, and the concept of risk management, are implicit in the Act and subsequent UK Health and Safety Regulations and are reflected in NHS Fife Policies.

2.4 The Framework has been developed in the context of recovering from the impact of the global pandemic on our communities, staff, patients, and partners and as we consider how to redesign services fit for the future.

2.5 The Framework is aligned to the Population Health and Wellbeing Strategy 2023-28 and delivery against the four strategic priorities set out in Figure 1 below.

Figure 1

2.6 Framework Review

The Framework and the Board risk management arrangements will be reviewed every 2 years, with an update provided to the Audit and Risk Committee and the Board. This will ensure that the core framework remains current, reflects local and national developments and priorities, and drives continuous improvement in risk management across the Board.

2.7 What is Risk?

Risk can be defined as uncertainty of outcome, whether positive opportunity or negative threat. It is measured in terms of the likelihood and impact or consequence of the risk materialising.

2.8 Risks and Issues

Risks and issues can often get confused. It is important to differentiate between the two.

A risk is an 'uncertain future event', (or set of events), which, should it occur, will have an effect on the organisation's ability to achieve its objectives (The Orange Book, 2023). An effect is a deviation from the expected. It can be positive, negative or both, and can address, create or result in opportunities and threats (ISO, 31000, 2018).

A useful way of remembering the difference is:

A Risk is something that hasn't happened yet but has a likelihood of occurring.

An Issue is something that has happened and / or is already present. It was not planned and should be addressed as part of day to day management and governance processes.

In other words, **risks** are potential future problems and **issues** are current problems, i.e. already present[1].

If a risk materialises, it becomes an issue and should be managed appropriately.

Example:

Project risk: Critical resource might leave a project. Action: Identify potential problems. Address before they happen. Quantify and act to treat, tolerate, transfer or terminate.

Project issue: Team member resigns. Action: Problem resolution & decision making.

As a principle, a risk that becomes an issue should result in the risk being closed and an issue being raised and addressed. If on handling the issue, a risk remains, a new risk should be created; this can be linked to the original risk to provide evidence of continuity.

Appendix 1 contains a glossary of terms used in this document.

2.9 What is Risk Management?

Risk Management is the co-ordinated activities designed and operated to respond to and manage risk and exercise internal control within an organisation (The Orange Book, 2023). It is a continuous and evolving process which aims to reduce risk to organisations.

2.10 Why is Risk Management Important?

Effective risk management can help to:

- Ensure that decision making is informed and risk-based, to maximise the likelihood of achieving key strategic objectives and effective prioritisation of resources
- Ensure compliance with legislation, regulations, and other mandatory obligations
- Provide assurance to internal and external governance bodies that risks are being effectively controlled
- Prevent injury and / or harm, damage and losses
- Support organisational resilience
- Protect the assets and reputation of the organisation
- Achieve effective and efficient processes throughout the organisation
- Anticipate and respond to changing political, environmental, social, technology and legislative requirements and / or opportunities

2.11 Risk Management - Everyone's Business

[1] https://simplicable.com/new/risk-vs-issue 18/06/20

This Framework applies to the management of risk across all areas of NHS Fife including domiciliary settings, and to all employees of NHS Fife working in the Acute Services Division (ASD), the NHS Fife services delegated to the Integration Joint Board (IJB) managed through Fife Health & Social Care Partnership (HSCP), and the NHS Fife Corporate Directorates. It also applies to permanent and temporary contractors, honorary contract holders, students, bank, agency and volunteer staff working in NHS Fife and the HSCP, and by agreement, independent GP*, Dental*, Pharmacy* and Optometry*contractors working within, or on behalf of NHS Fife and the IJB.

It is important that all staff are involved in managing risk, regardless of their role and where they work. Examples of how each of us can manage risk are set out in Figure 2 below.

Figure 2

3. Framework Overview

Our approach to risk management is summarised below.

Objectives	• The safety of patients, staff and others coming into our services is protected • Risks to the delivery of our strategic priorities and organisational objectives are identified and mitigated through proactive action planning. • Risk management supports organisational change and service development when considering opportunities and risks to improve services. • A proactive approach to risk management as an effective mechanism for managing risks through effective action plans. • Board organisational risk appetite will be agreed and communicated annually.

Enablers 	• Ensure visibility of the organisation's risk profile, to enable effective and informed decision making. • Ensure a structured and consistent approach to managing risk from ward to board. • The Datix system facilitates the consistent recording, management and escalation of risk, across the organisation. • Clear systems and processes will be in place for the escalation or risks. • Effective risk management will be used to support decision making, planning and performance arrangements, by providing appropriate information for assurance to the respective management and governance structures. • Risks will be aligned as appropriate to groups and governance committees and will feature routinely on agendas. The Risk Management Team will: • Provide organisational support to ensure effective risk management practice. • Deliver training and educational resources to support staff to fulfil their roles & responsibilities in relation the risk management.
Our Values 	• We will deliver our risk management responsibilities within the context of our core values of; Care and Compassion, Dignity and Respect, Openness, Honesty and Responsibility, Quality and Teamwork.
Assurance and Strategic Oversight 	• The Board will set an effective risk management culture. • The Director of Finance and Strategy will provide executive leadership for risk management arrangements on behalf of the Chief Executive. • The Executive Directors will deliver their responsibilities for ensuring effective risk management through active engagement in the process and reporting through the governance committees and NHS Fife Board. • Governance Committees will deliver their responsibilities in relation to effective scrutiny of risk management in their areas of focus. • The Audit and Risk Committee (A&RC) will support the Board by, reviewing and advising on the effectiveness of the risk identification, management and reporting processes.

4. Scope

4.1 This Framework applies to the management of risks, including clinical, environmental, financial, staff health and wellbeing across all areas of NHS Fife service provision.

5. Strategic Context

5.1 The diagram below summarises:
- The national documents which influence our approach to risk management;
- NHS Fife strategies with which this Framework and its delivery must align; and

- Local policies and procedures which align to the Framework.

National Policy & Strategy	Board Strategy, Codes & Plans	Local Policy & Procedures
• Health & Safety at Work etc Act 1974 • NHS Quality Improvement Scotland National standards: Clinical Governance and Risk Management: Oct 2005 • The Reporting of Injuries Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995 (as amended 2013) • Scottish Government (SG) The Healthcare Quality Strategy for Scotland, May 2010 • Scottish Capital Investment Manual, 2017 • SG Audit & Assurance Handbook, 2018 • NHS Scotland Blueprint for Good Governance DL 2022) 02 • HIS Learning from Adverse Events through Reporting and Review: A National Framework for NHS Scotland, Dec 2019, 4th edition • NHS Scotland Whistleblowing Standards, April 2021 • NHS Recovery Plan 2021-2026 • National Workforce Strategy for Health and Social Care in Scotland(2022) • SG Delivering Value Based Health & Care - A Vision For Scotland Realistic Medicine, Dec 2022 • NHS Scotland Climate Emergency and Sustainability Strategy, 2022-26	• NHS Fife Population Health and Wellbeing Strategy 2023-28 • NHS Fife Medium-Term Financial Plan 2023-26 • NHS Fife Property and Assets Strategy 2023-26 • NHS Digital and Information Strategy 2019-2024 • NHS Clinical Governance Strategic Framework 2022-2025 • NHS Fife Workforce Plan 2022-2025 • NHS Fife Greenspace Strategy 2023 • NHS Fife Code of Corporate Governance • NHS Fife Annual Delivery Plans • Plan for Fife 2017-2027	• NHS Fife Complaints Handling Procedure, 2021 • NHS Fife Corporate Business Continuity Policy, May 2021 • NHS Fife Data Protection & Confidentiality Policy GP/I5 • NHS Fife Health & Safety Policy GP/H1, 2022 • NHS Fife Infection Control Policy, GP/18, 2022 • NHS Fife Safe &Secure use of Medicines Policy & Procedure V10, April 2023 • NHS Fife Adverse Events Policy GP/I9, 2023 • Fife Council Risk Management Policy and Strategy ,2023 • Fife Integration Joint Board Risk Management Policy and Strategy 2023

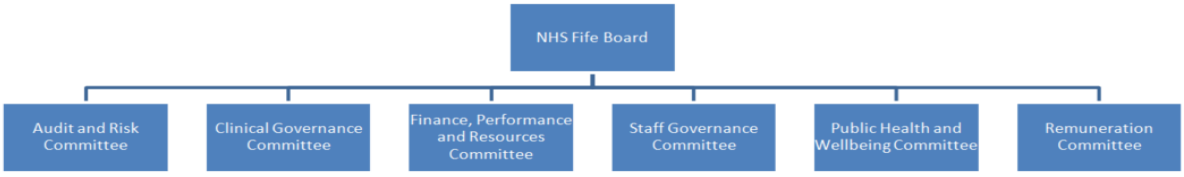
6. Governance Structures

6.1 This section sets out the oversight, assurance and monitoring from the point of service delivery to NHS Fife Board.

6.2 Fife NHS Board is responsible for the management of risk in NHS Fife. There are a number of structures below the Board which have responsibility to assess and monitor the risk management systems and processes and initiate action and improvements when required.

6.3 The Corporate Governance Structure within NHS Fife includes the NHS Fife Audit and Risk Committee (ARC), a key governance committee of the Board as set out in Figure 3 below.

Figure 3 NHS Fife Governance Structure



6.4 The Board is responsible for approving the Risk Management Framework and setting the risk appetite. Ultimately, the Board must ensure that the risk register reflects the risks the organisation is facing and that there is an effective system of risk management in place.

6.5 The ARC's responsibility is to provide the Board with assurance on the effectiveness of risk management arrangements and confirm that a sound system of internal control is maintained.

6.6 Operationally, the Executive Directors' Group (EDG) acts as a point of escalation for risk management related matters as required through the internal management structure.

6.7 The Chief Executive, as Accountable Officer of NHS Fife, and the Director of Finance & Strategy hold various professional responsibilities for ensuring effective organisational risk management arrangements. EDG is the forum for broader discussion and decision-making, in relation to risks to the delivery of the Board's strategic priorities and key operational, clinical and performance issues, and is a key conduit for overall assurance reporting to the standing committees and the Board.

6.7 A Risks and Opportunities Group (ROG) has been created which has delegated responsibility from the EDG to progress the activities required to support and embed an effective risk management framework and culture through NHS Fife. The ROG will periodically report to EDG and the ARC, making recommendations, providing considerations, or in the form of escalation if required as part of its role and remit. The Group's Terms of Reference are set out in Appendix 2.

6.8 The purpose of the ARC and linkages to the Framework are summarised below:

	Purpose	Where this framework aligns with the ARC role in relation to risk management
1	The main objective of the Audit and Risk Committee is to support the Accountable Officer and Fife NHS Board in meeting their assurance needs.	Supporting the Chief Executive/Accountable Officer and Fife NHS Board formulate their assurance needs, through the implementation of a well-designed assurance framework, with regard to risk management, governance and internal control. The committee reviews and approves the Internal Audit Strategic and Annual Plans having assessed their appropriateness to give reasonable assurance on the whole of risk control and governance. The committee work plan is designed to capture key planning for audit and risk activity with reports scheduled.
2	Review and challenge constructively the assurances that have been provided as to whether their scope meets the needs of the Accountable Officer and Fife Health Board; Review the reliability and integrity of those assurances including the evidence base.	• Promote Committee Assurance Principles. • Propose or endorse modifications to risk management processes to embed the Principles and enhance assurance lines.
3	Draw attention to weaknesses in systems of risk management, governance and internal control, and making suggestions as to how those weaknesses can be addressed.	• Consider strengths and areas of weakness highlighted in internal audit reports including Internal Controls Evaluation (ICE). • Review the effectiveness of risk management arrangements including risk identification and mitigation. • Consider risk management KPI data presented for assurance.

4	The Committee is charged with ensuring that there is an appropriate publicised Risk Management Framework with all roles identified and fulfilled.	The Framework: • Promotes a positive risk management culture where risk is everyone's business. • Describes enablers to effective risk management. **Sets out -** • the approach to managing risk • governance structures and terms of reference • risk management roles and responsibilities • risk appetite and how this is applied • an overview of risk management activities and how these support an effective system of risk management.
5	To discharge its advisory role to the Board and Chief Executive/Accountable Officer, and to inform its assessment on the effectiveness of corporate governance, internal control and risk management, the Committee shall: • seek assurance on the overall system of risk management for all risks and risks pertinent to its core functions; including the adequacy & effectiveness of the Corporate Risk Register, in terms of coverage of key risks to the Board, identification of gaps in control and assurance and the impact of changes to the risk register on the assurance needs of the Board and the Accountable Officer.	A Corporate Risk Register is in place The risks are: • mapped to the strategic priorities • aligned to governance committees for scrutiny and assurance • regularly reviewed • reported bi-monthly to the committees • considered at EDG & Risks & Opportunities Group • subjected to assessment against the Assurance Principles to determine the level of assurance provided • an annual risk management report will be assessed to confirm if there have been adequate and effective risk management arrangements throughout the year.
6	To escalate any issues of concern to the NHS Fife Board.	The Agenda contains' Items for Escalation' by the Committee Chairperson.

6.9 Partnership Working: Integration Framework and Services Delegated to the Integration Joint Board

To ensure there is clarity around governance, it is important that this framework sets out the risk management arrangements for services which are delegated to the Integration Joint Board (IJB).

The IJB Risk Management Strategy and Policy, 2023 sets out details of the risk management approach and vision, how the strategy will be implemented and expectations in relation risk leadership and accountability, resourcing risk management training, learning and development, monitoring and reporting and communication.

Management of operational clinical risks associated with services delegated to the IJB rests with NHS Fife Board. The systems and processes through the stated governance structure support effective management and mitigation of these risks. Risks with the potential to impact more than one partner will be identified for

inclusion in one or more of the following risk registers: NHS Fife Corporate Risk Register; IJB Strategic Risk Register.

Any such emerging operational risks should be submitted to the NHS Fife Executive Directors' Group for consideration and decision on action and/or addition to the NHS Fife Corporate Risk Register. Any potential IJB Strategic Risks will be considered through the IJB Governance routes via the IJB Chief Officer.

As a partner body of the IJB, NHS Fife will continue to operate appropriate risk management processes for operational risk. The NHS Board Chief Executive will ensure that processes are in place to alert the IJB Chief Officer to any strategic or operational risks which are likely to impact on the delivery of the IJB's Strategic Plan.

As a partner body of the IJB, NHS Fife will provide formal assurance to the IJB on the operation of its risk management arrangements and of the adequacy and effectiveness of key controls which could impact on the achievement of IJB objectives. The IJB will provide reciprocal assurance, including to other IJBs in their capacity as being responsible for hosted services, on its risk management processes and key controls.

NHS Fife risk management staff will participate in meetings as necessary to consider the implications of risks and provide relevant advice. Additionally, the Board will routinely seek to identify any residual risks and liabilities that it retains in relation to the activities under the direction of the IJB.

7. Risk Management Approach

7.1 This section sets out the key components of our approach to risk management:

- Risk Process
- Risk Definitions
- Risk Registers
- Risk Escalation
- Risk Appetite

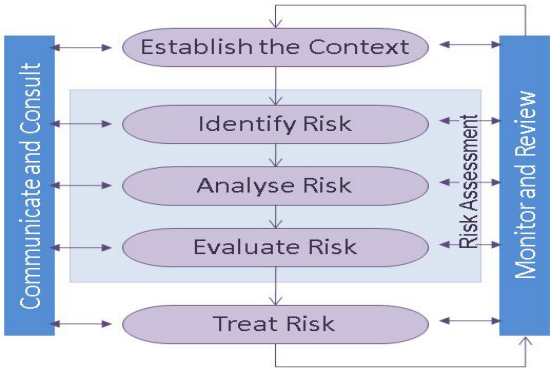
7.2 The NHS Fife methodology for achieving the objectives set out in section 3 above, is detailed below.

7.3 Risk Process

Risk management is a dynamic process. Regular, timely review of existing risks and monitoring of the environment is necessary to ensure the risks captured reflect the current profile of the organisation.

The steps to identifying and responding to risks are summarised in Figure 4 (Australia/New Zealand Risk Management Standard, AS/NZS 4360:2004).

Figure 4



NHS Fife will embed good risk management practice by promoting the consistent application of this process across all areas. This Framework provides guidance to support implementation.

Establish the Context

It is important to be clear about the context in which a risk is being generated. This should relate in some way to the achievement of objectives. It could be specific e.g. to delivery of a project, or generic and applicable across the organisation e.g. patient safety or related to the safe completion of a task.

Identify Risk

This is the means by which we identify where, when, why, and how an event could arise that could impact on the achievement of our objectives. Risks will be identified at all levels of the organisation e.g. wards, departments, directorates, divisions and services.

There are many ways to identify risks. This includes considering what has happened in the past and anticipating what might occur in the future. Ideally, risk identification should be a collaborative exercise and involve staff with understanding and experience of the topic or the area of service delivery under review.

Examples of opportunities to identify risks are set out below.

Risk Identification Opportunities	
Day to day business / clinical practice Safety Huddles Team meetings Development sessions	Risk workshops Risk surveys Reviews of existing risks Management meetings

Risks may be identified from internal and external sources including those set out below.

Information Sources	
• adverse event reviews • audits - internal/clinical • benchmarking • business cases • changes to guidelines, legislation, regulation, standards • claims / complaints data • internal / external reviews / investigations/ inspections • horizon scanning • media interest	• risk assessments • safety alerts • service change • staff surveys • patient/ user feedback • planning & performance processes • project plans • training needs analyses • walkrounds • workforce data

Risk Definitions

Corporate risk- A corporate risk can be defined as something which can either affect, or be created by, our decisions about strategy e.g. internal and external events that may make it challenging for the organisation to achieve its objectives **i.e.** threatens our ability to deliver the Population Health and Wellbeing Strategy.

In NHS Fife, these risks are mapped to one of the four strategic priorities and form our strategic risk profile. The corporate risks are in a state of continuous review throughout the financial year. The Executive Directors maintain a regular focus on the risks through the EDG standing agenda item on Quality, Performance, Workforce & Risk, specifically in preparation for governance committees, and opportunistically through horizon scanning for new or emerging risks or through recommendation from ROG.

Operational risk - An operational risk is one which may impact on our internal day-to-day business. These risks are identified, agreed and managed by the Executive Directors and their teams and escalated as necessary**.** These often present due to flawed or failed processes, policies, systems or events that disrupt operational delivery of services.

Project / Programme Risks - these are risks identified to the delivery of a specific organisational project or programme. Before the project or programme starts, the risks should be recorded on the aligned risk register and periodically reported to the PMO, project or programme board.

Risk Description

Having identified a risk and agreed its category, it is vital to describe it clearly and concisely to ensure that the risk, its causes and potential consequences are easily understood. This is important when designing and implementing controls and actions to manage and mitigate the risk, and determining their effectiveness. Descriptions should include the **risk, cause, and effect**. When wording the risk, you should phrase as follows:

"There is a risk that [something could happen], **because of** [explain why this could happen], **resulting in** [describe the consequence and /or impact on objective if the risk happens]" .e.g.
"There is a risk that the Board may not have sufficient staffing resource to safely operate clinical services due to recruitment and retention challenges, which could result in an increase in adverse events and loss of public confidence.

Analyse and Evaluate
Risks are analysed by combining the likelihood of the risk happening with the consequence of it materialising. This gives us the risk score. It is important to assess and evaluate the risk consistently. To do so, we use the NHS HIS risk assessment matrices shown at Appendix 3. Using a standardised tool like this adds some objectivity to the process. The matrices include a **5x5 scoring mechanism** for likelihood and consequence which identifies a score between 1 (1x1) at the lowest and 25 (5x5) at the highest, as well as a range of **consequence descriptors.**

This approach is used to assess the initial, current and target risk scores.

Initial Risk Score: This is the score when the risk is first identified with no controls or mitigations in place. It is sometimes called the original, inherent or gross score. This score will **not change** for the lifetime of the risk and is used as a benchmark against which we measure the effect of risk management actions. The score should be assessed before considering any control measures or actions.

Current Risk Score: This is the score with controls and mitigations in place. It is sometimes called the residual or net score. This score must be regularly reviewed and assessed to determine the effectiveness of actions to reduce the risk score towards the planned target. This score will also determine if the risk should be considered for escalation.

Target Risk Score: This is the planned score that is expected after the controls and mitigating actions have been fully implemented. The target risk score should reflect the organisation's risk appetite i.e. the amount and type of risk NHS Fife is willing to accept. Risk controls and actions should be designed to reduce the risk score towards the target level and in line with risk appetite.

Risk assessments should initially be scoped out on the NHS Fife Risk Scoping Template at and shared with appropriate colleagues to reach consensus **before** entering in Datix.

Risk Likelihood (L): Likelihood of a risk occurring is considered with current mitigation measures in place, not the proposed mitigation measures. The likelihood ranges from a score of **1** (Rare) to **5** (Almost certain).

Risk Consequence (C): The consequence of the risk is assessed against the following descriptors:

- Patient experience
- Injury to patient, staff ,visitors, others
- Objectives/ project
- Complaints/ claims
- Service business interruption
- Staffing and competence/
- Financial including loss /damage/ fraud
- Inspection/ audit
- Adverse publicity reputation

The consequence score ranges from **1** (Negligible) to **5** (Extreme). It should be assessed against all relevant descriptors; the descriptor generating the highest scoring criteria will identify the overall score for that risk.

Risk Rating: Risk rating is a numerical combination of the likelihood score x the consequence score.

Risk Level: We use the following definitions for risk scores- level and rating.

LEVEL	RATING
High:	15 -25
Moderate:	8 -12
Low:	4 - 6
Very Low:	1 - 3

Treat

Risk Controls
Risk controls are measures to effectively mitigate a risk to the level acceptable to the organisation (i.e. to a planned target score).You should consider any controls currently in place to reduce the likelihood of the risk occurring and / or the consequence should it materialise; the adequacy of those controls; record what is in place and identify any gaps and additional required actions.
Controls can be preventative or contingency and should reduce the likelihood and / or consequence.

- Preventative Controls: Mitigating actions which will work to control the cause of the risk and prevent it happening in the first place e.g. policies, procedures, projects, training courses, business continuity plans legislation, national directives protective measures, contingency plans, meetings

- Contingency Controls: Actions that can be put in place to reduce the risk impact if it does materialise.

It is essential to assess whether the controls identified are, or will be effective i.e.

- What do you have in place to manage the cause and / or impact of the risk?
- Do they work and what evidence do you have of the effectiveness? For example, a policy which is in place but never complied with is not an effective control.
- Are there any gaps in your controls?
- Do you have all the information you need about the risk or do you need more?
- If several activities are required to manage the risk, how will you prioritise these?
- Are the controls within the remit of your department? If not, consider who you need to liaise with to ensure that appropriate controls are put in place.
- If you implement the controls you have identified, will these manage the risk towards the planned target? If not, then further controls are required.

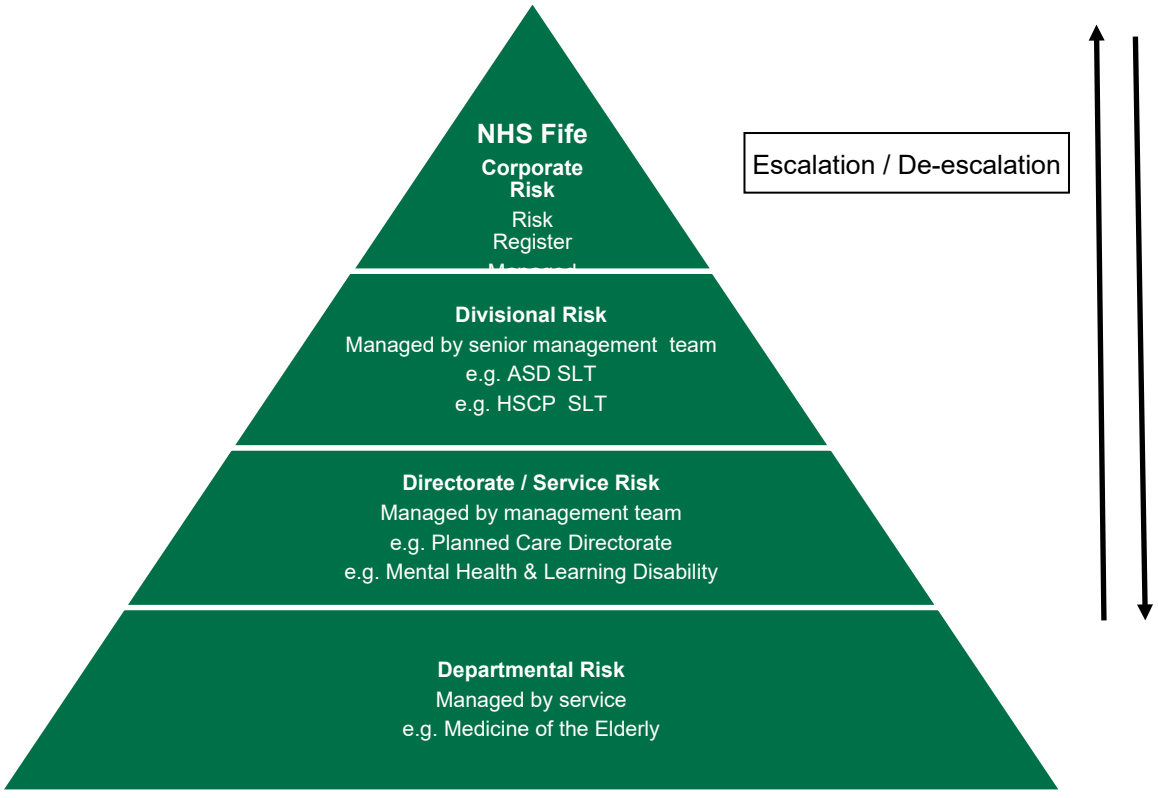
Mitigating Actions
Where further actions are required to manage a risk these should be **SMART**
Specific - clear, focussed, unambiguous
Measurable - quantifiable - clearly defined outcome
Achievable - realistic and appropriate
Relevant - linked to what is to be achieved.
Time - bound - realistic with defined start and end date for achieving the outcome

7.4 Risk Registers

Following completion of the risk assessment, and when approved, the risk must be recorded in a risk register. A risk register is an information log created by an organisation to record its risks and responses. It is a tool intended to help managers achieve their objectives. It should drive and provide evidence of risk management activities and act as a means or source for risk reporting. Risk registers must be maintained and reviewed to ensure they are up to date and effective.

The repository for risks in NHS Fife is the Datix Risk Register module. Appendix 4 provides guidance to the core risk register fields. Risk registers exist at different levels across the organisation for specific portfolios, programmes, projects, and day-to-day activities.

Risk Register Hierarchy



Acute Services Division (ASD)
Executive Directors' Group (EDG)
Health & Social Care Partnership (HSCP)
Senior Leadership Team (SLT)

7.5 Monitor and Review

Healthcare is delivered in a dynamic and challenging environment. It is therefore necessary to regularly

monitor, review and update our risks. This includes re-assessing for changes in context and risk score, management controls and/or or actions. The process should look to answer the following questions.

- Is the organisation taking the right risks?
- Is the management of risk effective? i.e. Are risks reducing to an acceptable level, increasing or static?
- Is risk management providing useful, timely information that helps improve the organisation's decisions?

The risk review timescales are set out below and in the Datix Risk Register.

Current	Review & Update	Proposed Review & Update
High: 25	at least monthly	Within 1 month
High: 15 - 20	at least quarterly	Within 1 month
Moderate: 8 -12	at least 6 monthly	No longer than 3 months
Low: 4 - 6	at least annually	No longer than 3 months
Very Low: 1 - 3	at least annually	No longer than 3 months

Steps in a Risk Review

When reviewing a risk, you should consider the following:

- Is the description valid? Does it make sense? Does it match the current operational challenge?
- Do the scores feel right?
- Is the rationale for the current score valid?
- Are there internal or external factors / influences that might alter the risk score?
- Do the controls match the stated risk?
- Are the controls working effectively as intended or not? Is the risk decreasing towards target? If not, why? What more / different is needed?
- Is the risk target realistic?
- If the score shows that the risk is increasing or remaining static, check the measures you have in place and consider what else might be needed and add as necessary. When a risk appears static, this might indicate the risk has merely been identified but is not being actively managed and requires an alternative approach / interventions and /or escalation.
- What level of assurance can you provide?
- What impact do you expect additional measures to have on likelihood and / or consequence?

Following a Risk Review

You must record the outcome of risk reviews in Datix to show evidence of monitoring. This includes:

- updates to current risk score - rating and level
- changes to controls and actions
- a progress note where applicable

Risk owners and teams can upload relevant information to the Documentation field within the Datix risk record to provide supporting evidence of risk management activities.

Guidance for managers and risk owners and who are responsible, through their role and the work of their teams, to ensure effective risk management continues to receive the appropriate prioritisation, is provided in "Risk Management - Operational Guidance. Working with the Micro strategy Datix Risk Summary Dashboard". This developing guidance provides a method for individuals, departments, services, directorates, management and leadership teams, to review and manage risks in a consistent and time effective manner. It suggests activities to help teams to further develop their approach to risk management and prioritise their focus on e.g. high risks, overdue risks and risks that have been open for a long time.

7.6 Risk Escalation

Risk escalation is a process that ensures risks that cannot be managed by a local team, department or specialty are escalated appropriately. To ensure that these risks are managed effectively, they must be escalated in a timely way to the appropriate level in the organisation and to external stakeholders where necessary. This allows visibility of risks and support to be provided when required. Timely escalation ensures that management are informed, and can consider necessary action at the earliest opportunity.

All staff in NHS Fife have a responsibility for identifying risk. If you identify a risk that you think may require escalation, e.g. a risk is confirmed as or moves to being Very High (25), raise this first with your line manager to allow them to decide on the appropriate action having considered factors including:

- the risk likelihood and consequence scores
- the effectiveness or otherwise of current management actions / mitigations
- the threat presented by the risk e.g. to organisational objectives / national standards
- who needs to be made aware e.g. General Manager, Head of Service, Executive Director who must establish if the impact of the risk is e.g. across the organisation or will impact on its reputation

Before escalating or de-escalating a risk, you should consider the following points:

Escalation	De-escalation
• Is there evidence that controls & actions are ineffective in reducing or eliminating the risk? • Have all controls & local solutions been implemented? • Are there any alternative controls? • Are consequences so severe that the risk needs higher visibility? • Is the likelihood score justified? • Is the "target rating" realistic? If so, what additional mitigation could be taken or is there a need to escalate? • Is it agreed that an area does not have resource / authority to manage the risk? • Does the risk impact on other areas? • Are similar risks appearing on other operational risk registers indicating the need for corporate oversight?	• The risk has been reviewed by the risk owner and next level manager • The risk has had further mitigating action and has now been reduced with monitoring required over an agreed period of time. • The risk will be transferred (outsourced) and/ or closed. • The risk is acceptable and will be de- escalated back to source for assurance monitoring. • The risk will be closed

For guidance, see the Escalation Flowchart at Appendix 5.

N.B. Risks can be de-escalated back to the originating level for monitoring if a sustainable risk level has been achieved at or below the risk appetite.

Closing a Risk

When a risk has been sustainably mitigated to the lowest possible level / reached its planned risk target, and is no longer considered active, or no longer describes the current challenge, it should be considered for closure. It may be necessary to reframe the current risk. The risk owner should carry out a full risk review with other stakeholders / team members, to reach a decision on its closure as follows:

Corporate risks – review through EDG and the relevant governance committee. This may follow a recommendation from the ROG. A deep dive review will be carried out initially for EDG consideration and then to the aligned governance committee for a decision.

Operational risks – review through the Directorate / Service / Corporate management team and or clinical governance / risk fora

Programme / Project risks - through the Programme/ Project Board / PMO

If there is consensus that a risk is no longer active, it may be closed. The Datix record must be updated to reflect the reason for closure, decision maker (s), and the date of closure. The risk will remain on the electronic system to enable a historical view of the risk.

7.7 Risk Appetite

Simply put, risk appetite is the amount of risk the Board is willing to take or tolerate in the pursuit of its objectives. It underpins effective risk management and should reflect our functions, purposes and be balanced against our ambition. Risk Appetite:

- supports a consistent approach to risk across an organisation and ensures that we are operating within acceptable limits
- informs decision making - ensures resources are not spent on further reducing risks already at an acceptable level
- promotes prioritisation of resource, including corporate focus and management time e.g. on risks above appetite; this could inform choices for deep dive reviews
- removes subjectivity
- innovation vs status quo - risks vs opportunity

The Board sets the Risk Appetite and captures it in a Risk Appetite Statement. Risk appetite is not static; it varies depending on internal and external factors and so should be reviewed and updated at least annually.

Risk Appetite Descriptors
To ensure a common understanding of 'levels' of risk appetite, we use the following descriptors:

Low - Regarding statutory functions, we have very little appetite for risk, loss, or uncertainty. We are prepared to accept low levels of risk, with a preference for ultrasafe delivery options, while recognising that these will likely have limited or no potential for innovative opportunities.

Moderate - Prepared to tolerate only modest levels of risk to achieve acceptable, but possibly unambitious outcomes and limited innovation.

High - Willing to consider and / or seek all delivery options (original / ambitious / innovative), and tolerate those with the highest likelihood of successful outcomes, in pursuit of objectives even when there are elevated levels of associated risk.

Risk Appetite Statement
A Risk Appetite Statement describes the level that an organisation is prepared to accept against certain categories or types of risk. NHS Fife set its risk appetite for key aspects of the delivery of health and care in 2022, as we emerged from the pandemic and developed the Population Health and Wellbeing Strategy. Our Risk Appetite Statement aligns to the 4 strategic priorities and is set out at Appendix 6.

7.7 Assurance

Assurance provides:	Evidence / Certainty / Confidence
To:	Directors / Organisation / The Board / The Public / External Agencies
That:	What we are currently doing is making a positive impact on risks

Assurances should be based on credible evidence that risks are being adequately managed with key controls and mitigations identified, implemented and working effectively in terms of relevance, proportionality, reliability and sufficiency. To support our approach and add consistency to our assurance reporting, we have adopted the 4-level assurance model used by Internal Audit.

Level of Assurance		System Adequacy	Controls
Substantial Assurance		A sound system of governance, risk management and control exists, with internal controls operating effectively and being consistently applied to support the achievement of objectives in the area audited.	Controls are applied continuously or with only minor lapses.
Reasonable Assurance		There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified which may put at risk the achievement of objectives in the area audited.	Controls are applied frequently but with evidence of non-compliance.
Limited Assurance		Significant gaps, weaknesses or non-compliance were identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the area audited.	Controls are applied but with some significant lapses.
No Assurance		Immediate action is required to address fundamental gaps, weaknesses or non-compliance identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the area audited.	Significant breakdown in the application of controls.

This model forms part of the Assurance Principles provided to the EDG, Governance Committees and the Board within the Corporate Risk reports and Deep Dive Reviews.

The Principles also refer to what is often called the "three lines of assurance" model. This provides a framework for undertaking a comprehensive assessment of the effectiveness of risk controls and actions and allows a conclusion to be reached on the level of assurance given and obtained. It is summarised below.

1st line:	Management assurance from "front line " or operational areas that own the risks and are responsible for controlling them day-to-day and for taking corrective actions to address deficiencies. e.g. applying policies and procedures, understanding the key controls, and how well those are working**.**
2nd line:	Oversight of management activity, separate from those responsible for delivery, but not independent of the organisation's management chain e.g. corporate governance /compliance functions to assist the first line fulfil their assurance responsibilities. Includes e.g. quality assurance, inspection, to determine compliance with standards / policy / regulatory considerations.
3rd line:	Independent and objective assurance reports on the integrity and effectiveness of risk management & related controls, including the quality of assurance derived from the 1st & 2nd lines. Typically provided by internal audit but also external audit, accreditation bodies, regulators, Royal Colleges.

The Assurance Principles are set out in Appendix 7.

Deep Dive Review
A key component of our assurance approach is a risk deep dive review. The role of a 'deep dive' is to allow us to gain a detailed understanding of a risk; in particular, its strategic context, root causes and consequences, risk scores and rationales, and relationship to risk appetite. Critically, it should focus on the performance of controls and mitigating actions in achieving the risk target. In this way a deep dive can test assumptions, highlight gaps and identify the need for additional information and / or areas for improvement.

Generally, though not exclusively the triggers for undertaking a deep dive review will be:

Proposal of a New Corporate Risk: *A potential risk is identified to the delivery of strategic priorities*

Deteriorating Corporate Risk: *A risk has deteriorated i.e. current risk level increased from when initially identified/risk level causes risk to exceed risk appetite*

Static Risk: *There is stasis in a corporate risk beyond the target date for achieving the target risk rating*

Proposed De- escalation or Closure of Corporate Risk: *Risk has achieved or surpassed its planned risk target*

Deep dives may also be commissioned by the aligned governance committee or via a recommendation from EDG in response to other priorities or concerns.

Key Performance indicators (KPIs)
Measuring, managing and monitoring risk management performance is key to the delivery of objectives. We will develop and use KPIs to assess the effectiveness of the risk management system and provide assurances to the governance committees and the Board.

7.9 Communicate and Consult

The communication of clear, relevant, reliable risk information is essential to effective risk management. The Model Meeting Paper SBAR Template provides a section in which key risks relevant to the report submitted should be described in line with the supporting guidance.

Key organisational risk reports include the following:

Reporting to the Board:
The Corporate Risk Register will be reported to the Board on a 6 monthly basis or by exception as required. Additionally, the Strategic Risk Profile, as a dashboard set in the context of the Board's risk appetite, forms a component of the monthly Integrated Performance & Quality Report (IPQR).

Reporting to the Audit & Risk Committee
The Corporate Risk Register Report will be reported to each meeting of the Committee for consideration, review and comment; this will be at least quarterly. Risk KPIs will also be reported to the Committee. An Annual Risk Management Report will be provided to inform the Committee's opinion on the overall system of risk management at year end.

Reporting to the Governance Committees
An overarching Corporate Risk Register report will go bi- monthly to each committee , according to its areas of scrutiny, with detailed reviews on specific corporate risks every 4 months, unless by exception. A risk may be referred to more than one committee depending on its nature and relevance.

Annual Risk Management Report

An Annual Risk Management Report will be presented to the EDG, the Audit & Risk Committee and the Board. This will include a formal conclusion on the adequacy and effectiveness of the risk management arrangements, supported by appropriate evidence.

Directorates and Services
Departments will carry out regular risk reviews which will be monitored and reported through their governance groups and committees to ensure that there is appropriate oversight, discussion, action planning and where indicated, escalation.

Fife Integration Joint Board
The reporting requirements and responsibilities relating to risks to delegated services are set out in the Fife IJB Risk Management Strategy.

Risk management staff from both parties will work together to ensure that risk management arrangements are aligned to facilitate effective escalation of risks and provision of assurance.

Patients and the Public
NHS Fife seeks to inspire confidence and trust in its services and will:

- be open with the public about our understanding of the nature of known risks
- engage with stakeholders as appropriate in relation to risks that affect them
- embrace the principles of value based health and care including realistic medicine, to achieve the outcomes and experiences that matter to patients, their families and carers. This will support delivery of care that reduces harm and waste.
- provide assurance through the Annual Risk Management Report that we have in place adequate and effective systems to manage risk

8. Implementation

To support the implementation of this Framework, we will develop an annual delivery plan which will set out how we will achieve our objectives each year. Progress against the plan will be monitored by the Risks and Opportunities Group, and reported to the Audit and Risk Committee, and within the Annual Risk Management Report.

The information will be accessible for staff to download via Staff Link and accessible to patients and members of the public on the NHS Fife web site - nhsfife.org.

9. Training and Development

For risk management to be effective and embedded across the organisation, staff must understand its benefits and their responsibilities. Resources, training and development sessions to enable staff to acquire the knowledge and skills necessary for their role will be provided and advertised via Staff Link and /or targeted communications.

For advice, guidance and support related to risk management, please contact pauline.cumming@nhs.scot

10. References

- The Orange Book: Management of Risk - Principles and Concepts, 2023
- ISO 31000 Risk Management- a practical guide, 2018
- Fife Health & Social Care Partnership - Integration Joint Board Risk Management Policy and Strategy, 202

Glossary of Terms

A Risk: Something that hasn't happened yet but has a likelihood of occurring.

Adverse Event: An event that could have caused, or did result in, harm to people or groups of people. N.B. Groups of people include any functional grouping of individuals such as an organisation.

Assurance: Stakeholder confidence in our service gained from evidence showing that risk is adequately managed and that critical controls have been identified, implemented and are effective.

Consequence: Most predictable impact to individual or organisation if circumstances were to occur.

Contingency: An action or arrangement that can be implemented to minimise impact and ensure continuity of service when things go wrong.

Current Risk Score: The risk score identified taking into account controls currently in place to manage the risk.

Deep Dive Review: Standard quality assurance tool. Its purpose is to drive continuous quality improvement. Technique is intended to solve problems, generate ideas and understand a situation.

Eliminate Risk: Do things differently & remove the risk where it is feasible to do so.

Governance: The system by which organisations are directed and controlled to achieve objectives and meet the necessary standards of accountability, probity and openness in all areas of governance.

Horizon scanning: Systematic examination of potential threats, opportunities and likely future developments which may be at the margins of current thinking and planning. Can explore novel and unexpected issues as well as persistent problems or trends, help to anticipate, identify and prepare for new or changing risks, developments, trends or changes in workplaces, including those arising from socio-economic, workplace trends that could have an impact on ability to deliver on objectives.

Initial Risk Score: The score identified by assessing the risk with no controls, mitigation or contingency plans in place.

Internal Control: Corporate governance arrangements designed to manage the risk of failure to meet objectives.

Issue: Something that has happened and / or is already present.

Likelihood: Probability of an event occurring, wherever possible based upon the frequency of previous occurrences, which can be expressed quantitatively or qualitatively.

Near Miss: Where no harm, loss or damage is caused but could have resulted in harm, loss or damage in other circumstances.

Partnership: Way of working where staff at all levels and their representatives are involved in developing and putting into practice the decisions and policies which affect their working lives and service delivery.

Reduce risk: Take action to control the risk either by taking actions which lessen the likelihood of the risk occurring or the consequences of occurrence.

Risk: Uncertainty of outcome, whether positive opportunity or negative threat, of actions and events have an impact on the organisation's ability to achieve its objectives. It is the combination of the likelihood and impact or consequence of the risk materialising.

Risk Appetite: The amount and type of risk that an organisation is willing to take in order to meet their strategic objectives.

Risk Assessment: A systematic process of assessing the likelihood of something happening (frequency or likelihood) and the consequence if the risk actually happens.

Risk Control: Management measures to effectively manage a risk to within an acceptable level. Can be preventative or contingency in nature and will reduce the likelihood and/ or consequence.

Risk Culture: Reflects the overall attitude of the management of an organisation towards risk.

Risk Escalation: The process of delegating upward, ultimately to the Board, responsibility for the management of a risk deemed to be impractical or not reasonably practicable to manage locally.

Risk Evaluation: An estimate of the probability and /or frequency of the risk occurring and the impact or severity if it does**.**

Risk Handler: Person responsible for updating the risk in Datix.

Risk Identification is the process of determining risks that could potentially impact in some way on the achievement of our objectives. It includes documenting and communicating the concern.

Risk Level: Risk expressed as a combination of its likelihood and severity of consequence.

Risk Management: The integrated approach (culture, processes, structures) to the identification, analysis, control and monitoring of risk which may threaten the achievement of objectives. It involves the systematic identification, evaluation and treatment of risk. It is a continuous and evolving process which aims to reduce risk to organisations and individuals alike.

Risk Matrix: Scoring mechanism to identify the severity of a risk, by multiplying likelihood x impact, across pre-set categories.

Risk Maturity: The level of risk management capability within an organisation.

Risk Owner: The lead person assigned with responsibility for ensuring that the risk is adequately controlled and monitored.

Risk Register: A tool used to capture and monitor risks. Includes all information required about the particular risk and to be used as a management tool and conduit for risk reporting.

Target Score: An acceptable level of risk based on the category of risk and risk appetite.

Tolerance: The boundaries of risk taking outside of which the organisation is not prepared to venture in the pursuit of its long term objectives. The maximum level of risk the organisation can tolerate regarding each type of risk before the organisation is significantly impacted.

Threat: A negative scenario which could give rise to risks.

APPENDIX 2

NHS FIFE
RISKS AND OPPORTUNITIES GROUP
TERMS OF REFERENCE

1. Purpose

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

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

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

2. Composition

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

Associate Director of Digital and Information (Co-chair)
Assistant Director, Research, Innovation and Knowledge
Director of Allied Health Professions (AHPs)
Associate Director of Communications
Associate Director of Planning and Performance
Associate Director of Quality and Clinical Governance (Co-chair)
Director of Nursing – Corporate
Deputy Director of Finance
Deputy Director of Pharmacy and Medicines
Deputy Director of Workforce
Deputy Medical Director (Acute)
Estates Manager, Compliance
General Manager, Acute Services Division
Head of Corporate Governance and Board Secretary
Healthcare Public Health Consultant
Health & Social Care Partnership (HSCP) Representative
Risk Manager
Staff Side Area Partnership Forum Representative

2.2 A member of the Internal Audit team will be **in attendance** at meetings.

2.3 Other colleagues may be invited to attend meetings to contribute to particular topics as required.

2.4 If a core member is unable to attend, they should identify a deputy to do so on their behalf.

2.5 Members of the group commit to role modelling positive attitudes and behaviours which align to NHS Fife's organisational values.

3. Role and Remit

3.1 The role and remit of the ROG is to:

a) Maintain an overview of the corporate risks and their links to strategic priorities.
b) Assess the corporate risk register using knowledge and understanding from members' respective areas of responsibility and assist the Executive Directors' Group (EDG) and the governance committees with recommendations (by way of a regular exception report) in relation to:
   - the risk levels including target, and corresponding risk appetite level
   - adequacy of controls (stabilising risk) and actions (current and future to reduce risk)
   - specific timescales for impact of risks and ensuring that actions and corresponding timescales for delivery are appropriate
   - identifying risks which require a more detailed assessment to ensure improvement is delivered
   - horizon scanning of risks and opportunities which may impact the risk profile
   - providing assurance that the corporate risk register reflects and aligns to the strategic priorities and in year corporate objectives
   - assessment of immediate, mid and long term risks in terms of proximity
c) Ensure a prioritised programme of work which responds to the Annual Delivery Plan (ADP), the corporate risk register and connects to the Integrated Performance & Quality Report (IPQR) deliverables and the Strategic Planning Resource Allocation (SPRA), with a view to reducing the risk exposure.
d) Maintain oversight of the operational risk profile.
e) Monitor risk performance through the implementation of key performance indicators.
f) Identify operational risks for escalation.
g) Develop a work plan which effectively embeds the NHS Fife Risk Management Framework. This will be submitted to EDG and to the Audit and Risk Committee (ARC).
h) Provide leadership across respective areas of responsibility to promote, support and embed an effective risk management culture.
i) Contribute to and monitor the development of organisational support to ensure effective risk management practice through:
   - delivery of targeted education and training; and
   - regular communications on developments in policy and process

4. Meetings and Reporting Arrangements

4.1 Meetings will be held bi-monthly.
4.2 The group will be quorate when at least one of the co-chairs plus at least 8 other members are present.
4.3 The ROG will report to EDG periodically, making recommendations, providing considerations or in the form of escalation if required as part of its role and remit.
4.4 The ROG will report to ARC periodically, making recommendations or providing considerations from its role and remit.
4.5 Individual members will report into respective local governance groups to ensure a focus on effective risk management arrangements. These groups include: e.g. Clinical Governance Oversight Group (CGOG), Senior Leadership Teams (SLTs), Public Health Assurance Committee (PHAC)
4.6 These reporting arrangements are additional to the existing reporting requirements conducted by the Risk Management team.

5. Review

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

Date of Approval: 8 August 2023

Review Date: April 2024

Risk Assessment Matrix

A risk is assessed as **Likelihood x Consequence**

Likelihood is assessed as Remote, Unlikely, Possible, Likely or Almost Certain

Figure 1 Likelihood Definitions

Descriptor	Remote	Unlikely	Possible	Likely	Almost Certain
Likelihood	Can't believe this event would happen – will only happen in exceptional circumstances (5-10 years)	Not expected to happen, but definite potential exists – unlikely to occur (2-5 years)	May occur occasionally, has happened before on occasions – reasonable chance of occurring (annually)	Strong possibility that this could occur – likely to occur (quarterly)	This is expected to occur frequently / in most circumstances – more likely to occur than not (daily / weekly / monthly)

Consequence is assessed as, Negligible, Minor, Moderate, Major or Extreme.

Risk Level is determined using the 5 x 5 matrix below based on the AUS/NZ Standard. The risk levels are:

- Very Low Risk (VLR)
- Low Risk (LR)
- Moderate Risk (MR)
- High Risk (HR)

Figure 2 Risk Matrix

Likelihood	**Consequence**				
	Negligible 1	**Minor 2**	**Moderate 3**	**Major 4**	**Extreme 5**
Almost certain 5	LR 5	MR 10	HR 15	HR 20	HR 25
Likely 4	LR 4	MR 8	MR 12	HR 16	HR 20
Possible 3	VLR 3	LR 6	MR 9	MR 12	HR 15
Unlikely 2	VLR 2	LR 4	LR 6	MR 8	MR 10
Remote 1	VLR 1	VLR 2	VLR 3	LR 4	LR 5

Risks once identified, must be categorised against the following consequence definitions

Figure 3 Consequence Definitions

Descriptor	Negligible	Minor	Moderate	Major	Extreme
Patient Experience	Reduced quality of patient experience / clinical outcome not directly related to delivery of clinical care.	Unsatisfactory patient experience / clinical outcome **directly related to care provision – readily resolvable.**	Unsatisfactory patient experience / clinical outcome, short term effects – expect recovery <1wk.	Unsatisfactory patient experience / clinical outcome, long term effects – expect recovery - >1wk.	Unsatisfactory patient experience / clinical outcome, continued ongoing long term effects.
Objectives / Project	Barely noticeable reduction in scope / quality / schedule.	Minor reduction in scope / quality / schedule.	Reduction in scope or quality, project objectives or schedule.	Significant project over-run.	Inability to meet project objectives, reputation of the organisation seriously damaged.
Injury (Physical and psychological) to patient / visitor / staff.	Adverse event leading to minor injury not requiring first aid.	Minor injury or illness, first aid treatment required.	Agency reportable, e.g. Police (violent and aggressive acts). Significant injury requiring medical treatment and/or counselling.	Major injuries/long term incapacity or disability (loss of limb) requiring medical treatment and/or counselling.	Incident leading to death or major permanent incapacity.
Complaints / Claims	Locally resolved verbal complaint.	Justified written complaint peripheral to clinical care.	Below excess claim. Justified complaint involving lack of appropriate care.	Claim above excess level. Multiple justified complaints.	Multiple claims or single major claim/. Complex justified complaint
Service / Business Interruption	Interruption in a service which does not impact on the delivery of patient care or the ability to continue to provide service.	Short term disruption to service with minor impact on patient care.	Some disruption in service with unacceptable impact on patient care. Temporary loss of ability to provide service.	Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked.	Permanent loss of core service or facility. Disruption to facility leading to significant "knock on" effect
Staffing and Competence	Short term low staffing level temporarily reduces service quality (less than 1 day. Short term low staffing level (>1 day), where there is no disruption to patient care.	Ongoing low staffing level reduces service quality. **Minor error** due to ineffective training / implementation of training.	Late delivery of key objective / service due to lack of staff. **Moderate error** due to ineffective training / implementation of training. Ongoing problems with staffing levels.	Uncertain delivery of key objective / service due to lack of staff. **Major error** due to ineffective training / implementation of training.	Non-delivery of key objective / service due to lack of staff. Loss of key staff. **Critical error** due to ineffective training / implementation of training.
Financial (including damage / loss / fraud)	Negligible organisational / personal financial loss (£<10k)	Minor organisational / personal financial loss (£10k-100k)	Significant organisational / personal financial loss (£100k-250k)	Major organisational / personal financial loss (£250 k-1m)	Severe organisational / personal financial loss (£>1m)
Inspection / Audit	Small number of recommendations which focus on minor quality improvement issues.	Recommendations made which can be addressed by low level of management action.	Challenging recommendations that can be addressed with appropriate action plan.	Enforcement action. Low rating Critical report.	Prosecution. Zero rating Severely critical report.
Adverse Publicity / Reputation	Rumours, no media coverage. Little effect on staff morale.	Local media coverage – short term. Some public embarrassment. Minor effect on staff morale / public attitudes.	Local media – long-term adverse publicity. Significant effect on staff morale and public perception of the organisation.	National media / adverse publicity, less than 3 days. Public confidence in the organisation undermined Use of services affected	National / International media / adverse publicity, more than 3 days. MSP / MP concern (Questions in Parliament). Court Enforcement Public Enquiry, FAI

Based on NHS Quality Improvement Scotland (February 2008) sourced AS/NZS 4360:2004: Making it Work: (2004) and Healthcare Improvement Scotland, Learning from Adverse Events: A national framework (4th Edition) (December 2019)

CORE DATIX RISK REGISTER FIELDS

Field Name	
ID	Unique identifier number for each new record created within Datix. This should be used to identify risk.
Title	Full title of risk
Risk Type	e.g. Strategic / Operational / Programme or Project
Position of Risk	The specific risk register(s) in which an individual risk is currently located
Description	Standardised way of expressing the risk. clearly and concisely to describe the risk event, the cause and the effect. There is a risk that /or of … due to/ caused by… which could lead to an impact/effect on…
Risk Level Initial	Score when the risk is first identified and is assessed with no steps taken to control or manage the risk. This score will not change for the lifetime of the risk and is used as a benchmark against which the effect of management actions will be measured. Sometimes called 'inherent' risk '
Risk Level Current	Score taking account of current controls in place. Reflects the score at the time the risk was last reviewed in line with review dates. It is expected that this score will reduce and move toward the planned Target Risk Score as action to mitigate the risks are developed and implemented. Sometimes called 'residual' risk
Planned / Proposed Actions / Mitigations	Identify actions to manage the risk / reduce likelihood of occurrence (and consequence)and move towards target , and any additional measures to further mitigate the risk
Risk Level Target	Planned risk score after all proposed actions have been implemented. By setting a target, we can determine how effectively the risk is being managed and /or if management actions need to be reviewed
Current Management Actions	Measures in place to control and manage the risk e.g., processes; policies; procedures, practices; devices, training, legislation)
Previous Management Actions	At the review, any redundant management actions must be moved from the current management actions field into this archive field.
Progress Notes	Any **brief** additional notes relating to progress **not** management actions
Risk Owner	The person with ultimate responsibility for the risk and its effective management
Risk Handler	Person responsible for ensuring risk is recorded in Datix and all updates are acquired for review?
Risk Status	Shows if risk is active or closed
Approval Status	Indicates if the risk has been approved
Opened	The date that the risk was first identified & added to Datix
Review Date	The date the risk was last reviewed
Next Review	The date by which the risk must be reviewed in its entirety
Risk Type / Sub Type	How the risk is categorised e.g. clinical; health & safety
Service/Directorate	Indicates the Service or Directorate where the risk originated
Actions	
Action ID	Datix will generate an ID number for every action created
Assigned by	Name of the person who has created the action
Assigned to	Name of person responsible for ensuring completion of the action
Description/synopsis	Brief summary
Due Date	Date when action is due for completion
Completed by	Name of person completing the action
Completed Date	Date action completed
Documents	
e.g. a report/ business case / risk assessment, can be added into this section and made available for others to view	

APPENDIX 5

NHS Fife Risk Appetite Statement July 2022

Risk Appetite Descriptors

To ensure a common understanding of 'levels' of risk appetite, the following definitions have been adopted by the NHS Fife Board.

Low - Regarding statutory functions, we have very little appetite for risk, loss, or uncertainty. We are prepared to accept low levels of risk, with a preference for ultrasafe delivery options, while recognising that these will likely have limited or no potential for innovative opportunities

Moderate - Prepared to accept only modest levels of risk to achieve acceptable, but possibly unambitious outcomes and limited innovation.

High - Willing to consider and / or seek all delivery options (original / ambitious / innovative), and accept those with the highest likelihood of successful outcomes, in pursuit of objectives even when there are elevated levels of associated risk

Risk Appetite Statement

NHS Fife's Population Health and Wellbeing Strategy (2022-2027) sets an organisational vision that the people of Fife live long and healthy lives. A strategic framework, developed by our staff and built on our vision and values details how our priorities will link to National Care Programmes, underpinned by system enablers.

The Board recognises that it is not possible to eliminate all the risks which are inherent in the delivery of health and care and is willing to accept a certain degree of risk when it is in the best interests of the organisation, and ultimately, the population of Fife and people we serve. The Board has therefore considered the level of risk that it is proposed to accept for key aspects of the delivery of health and care, and these are described in line with our four organisational aims.

1. Improving health and wellbeing

The Board has a *high* risk appetite in this domain.

We are willing to consider original, ambitious, and innovative delivery options and accept those worth the highest likelihood of outcomes in influencing improvements in population health. We will proactively engage and involve 1/3 stakeholders in the design and delivery of services to meet their needs and explore transformational and sustainable change to align with our strategic ambition in this domain.

We will seek to maximise our influence on tackling social determinants of health through our ambitious strategy, and through contributing to the local population as an Anchor institution.

2. Improving the quality of health and care services

The Board has a *moderate* risk appetite in this domain.

We acknowledge that healthcare operates within a highly regulated environment, and we must meet high levels of compliance expectations in line with national standards and various regulatory sources.

We will endeavour to meet those expectations within a framework of prudent controls, balancing the prospect of risk elimination against pragmatic, operational imperatives Our focus is on delivering core health and care services safely. However, with the opportunity of potentially improved outcomes, where appropriate controls are in place, the Board may decide to accept risk and adopt innovative approaches in pursuit of these.

3. Improving staff experience and wellbeing

The Board has a *moderate* risk appetite in this domain.

We acknowledge the standard of expectations placed on the Board and individuals in relation to Staff Governance Standards with no intent to deviate, and we are committed to Partnership working. Our Workforce Strategy identifies the current and anticipated future workforce challenges the Board needs to address and defines the type of organisation and employer we aspire to be.

We acknowledge the innovation required to attract and retain the right people with the right skills and values to deliver our strategic ambition.

4. Delivering value and sustainability

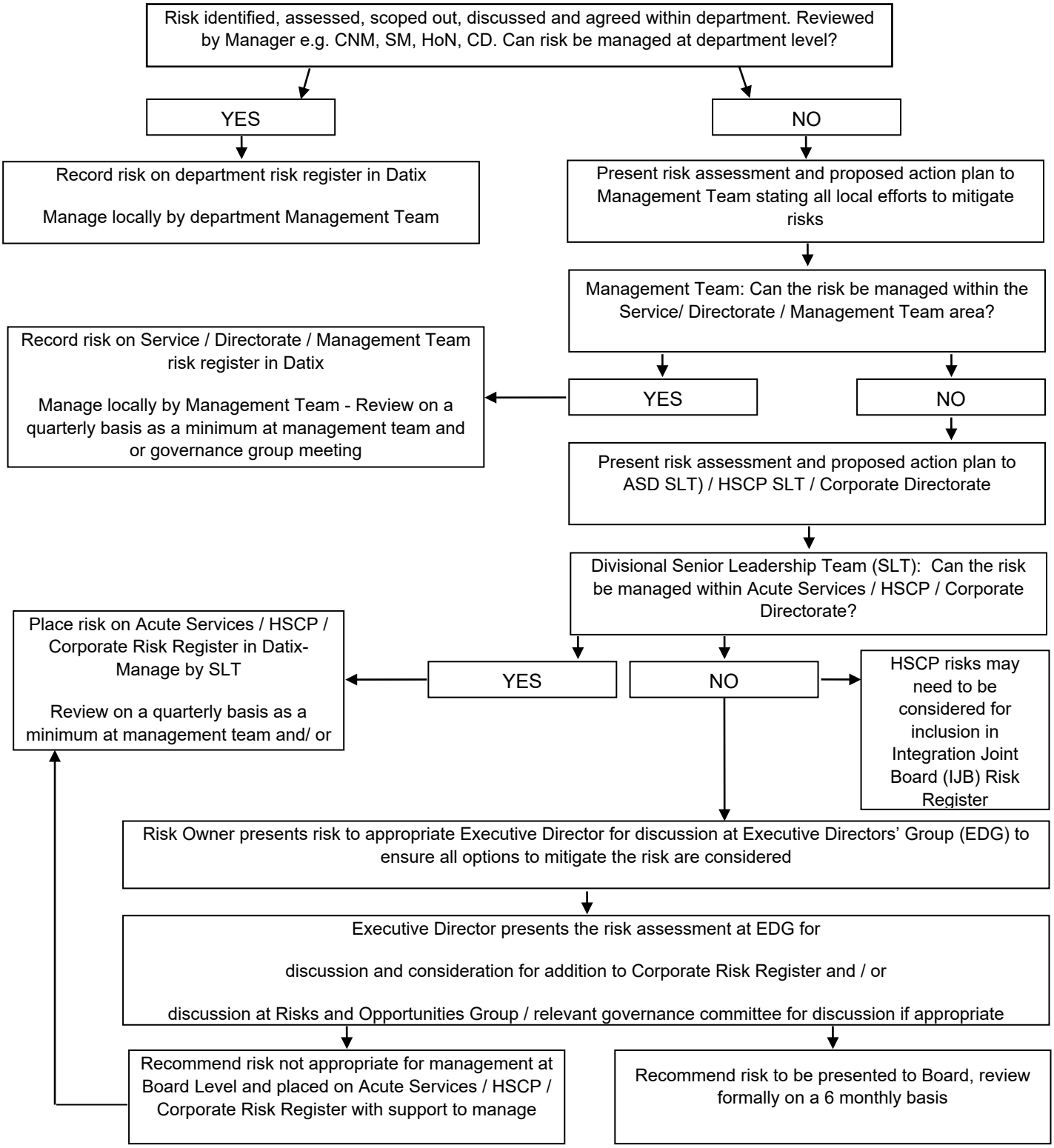
The Board has a *moderate* risk appetite in this domain.

We acknowledge our requirements to adhere to Standing Financial Instructions, and financial statutory duties, as well as maintenance of robust financial controls, including our statutory responsibility to maintain the financial balance and sustainability of the organisation

In relation to investments, we understand we are accountable for the delivery of best value and efficiency in resource allocation. Therefore, capital investment and planning to enhance and develop services will require to demonstrate 'value added'. Realising benefits and efficient resource allocation are key drivers in making financial decisions and opportunities.

We recognise our ambition to achieve 'Net-Zero' status in line with Scottish Government direction. We realise this will require changes to the way we work and deliver services to maximise our reduction in our carbon footprint and maximise benefit to the environment.

NHS Fife Risk Escalation Flowchart



APPENDIX 7

Committee Assurance Principles

Purpose and Remit

The overall purpose of the Board is to ensure efficient, effective and accountable governance, to provide strategic leadership and direction, and to focus on agreed outcomes.

Detailed scrutiny should take place at committee level, with each committee providing assurance and escalating key issues as required.

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

The Assurance Principles set out below have been developed to support the assurance function.

Assurance Principles

Risk Assurance Principles:

Board

- Ensuring efficient, effective and accountable governance

Standing Committees of the Board

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

Committee Agenda

- Agenda Items should relate to risk (where relevant)

Seek Assurance of Effectiveness of Risk Mitigation

- Relevance
- Proportionality
- Reliable
- Sufficient

Chairs Assurance Report

- Consider issues for disclosure
  - → Escalation
- Emergent risks or
  - → Recording
- Scrutiny or risk delegated to Committee

Year End Report

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

General Questions:

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

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

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

Level of Assurance:

Substantial Assurance	Reasonable Assurance	Limited Assurance	No Assurance
			

Document developed from diagram produced by NHS Lanarkshire based on principles compiled by the Assurance Mapping Group of members of Boards covered by the FTF Internal Audit Service. 2022

APPENDIX 8

Risk Management Roles and Responsibilities

The Board

- Approve the Risk Management Framework;
- Set the organisation's risk appetite;
- Oversee and seek assurance that the risk management system is effective;
- Receive a report on the Corporate Risk Register at least bi- annually, ensuring this reflects the organisation's risks

NHS Fife Chief Executive

- The Chief Executive of the NHS Board, as Accountable Officer, is personally answerable to Parliament, and accountable to the Board for the effective management of risk.

Director of Finance and Strategy

- The Director of Finance and Strategy is the executive lead for risk management.

Executive Directors

- Support the Chief Executive by fulfilling their risk management responsibilities;
- Contribute to setting the Board's risk appetite;
- Promote the importance of risk management and foster a good risk culture within their areas of responsibility;
- Ensure that the Board's risk management processes are actively promoted, and adhered to, across their teams and within their areas of responsibility;
- Receive and scrutinise regular risk reports on risks associated with their areas of responsibility;
- Escalate risks to EDG where appropriate;
- Ensure there is a focus on learning from past events, whether these are positive or negative, to improve staff anticipation and preparedness to address future situations.

Risk Manager

- Is responsible for the implementation of the Risk Management Framework;
- Ensures risks are properly identified, understood and managed across all levels within the organization;
- Reports on the organisation's risk profile at various levels to the standing committees, and the NHS Board;
- Periodically reviews the Risk Management Framework and arrangements, identifying areas for potential improvement;
- Drives an improving risk culture through risk education, awareness and embedding into day-to-day management

Line Managers (Service Managers, Clinical Nurse Managers Senior Charge Nurses, Directorate, Departmental or equivalent)

- Responsible for ensuring effective systems for risk management are in at ward, service or departmental level.

Risk Owner

- Accountable for ensuring the effective management of a risk, and providing assurance that controls are operating effectively

Director of Health and Social Care / Chief Officer(DoHSC/CO)

- The DoHSC/CO has overall accountability for the IJB's risk management framework, ensuring that suitable and effective arrangements are in place to manage the risks relating to the functions within the scope of the IJB. The DoHSC/CO will keep the Chief Executives of the IJB's partner bodies informed of any significant existing or emerging risks that could seriously impact the IJB's ability to deliver the outcomes of the Strategic Plan or the reputation of the IJB.

Chief Financial Officer

- The Chief Financial Officer(CFO) will be responsible for promoting arrangements to identify and manage key business risks, risk mitigation and insurance. The CFO is a member of the Fife Council Risk Management strategy group and the NHS Fife ROG.

Internal Audit

- Internal Audit will provide an objective evaluation and opinion on the adequacy and effectiveness of the Board's governance, risk and control arrangements through implementation of the Internal Audit plan.

External Audit

- External Audit will provide an independent evaluation to inform the Board's Governance Statement.

NHS Fife provides accessible communication in a variety of formats including for people who are speakers of community languages, who require Easy Read versions, who speak BSL, read Braille or use Audio formats.

NHS Fife SMS text service number 07805800005 is available for people who have a hearing or speech impairment.

To find out more about accessible formats contact:
fife-UHB.EqualityandHumanRights@nhs.net or phone 01592 729130

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NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**13 December 2023**
Title:	**Internal Audit Progress Report**
Responsible Executive/Non-Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Barry Hudson, Regional Audit Manager / Jocelyn Lyall, Chief Internal Auditor**

1 Purpose

This is presented for:

- Assurance
- Discussion

This report relates to a:

- Local policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this report is to:

- Provide the Audit and Risk Committee with assurance on the progress of the internal audit plans.

2.2 Background

The internal audit year runs from May to April. The Internal Audit team continues to progress the remaining reviews from the Internal Audit Plans under the supervision of the Chief Internal Auditor. Audit work completed allows the Chief Internal Auditor to provide the necessary assurances prior to the signing of the annual accounts.

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

A large element of our year-end assurance work has been delivered through the Internal Control Evaluation (ICE) and action to progress recommendations from the ICE will be reported within the 2023/24 Annual Internal Audit Report and monitored through throughout the year via the Audit Follow Up system.

2.3 Assessment

Due to staff absence, we have experienced delays in finalising audits from the previous audit years. All staff have now returned and all remaining reviews from 2022/23 have been issued or finalised, and we continue to progress the 2023/24 plan.

Taking due consideration of the time lost due to staff absence, the Regional Audit Manager, Chief Internal Auditor and the Director of Finance and Strategy have discussed revisiting the Audit Plan for 2023/24. Audit and Risk Committee members will be asked to electronically approve any changes in January/February 2024.

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 Internal Audit Reports issued since the last Audit and Risk Committee.

2.3.1 Quality/ Patient Care

The Institute of Healthcare Improvement Triple Aim (Better population health, better quality of patient care, financially sustainable services) is a framework that describes an approach to optimising health system performance and is a core consideration in planning all internal audit reviews.

2.3.2 Workforce

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

2.3.3 Financial

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

2.3.4 Risk Assessment/Management

The internal audit planning process which produces the 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

Members are asked to **discuss** and take **assurance on** the progress on the delivery of the Internal Audit Plan(s).

3 List of appendices

Appendix 1 – Internal Audit Progress Report.

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FTF Internal Audit Service

Internal Audit Progress Report

Introduction

This report presents the progress of internal audit activity up to 4 December 2023.

Internal Audit Activity

The following audit products, with the audit opinion shown, have been issued since the last Audit and Risk Committee meeting on 31 August 2023. Each review 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.

NHS Fife Completed Audit Work

Audit 2022/23 and 2023/24	Opinion on Assurance	Recommendations	Draft issued	Finalised
Corporate Governance				
B08/24 Internal Control Evaluation (ICE)	N/A	1 Moderate 4 Merits Attention	27 November 2023	5 December 2023

Fife IJB Completed Audit Work

Audit 2022/23 and 2023/24	Opinion on Assurance	Recommendations	Draft issued	Finalised
Clinical and Care Governance				
F06-22 Clinical and Care Governance	Reasonable	Two Significant Three Moderate	18 August 2023	31 October 2023

NHS Fife Draft Reports Issued

	Draft issued
B13/23 Resilience and Business Continuity	4 December 2023
B14/23 Strategic Planning	8 December 2023
B17/23 Workforce Planning	11 December 2023

Fife IJB Draft Reports Issued

	Draft issued
F05-23 Workforce Planning	26 October 2023

NHS Fife Work in Progress and Planned:

Audit 2022/23 and 2023/24		Status	Target Audit and Risk Committee
B13/24	Policies and Procedures	Planning	May 2024
B14/24	Risk Management	Planning	May 2024
B15/24	Environmental Management	Planning	May 2024
B16/23 & B20/24	Medicines Management • Prior year assignment combined with current year	WIP	March 2023
B20/23 & B23/24	Financial Process Compliance • Prior year assignment combined with current year	WIP	March 2023

Fife IJB Work in Progress and Planned:

Audit	Status	Target Audit and Risk Committee
F05-24 Internal Control Evaluation	Planning	May 2024
F04-23 Contract/Market Capacity	WIP	December 2023

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 August 2023 where a progress report was considered.

1. B08/24 – Internal Control Evaluation

Separate agenda item at the December 2023 Audit and Risk Committee meeting.

2. F06/22 – Clinical and Care Governance Arrangements

In this audit we reviewed the planned implementation of the Clinical and Care Governance Framework and risks, accountabilities, performance management and assurances in this area. The audit also had a specific focus on Responsibilities for Vulnerable Adult and Children.

As part of the development of the Clinical and Care Governance Strategic Framework, several good governance areas have already been progressed and Management have agreed actions as follows:

- Improvements in governance arrangements and assurance reporting alongside the Blueprint for Good Governance, to make sure that assurances are reliable, relevant and sufficient, link to risk, there is no omission or unnecessary duplication. This will include documenting assurance routes for Adult and Child Protection.
- Improvements in linkages between risk and performance reporting. The risk mitigations recorded against risks 10 and 11 in the IJB's strategic risk register will be updated to reflect the issues identified in this report. As part of the deep dive risk review process, the risks will also be reviewed to consider appropriate target levels, the risk appetite of the IJB and any external factors that may influence the risk.
- Regular reporting on Adult and Child Protection to the Fife Council People and Communities Scrutiny Committee and the IJB's Quality and Communities Committee and SLT Governance and Assurance will be put in place to provide assurance.
- The Fife HSCP Scheme of Delegation will be updated to reflect the Integration Scheme, and specifically the legislative responsibilities of the Director of Health and Social Care for Adult Support and Protection and Child Protection.

3. F03-24 – Fife IJB Annual Report

The Chief Internal Auditor concluded that Reliance can be placed on the IJB's governance arrangements and systems of internal controls for 2022/23.

Internal Audit confirmed that four of the six recommendations from the 2021/22 annual report were complete and two were planned for completion by July 2023. These recommendations related to improvement in Whistleblowing and Fraud arrangements and the programme of deep dive risk reviews.

Notwithstanding our positive assessment of the work undertaken, the current external and internal environment in which the IJB operates is exceptionally complex and extremely challenging and there can be no guarantee that arrangements being put in place will mitigate risk to acceptable levels.

The new Strategic Plan and associated developments will require careful monitoring of implementation with a strong focus on transformation i.e. what Fife IJB will do differently to be able to deliver on its strategic objectives within severe financial and workforce constraints. Governance arrangements must monitor whether that transformation is delivering improvements sufficient to enable sustainable services and whether it is delivering the necessary, expected benefits. This will be particularly significant in Fife IJB given that delivery of its Strategic Plan is heavily dependent upon delivery of an extensive transformation programme.

We noted the significant work in the following areas:

- Approval of a new governance structure in April 2022.
- Publication of the of the Fife IJB Strategic Plan 2023-26.
- Approval of the Communication and Engagement Plan in July 2022.
- Approval of the Commissioning Strategy 2023-2026 and associated Market Facilitation and Delivery Plan in May 2023.
- Approval of the Fife IJB Workforce Strategy 2022-25 and Action Plan in November 2022 and submission to Scottish Government by 30 November 2022.
- Approval of the Risk Management Strategy in March 2023 with strategic risks assigned to governance committees who provide oversight, scrutiny and assurance over them. The introduction of deep dive reviews for the high Strategic Risks will facilitate effective management of these risks. Development Sessions have been held for members on the new risk appetite which will be presented to Governance Committees in July 2023.

The IJB produced a Governance Statement for 2022/23 which concluded substantial assurance in respect of the Fife IJBs overall arrangements for risk management, governance and control for the year to 31 March 2023. The Governance Statement included a status update on recommendations from the IJB annual accounts for 2021-22. Further key improvement actions for 2023-24 were identified:

- Review of Directions Policy
- Creation of new HSCP Website
- Refresh of Publication Scheme
- Continuation of review of all strategies which support the Strategic Plan
- Refresh of Performance Framework
- Review of information flow from SLT to Governance Committee/IJB
- Roll out of Care Opinion

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**13 December 2023**
Title:	**Internal Audit – Follow Up Report on Audit Recommendations 2022/23**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Report Author:	**Barry Hudson, Regional Audit Manager/ Andy Brown, Principal Auditor**

1 Purpose

This is presented for:

- Assurance
- Discussion
- Decision

This report relates to the:

- Audit Follow up Protocol

This aligns to the following NHSScotland quality ambition:

- Effective

2 Report summary

2.1 Situation

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

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

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

2.2 Background

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

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

Internal Audit validate the evidence supplied by responding officers for actions they are confirming as complete, to confirm that those actions address the recommendations made.

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

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

The detailed follow-up status of actions to address recommendations made in previous Annual and ICE Reports is included in the 2023/24 ICE (B08/24), presented at agenda item 6.6. The status of remaining ICE and Annual Report recommendations is summarised in table at appendix B below but the detailed information is not repeated here. An update on these recommendations will be included in the next follow-up report.

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

2.3 Assessment

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

The table below shows the status of all remaining internal audit recommendations, other than ICE and Annual Report recommendations, at 30 November 2023, with comparable figures from the last Audit Follow-Up (AFU) report at 23 August 2023 (Ext = Extended, O/S = Outstanding & NYD = Not Yet Due).

	Nov 2023			Aug 2023		
Remaining Actions	**14**			**25**		
	Ext	O/S	NYD	Ext	O/S	NYD
Recommendations more than 1 year (*Appendix C)*	6	0	0	11	0	0
Recommendations less than 1 year	6	0	2	11	0	3

The table below shows the status of all remaining ICE and Annual Report recommendations at 30 November 2023 and shows good progress having since August 2023. Updates on these recommendations are reported in B08/24 Internal Control Evaluation (separate agenda item 6.6).

	Nov 2023			Aug 2023		
Remaining Actions	**9**			**20**		
	Ext	O/S	NYD	Ext	O/S	NYD
Recommendations more than 1 year (*Appendix C)*	0	0	0	0	0	0
Recommendations less than 1 year	2	0	7	9	0	11

Progress summary

All actions from the following report have been completed and validated:

Report Removed	**Reason**
B23/21 ITIL Processes	All actions completed and validated.

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

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

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

AFU Report Content

Appendices C and D provide detailed information on progress with all remaining recommendations that have had their target implementation date extended. Appendix C includes those that are **more** than a year old and Appendix D includes those that are **less** than a year old. It is proposed that in order to maintain focus on recommendations more than one year old and those with a higher priority, the format of appendix D is reviewed. Members are asked to consider if they wish to continue to be provided with:

- Updates on all recommendations less than one year (current format)

  or

- Updates only on recommendations less than one year that have a fundamental or significant priority.

2.3.1 Quality, Patient and Value-Based Health & Care

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

2.3.2 Workforce

There are no workforce implications arising from this report.

2.3.3 Financial

There are no direct financial implications arising from this report.

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 and Anchor Institution ambitions

Not applicable

2.3.6 Climate Emergency & Sustainability Impact

Not applicable

2.3.7 Communication, involvement, engagement and consultation

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

2.3.8 Route to the Meeting

Not applicable

2.4 Recommendation

Members are asked to take **assurance** and **discuss** the status of Internal Audit recommendations recorded within the AFU system.

Members are also asked to consider the content of appendix D – Recommendations less than 1 year and **decide** if the Committee wishes to:

- continue to receive the level of detail currently provided or receive updates only on recommendations less than one year old that have a fundamental or significant priority.

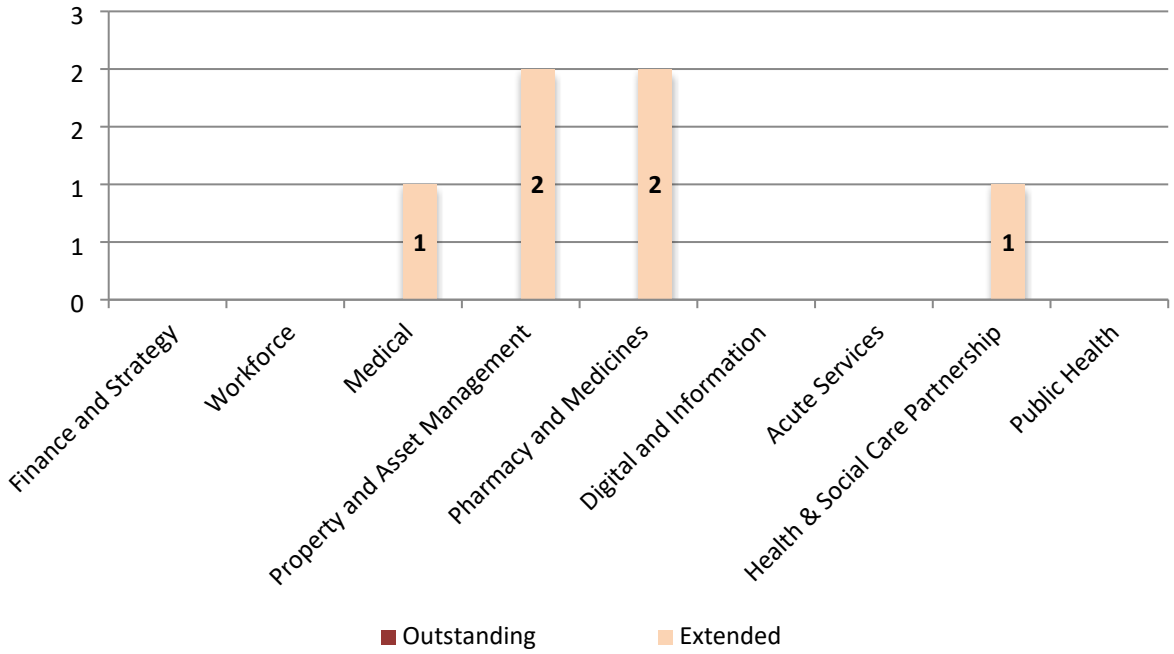
3. List of appendices

The following appendices are included with this report:

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

Recommendations More Than 1 Year

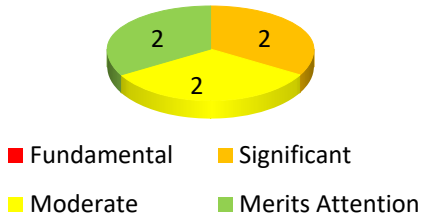
Outstanding and Extended by Directorate



Extended Recommendations RAG Status and Priority

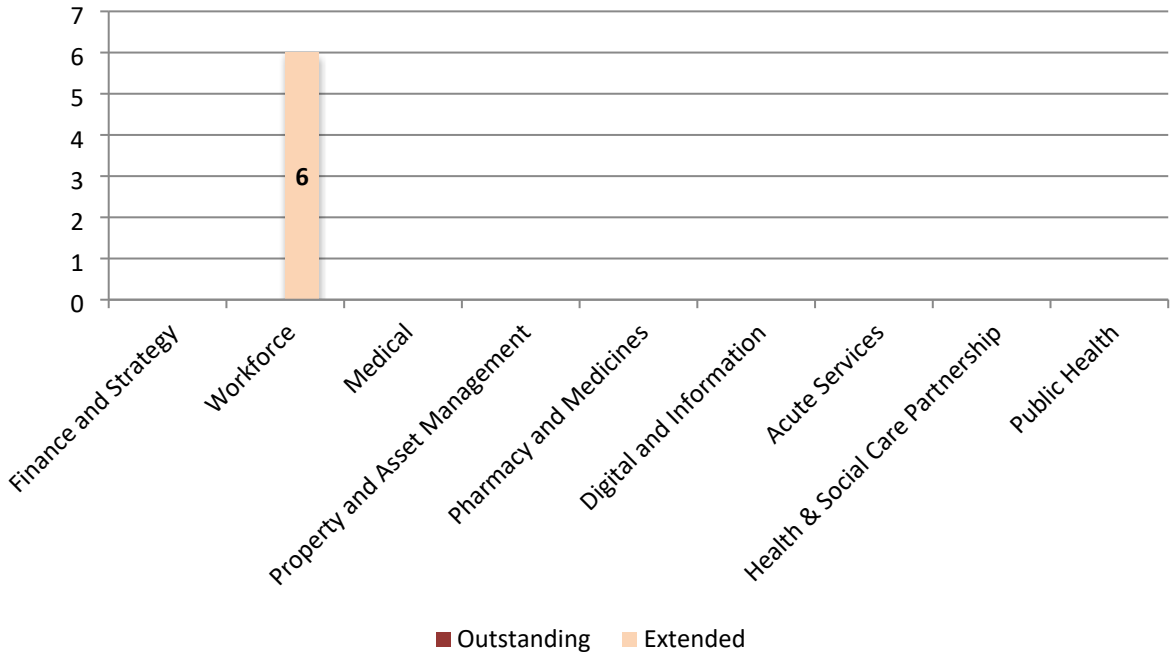
RAG Status

Priority



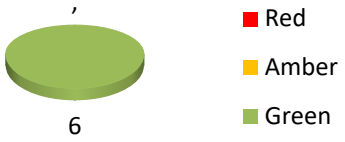
Recommendations Less Than 1 Year

Outstanding and Extended by Directorate

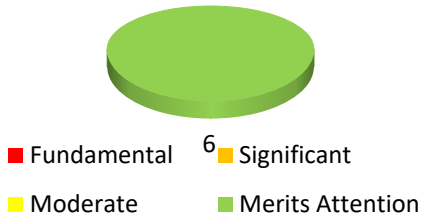


Extended Recommendations RAG Status and Priority

RAG Status



Priority



Internal Audit Reports with Remaining Actions	Date of Issue	Total Recs.	Complete	Superseded	Remaining		Extended	Outstanding	Not Yet Due		Not Validated
2020/21											
B13/21 Risk Management Strategy	Sep 21	5	4	0	1		1	0	0		-
B19/21 Clinical Governance Strategy and Assurance	Sep-21	2	1	0	1		1	0	0		-
B21/21 Medical Equipment and Devices	Nov-21	4	2	0	2		2	0	0		-
2020/21 Totals		**11**	**7**	**0**	**4**		**4**	**0**	**0**		**0**
2021/22											
B16/22 Prescription Stationery Security	May-22	11	9	0	2		2	0	0		-
2021/22 Totals		**11**	**9**	**0**	**2**		**2**	**0**	**0**		**0**
2022/23											
B18/23 Whistleblowing	May-23	11	5	0	6		6	0	0		-
B21/23 Patients' Property	May-23	4	2	0	2		0	0	2		-
2022/23 Totals		**15**	**7**	**0**	**8**		**6**	**0**	**2**		**0**
Overall Totals (Actions from reports where recommendations remain unaddressed)		**37**	**23**	**0**	**14**		**12**	**0**	**2**		**0**

Previous ICE and Annual Reports with Remaining Actions	Date of Issue	Total Recs.	Complete	Superseded	Remaining		Extended	Outstanding	Not Yet Due		Not Validated
2022/23											
B08/23 ICE – 2022-23	Mar-23	24	20	2	2		2	0	0		-
2022/23 Totals		**24**	**20**	**2**	**2**		**2**	**0**	**0**		**-**
2023/24											
B06/24 Annual Report – 2022-23	Jun-23	11	4	0	7		0	0	7		-
2023/24 Totals		**11**	**4**	**0**	**7**		**0**	**0**	**7**		**-**
Overall Totals (Actions from reports where recommendations remain unaddressed)		**35**	**24**	**2**	**9**		**2**	**0**	**7**		**-**

Report	3cRec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
2020/21 - Extended							
B13/21 Risk Management Strategy	3	S	Now that there is clarity around responsibility for operations, an Integration Joint Board (IJB) Risk Management Strategy should be produced and formally agreed with the parties as soon as possible and incorporated into the NHS Fife Framework. More detailed aspects of the risk management arrangements between NHS Fife and Fife IJB should be included in GP/R7 - Risk Register and Risk Assessment policy.	**Director of Health & Social Care**	~~31 Mar 22~~ ~~30 Sep 22~~ ~~31 Dec 22~~ ~~31 Aug 23~~ 31 Dec 23		The IJB Risk Management Strategy was approved by the IJB on 31 March 2023. NHS Fife approved the revised NHS Fife Risk Management Framework on 26 September 2023. This includes, at section 6.9, a description of the risk management arrangements for services which are delegated to the Integration Joint Board (IJB) and cross refences to the IJB Risk Management Strategy and Policy. The remaining action is for the NHS Fife Risk Appetite to be reviewed taking into account the risk appetite of the IJB.
B19/21 Clinical Governance Strategy and Assurance	1	S	Revision of Clinical and Care Governance Strategy addressing recommendations made in Internal Audit report B15/17 & B18/18 – Clinical Governance Strategy & Assurance and related governance improvements.	Associate Director of Quality and Clinical Governance **Medical Director**	~~31 Jan 22~~ ~~31 May 22~~ ~~31 Oct 22~~ ~~31 Jul 23~~ 31 Mar 24		The recommendation from this report has many component parts 1a to 1h. **The following elements are still to be addressed**: 1e – *CGC ToR to include its responsibility for providing assurance on Information Governance to Fife NHS Board* – This was not addressed in the latest Code of Corporate Governance but will be in the next issue. 1g – *Reflection on why some CGC sub-groups/committees are required to provide annual assurance before CGC concludes on its own annual assurance report/statement and others don't and for changes to assurance requirements to be made accordingly and reflected in the CGC workplan.* - The reason for the difference has been explained to internal audit and will be included in the SBAR for the presentation of sub group/committee annual assurance statements for 2023/24. Both of the actions remaining are scheduled for year-end which is appropriate.

Report	3cRec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
B21/21 Medical Equipment and Devices	1	M A	Updates required to both the GP/E4 – Medical Equipment Management Policy (including related appendices) and E14.1 - Equipment Procurement Operational Policy and these require to be authorised by the Capital Equipment Management Group (CEMG).	Head of Estates **Director of Property and Asset Management**	~~31 Jan 22~~ ~~31 Jul 22~~ ~~30 Jun 23~~ ~~31 Oct 23~~ 31 Mar 24		The Medical Equipment Management Policy (GP/E4) and related procedure GP/E4 have been updated and approved with a review date of 1 September 2025 and both are published on Stafflink. The publication of the E14 suite of policies on Stafflink is being progressed with changes to reflect feedback from the General Policies Group currently being made.
	3	M A	Evidence of new Equipment Request Forms (ERFs) being completed correctly with the added sections fully populated. CEMG membership to be updated to formally include a representative from Digital and Information (D&I).	Head of Estates **Director of Property and Asset Management**	~~31 Jan 22~~ ~~31 Jul 22~~ 30 Sep 23 31 Mar 24		A new Equipment Request Form (ERF) was introduced but a check by Internal Audit found that the forms were not being completed fully. Further changes are being made to the form and the use of MS Forms is being explored. A representative from D&I is now a member of the CEMG.
20/21 Extended	**4**						
2021/22 - Extended							
B16/22 Prescription Stationery Security	2a	M	Risk assessments of areas used in Pharmacy departments at VHK and QMH for the storage of Prescription Stationery.	Lead Pharmacist Medicine Governance and Medicines Supply Chain Manager **Director of Pharmacy & Medicines**	~~31 Oct 22~~ ~~30 Apr 23~~ ~~31 Oct 23~~ 29 Feb 24 TBC		Work has started to address the issues raised in the risk assessment but is not yet complete.

Report	3cRec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
	2b	M	Implementing a protocol for changing any combination locks remaining in use whenever anyone who knew the code leaves the service.	Lead Pharmacist Medicine Governance and Medicines Supply Chain Manager **Director of Pharmacy & Medicines**	~~31 Oct 22~~ ~~30 Apr 23~~ ~~31 Oct 23~~ 29 Feb 24 TBC		As per 2a above.
21/22 Extended	**2**						
Total > 1 Year	**6**						

ANNUAL and ICE REPORTS Report	Rec Number	Priority	Brief Description	Responsible Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
As the follow-up status of actions to address recommendations made in previous Annual and ICE Reports is included in some detail in the 2023/24 ICE (B08/24) which is also presented to the 13 December 2023 meeting of the Audit & Risk Committee, this information is not repeated here. An update on these will be included in the next follow-up report. There are no ICE/Annual Report recommendations with implementation dates that are greater than 1 year from the date of the publication of the report they were included in.							

Report	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
2022/23 - Extended							
B18/23 Whistleblowing	1a	M A	Confidential whistleblowing contacts to be updated.	Head of Workforce Resourcing & Relations **Director of Workforce**	~~31 Aug 23~~ ~~31 Oct 23~~ 31 Dec 23		The training of Whistleblowing Contacts will be completed on 17 November 2023 and at this point any changes to the full list of these contacts will be reflected in the posters and they will be distributed.
	1b	M A	Whistleblowing posters to be updated with new confidential contacts details.	Head of Workforce Resourcing & Relations **Director of Workforce**	~~31 Aug 23~~ ~~31 Oct 23~~ 31 Dec 23		As per 1a above
	1c	M A	Whistleblowing posters to be distributed.	Head of Workforce Resourcing & Relations **Director of Workforce**	~~31 Aug 23~~ ~~31 Oct 23~~ 31 Dec 23		As per 1a above
	6a	M A	Whistleblowing action plan to be presented to the Staff Governance Committee including target dates and responsible officers.	Head of Workforce Resourcing & Relations **Director of Workforce**	~~31 Jul 23~~ ~~31 Oct 23~~ 31 Mar 24		The status of actions included in the Whistleblowing Annual Reports will be included in the Quarter 3 Whistleblowing report and a specific action to review the format of annual and quarterly reports prior to the start of each financial year will also be added to this.
	6b	M A	The Staff Governance Committee quarterly report to include action plan completion progress.	Head of Workforce Resourcing & Relations **Director of Workforce**	~~31 Jul 23~~ ~~31 Oct 23~~ 31 Mar 24		As per 6a above.
	6c	M A	The whistleblowing action plan to the Staff Governance Committee to include scheduling of annual reviews of the format	Head of Workforce Resourcing & Relations	~~31 Jul 23~~ ~~31 Oct 23~~		As per 6a above.

Report	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
			of quarterly and annual reporting prior to annual report preparation.	**Director of Workforce**	31 Mar 24		
22/23 Extended	**6**						
Total < 1 Year	**6**						

ANNUAL and ICE REPORTS Report	Rec Number	Priority	Brief Description	Responsible Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
As the follow-up status of actions to address recommendations made in previous Annual and ICE Reports is included in some detail in the 2023/24 ICE (B08/24) which is also presented to the 13 December 2023 meeting of the Audit & Risk Committee this information is not repeated here. An update on these will be included in the next follow-up report.							

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

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

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

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

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**13 December 2023**
Title:	**Internal Control Evaluation**
Responsible Executive/Non-Executive:	**M McGurk, Director of Finance & Strategy**
Report Author:	**J Lyall, Chief Internal Auditor / B Hudson, Regional Audit Manager**

1 Purpose

This report is presented for:

- Assurance
- Discussion

This report relates to a:

- Local policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation and Background

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

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

2.2 Assessment

Key Themes

Audit Scotland – NHS Scotland 2023, issued February 2023, stated that 'the NHS in Scotland faces significant and growing financial pressures. These include inflation; recurring pay pressures; ongoing Covid-19 related costs; rising energy costs; a growing capital maintenance backlog; and the need to fund the proposed National Care Service. These pressures are making a financial position that was already difficult and has been exacerbated by the Covid-19 pandemic, even more challenging'. Internal Audit reports have recorded similar concerns and

highlighted the strategic changes required. The financial risk for NHS Fife, NHSScotland and the public sector has continued to increase.

As reported in the Internal Audit Annual Report for 2022/23, the challenge now is balancing short term risks against longer term risks which can only be mitigated through strategic change. T

We previously highlighted the need for realistic workforce plans. The NHS Fife Workforce Plan 2022-2025 was published in November 2022 and work is underway to inter-relate and align financial and workforce planning via the Strategic Planning Resource Allocation (SPRA) process.

Continuing staff shortages and increased demand for staff means that effective workforce planning remains key in supporting the achievement of the Board's operational, financial and strategic objectives.

Maintaining operational performance against mandated targets remains extremely challenging. While operational improvements will have a limited impact on performance, genuinely strategic solutions must be identified, with a focus on working closely with partners to address underlying capacity and flow issues. The Board has continued to respond, and risk assess to ensure the most urgent work is prioritised.

NHS Fife continues to progress its Risk Management Framework Improvement Programme. The Board's overall approach to risk management has been revised with a new Corporate Risk Register replacing the Board Assurance Framework. Current risk scores and achievement of target scores by target dates will require careful consideration and constant monitoring to ensure they fully reflect current risk and controls and are realistic.

The Clinical Governance Strategic Framework and associated Annual Delivery Plan were approved by Fife NHS Board on 28 March 2023. The framework outlines the governance and assurance reporting routes for clinical governance throughout the full span of NHS Fife responsibilities.

2.3.1 Quality, Patient and Value-Based Health & Care

The Institute of Healthcare Improvement Triple Aim (Better population health, better quality of patient care, financially sustainable services) is a framework that describes an approach to optimising health system performance and is a core consideration in planning all internal audit reviews.

2.3.2 Workforce

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

2.3.3 Financial

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

2.3.4 Risk Assessment/Management

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

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

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

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 Climate Emergency & Sustainability Impact

This report has no impact on the Board's likelihood of meeting the aims and targets outlined by the NHS Scotland Climate Emergency & Sustainability Strategy.

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

Members are asked to **discuss** and take **assurance** from the Internal Control Evaluation

3 List of appendices

Appendix 1 - Internal Control Evaluation Report.

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

FTF Internal Audit Service

Internal Control Evaluation 2023/24

Report No. B08/24

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

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

Audit Follow-Up Co-ordinator

Audit and Risk Committee
External Audit

Contents

Draft Report Issued	28 November 2023
Management Responses Received	6 December 2023
Target Audit & Risk Committee Date	13 December 2023
Final Report Issued	**07 December 2023**

EXECUTIVE SUMMARY

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

OBJECTIVE

2. The NHS Fife Internal Audit Plan provides cyclical coverage of all key elements of Corporate, Clinical, Staff, Financial and Information Governance.
3. Together the mid-year Internal Control Evaluation (ICE) and the Annual Report provide assurance on the overall systems of internal control, incorporating the findings of any full reviews undertaken during the year and providing an overview of areas which have not been subject to a full audit. These reviews do not, and cannot, provide the same level of assurance as a full review but do allow an insight into the systems which have not been audited in full. This interim review gives early warning of issues and provides a holistic overview of governance within NHS Fife.
4. The draft Annual Delivery Plan (ADP) 2023/2024 was signed off by Scottish Government (SG) on 11 August 2023. The NHS Fife draft Medium Term Plan for 2023-2026, was submitted to SG on 7 July 2023, with feedback to be provided. SG guidance advised that the draft Medium Term Plan should take into consideration service changes which Boards are preparing for locally over the next 3 years, and identify through horizon scanning, issues which may require local, regional, or national planning input.
5. The ICE will be presented to the December 2023 Audit and Risk Committee, allowing the year-end process to be focused on year-end assurances and confirmation that the required actions have been implemented. The ICE provides a detailed assessment of action taken to address previous internal audit recommendations from the 2022/23 ICE and Annual Report.
6. This review will be a key component of the opinion we provide in our Annual Internal Audit Report and will inform the 2024/25 Internal Audit planning process.
7. Our audit specifically considered whether:
    - Governance arrangements are sufficient, either in design or in execution, to control and direct the organisation to ensure delivery of sound strategic objectives.

AUDIT OPINION

8. Ongoing and required developments and recommended actions are included at Section 2.
9. The Annual Internal Audit Report was issued on 19 June 2023 and was informed by detailed review of formal evidence sources including Board, Standing Committee, Executive Directors Group (EDG), and other papers.
10. As well as identifying key themes, the Internal Audit Annual Report made six specific recommendations in the following areas
    - Ongoing development of risk management, risk appetite, deep dives, Key Performance Indicators (KPIs) and clarification and formalisation of the joint risk management process with Fife IJB.
    - Requirement to provide a year-end assessment to the Staff Governance Committee (SGC) concluding on implementation of the strands of the Staff Governance Standard and action required to achieve full compliance.

- Requirement for the SGC Annual Assurance Statement to include a statement confirming the Whistleblowing Champion's opinion on the adequacy of NHS Fife's whistleblowing arrangements.
- Requirement to present a financial sustainability action plan to the Finance, Performance and Resources Committee (FPRC) and Board, demonstrating clear links to the Population Health and Well Being Strategy (PHWS), the Workforce and Digital & Information strategies, and service redesign and transformation.
- Requirement to record, monitor and have contingency plans in place to manage the risk of a sudden cessation for brokerage, which, unmitigated, could impact on service provision.
- Requirement to identify and report to the CGC on those elements of the 2019-2024 Digital & Information (D&I) Strategy which will not be delivered by 31 March 2024, stating the impact upon NHS Fife's strategic ambitions and how this is being addressed in the next D&I Strategy. The next iteration should also include at the outset a resourcing and financial assessment to assess its likelihood of being delivered within the stated timescale and the risks associated with non-delivery.

11. Outstanding actions from previous ICE and Annual Internal Audit Report recommendations are shown in table 1. 11 actions have been completed since the issue of our Annual Internal Audit Report.
12. Overall, there has been good progress on actions to address recommendations from the 2022/23 ICE and Annual Report. Where action is still to be concluded, the Board has been informed of the planned approach and timescales, as well as associated improvement plans.
13. In this report we have provided an update on progress to date and, where appropriate, built on and consolidated previous recommendations to allow refreshed action and completion dates to be agreed.
14. We recommend that this report is presented to each Standing Committee so that key themes can be discussed and progress against the recommendations can be monitored.

KEY THEMES

15. Detailed findings are shown later in the report, and for context, relevant Corporate Risks against each strand of Corporate Governance are included. Key themes emerging from this review and other audit work during the year are detailed in the following paragraphs.
16. Audit Scotland – NHS Scotland 2022, issued February 2023, stated that 'the NHS in Scotland faces significant and growing financial pressures. These include inflation; recurring pay pressures; ongoing Covid-19 related costs; rising energy costs; a growing capital maintenance backlog; and the need to fund the proposed National Care Service. These pressures are making a financial position that was already difficult and has been exacerbated by the Covid-19 pandemic, even more challenging'. Internal Audit reports have recorded similar concerns and highlighted the strategic changes required. The financial risk for NHS Fife, NHSScotland and the public sector has continued to increase.
17. As reported in the Internal Audit Annual Report for 2021/22, the challenge now is balancing short term risks against longer term risks which can only be mitigated through strategic change. The shape of future strategy will be dependent on a number of complex factors, with some subject to change. However the Board has continued to respond, and risk assess, to ensure the most urgent work is prioritised.

18. We previously highlighted the risks associated with the National Workforce Strategy for Health and Social Care and the need for realistic plans. The NHS Fife Workforce Plan 2022-2025 was published in November 2022 and work is underway to inter-relate and align financial and workforce planning via the Strategic Planning Resource Allocation (SPRA) process. Workforce risks remain very high across NHSScotland, and the current risk and target risk scores will require careful consideration to ensure they reflect local, national and international pressures and the extent to which these are and can be mitigated locally.
19. Continuing staff shortages and increased demand for staff means that effective workforce planning remains key in supporting the achievement of the Board's operational, financial and strategic objectives.
20. Maintaining operational performance against mandated targets remains extremely challenging. While operational improvements will have a limited impact on performance, genuinely strategic solutions must be identified, with a focus on working closely with partners to address underlying capacity and flow issues.
21. NHS Fife continues to progress its Risk Management Framework Improvement Programme. The Board's overall approach to risk management has been revised with a new Corporate Risk Register replacing the Board Assurance Framework. A Risks and Opportunities Group continues to meet and aims to embed an effective organisational risk management framework and culture, including assurance mapping principles. Current risk scores and achievement of target scores by target dates will require constant monitoring to ensure they fully reflect current risk and controls and are realistic.
22. The Clinical Governance Strategic Framework and associated Annual Delivery Plan were approved by Fife NHS Board on 28 March 2023. The framework outlines the governance and assurance reporting routes for clinical governance throughout the full span of NHS Fife responsibilities.
23. This report contains a number of recommendations that reflect the changes to the risk environment in which the Board operates. Our recommendations are aimed at ensuring coherence between Governance Structures, Performance Management, Risk Management and Assurance.

KEY DEVELOPMENTS SINCE THE ISSUE OF THE ANNUAL REPORT INCLUDED:

- Following the approval of the PHWS in March 2023, NHS Fife has moved to the delivery stage with associated reporting to the Board and Committees.
- Reporting continues on OPEL (Operational Pressures Escalation Levels) on the NHS Fife intranet, to support proactive management of increased activity, and the related impact on capacity and flow.
- Approval of the Whole System Property and Asset Management Strategy at the September 2023 Board meeting.
- Approval of the Five-year Medium Term Financial Plan by the NHS Fife Board in March 2023.
- An updated approach to achievement of savings with 3 horizon levels for in year and the future.
- SG sign off of the 2023/24 Annual Delivery Plan (ADP) on 11 August 2023.
- Approval of the Risk Management Framework in August 2023 and ongoing development of Risk Management arrangements, including a Corporate Risk Reporting tool and Risk Summary Dashboard as guidance for risk owners.
- Approval of the Clinical Governance Strategic Framework by Fife NHS Board in March 2023 and the implementation of elements of associated Delivery Plan.

- Ongoing work to implement the Health & Care (Staffing) (Scotland) Act 2019 (Safe Staffing Legislation).
- Whistleblowing directives issued by the Independent National Whistleblowing Officer continue to be implemented by NHS Fife, with improvements being made to the procedures for completing investigations and reporting thereon.
- Continuing development of the Integrated Performance Quality Report (IPQR).

ACTION

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

ACKNOWLEDGEMENT

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

Jocelyn Lyall, BAcc CPFA
Chief Internal Auditor

TABLE 1		
Annual Report 2022/23 (B06/24) - Update of Progress Against Actions		
Agreed Management Actions with Dates	**Progress with agreed Management Actions**	**Assurance Against Progress**
1. Development of Risk Management a. Greater use of risk appetite including greater detail in risk reports presented to standing committees on how the risk appetite will affect strategy, decision-making prioritisation, budget setting and organisational focus. b. Deep Dive Reports to include: • Further assessment as to which key management actions will impact on the target score with success criteria stated. • A focus on key controls only, providing overt assurance and an overt conclusion on the effectiveness of implemented controls. • An assessment of the proportionality of proposed actions and whether they should be sufficient to achieve the target score. c. Revised Risk Management KPIs presented to the Audit and Risk Committee (ARC) that take account of previous internal audit recommendations and allow ARC members to assess the overall effectiveness of the system of Risk Management. d. Revised Risk Management Framework approved by the ARC providing a detailed description of joint Risk Management arrangements with the IJB including responsibility for operational risks, responsibility for sharing of information and responsibility for provision of assurance consistent with the IJB Risk Management Strategy. ***Action Owner: Director of Finance & Strategy*** **Original target implementation date 31 March 2024.**	a. Corporate Risks papers presented to each standing committee state if risks are within or outwith risk appetite. Review of the Board's risk appetite has not taken place yet. Risk reports to standing committees do not yet include greater detail on how the risk appetite will affect strategy, decision-making prioritisation, budget setting and organisational focus. b. The Risks and Opportunities Group (ROG) is progressing changes to the deep dive process, and these should be evident in deep dive papers presented to Standing Committees in the remainder of 2023/24. c. The development of KPIs for the risk management process is a work in progress. d. The revised NHS Fife Risk Management Framework, including a description of RM arrangements with the IJB that satisfies our recommendation, was approved by Fife NHS Board on 26 September 2023 (Complete).	 On track
2. Staff Governance Standards a. A year-end report to be presented to the Staff Governance Committee providing year-end feedback on: • The action taken on each strand of the Staff Governance Standards during 2023/24. • Reflection on how successfully and effectively these have been implemented.	a. The Annual Internal Audit Report for 2022/23 (B06/24) was presented to SGC on 20 July 2023 and the minutes record: *'The Director of Finance & Strategy highlighted the Staff Governance section within the report and was pleased to advise that there were only two recommendations, both in the lower category, which merit attention'* b. As per 2a above	 On track

• What actions are being taken forward into 2024/25, plus the further coverage planned for each strand during 2024/25. b. The Staff Governance Committee Annual Report and Statement of Assurance to include a conclusion on compliance with the different strands of the Staff Governance Standards based on the paper referred to in 2a above. ***Action Owner: Director of Workforce*** **Original target implementation date 31 March 2024.**	Internal Audit is monitoring implementation of these recommendations as part of the Audit Follow-up process and will contact management closer to the implementation date to confirm reporting will be completed as agreed.	
3. Whistleblowing The Staff Governance Committee Annual Report and Statement of Assurance including a statement confirming the Whistleblowing Champion's opinion on the adequacy NHS Fife's whistleblowing arrangements. ***Action Owner: Director of Workforce*** **Original target implementation date 31 March 2024.**	As per 2a above Internal Audit is monitoring implementation of this recommendation as part of the Audit Follow-up process and will contact management closer to the implementation date to confirm reporting will be completed as agreed.	 On track
4. Financial Sustainability Action Plan A Financial Sustainability Action Plan to be presented to the FPRC which: • Demonstrates clear links to the Population Health and Well Being Strategy, the Workforce and Digital & Information strategies, and service redesign and transformation. • Includes the following overtly to the required savings: ○ a clear process and timetable for the setting and implementation of organisation priorities ○ a clear methodology for agreeing areas for de-prioritisation. ○ a robust process for identifying and delivering service change. • Includes the process for formal monitoring of operational and strategic savings programmes. • Includes provision of overt positive assurance to the Board that NHS Fife has the capacity and capability (both in terms of planning and operations) to drive transformational change, whilst maintaining business as usual and delivering savings, both in the short and longer term. • Includes a clear delineation of the cultural changes required to ensure that financial sustainability receives sufficient priority both strategically and operationally, in the face of competing pressures and conflicting Scottish Government priorities. ***Action Owner: Director of Finance & Strategy***	The Financial Performance and Sustainability Report includes actions aimed at achieving financial sustainability and has been presented to EDG, FPRC and Fife NHS Board. The Financial Performance and Sustainability Report links to the Annual Delivery Plan which links to the Corporate Objectives which are aligned to the Public Health & Wellbeing Strategy. The process to determine corporate objectives for 2024/25 will include the setting and implementation of organisation priorities and de-prioritisation will be included in this. The broader service change objectives are aligned with the other significant change programmes. The Financial Improvement and Sustainability Board is monitoring actions being taken to improve efficiency savings performance.	 Completed

Original target implementation date 31 March 2024		
5. Brokerage Contingency Planning. NHS Fife to record, monitor and have contingency plans in place to manage the risk of a sudden cessation for brokerage, which, unmitigated, could impact on service provision. ***Action Owner: Director of Finance & Strategy*** **Original target implementation date 30 September 2023**	NHS Fife is in dialogue with SG who are aware of the potential brokerage required at Year-End.	 Completed
6. Digital & Information Strategy a. Clinical Governance Committee (CGC) to be updated regarding the impact on strategic ambitions & new D&I Strategy of elements from previous strategy not yet delivered. b. The new D&I Strategy to include a resource & financial assessment supporting the likelihood of the revised D&I Strategy being delivered within the stated timescale. ***Action Owner: Associate Director of Digital & Information*** **Original target implementation date 31 July 2024.**	a. The D&I Strategy update to CGC on 3 November 2023 included analysis of the delivery of items from the 2020-24 D&I Strategy and clearly shows items partially or not delivered. The update also identifies themes to be taken forward to the next iteration of the strategy (Complete). b. The D&I Strategy update to CGC on 3 November 2023 confirmed that this will be supported by a financial framework.	 On track
ICE Report 2022/23 (B08/23) - Update of Progress Against Actions		
Agreed Management Actions with Dates	**Progress with agreed Management Actions**	**Assurance Against Progress**
1. Committee Assurances a. The Board's action list, which is currently maintained and followed up by the Corporate Governance & Board Administration team, will be tabled for review at future Board meetings. b. Risk sections within the SBAR papers presented to the Standing Committees and the Board should fully articulate the risks associated with the report, the linkage to the relevant Corporate or Operational risk and any related consequences. c. SBARs on Policy Updates to include a risk assessment on each policy which has passed the renew date, highlighting the risks and possible consequences of the policy not being reviewed within the timescale and superseded policies will be removed from Stafflink. ***Action Owner: Head of Corporate Governance & Board Secretary*** **Original target implementation date 30 June 2023.**	a. The Board's Action List was included on the agenda for its meetings on 31 January and 28 March 2023 and a comparison of the two Action Lists shows that it is being updated between meetings (Complete). b. The revised SBAR template and associated guidance were issued in November 2023, so time is needed to evidence the use of these in practice at Board and Committee meetings. An extended timescale to 31 March 2024 has been agreed to allow this. c. Discussion on the policies that have lapsed review dates took place at EDG on 2 November 2023 and a risk-based approach to prioritise the review and update policies was agreed and relevant assurances regarding this were provided by the relevant responsible Executive Directors. FPRC were notified of this on 14 November 2023 (Complete).	 Minor slippage on agreed timelines

2. Risk Management a. Risk Management KPIs to be presented for approval and reported to the Audit and Risk Committee. b. Risk appetite to be overtly reflected in the corporate risk register updates to standing committees, particularly within target scores, when risks are updated and reviewed. ***Action Owner: Director of Finance & Strategy*** **Original target implementation date 30 June 2023.**	a. KPIs for Risk Management are still being updated and a date for presentation to ARC has not yet been agreed This recommendation has been superseded by B06/24 Point 1c. b. The Corporate Risk Register presented to ARC on 15 March 2023 includes the risk appetite for each strategic priority and indicates for each risk whether the current risk rating is above, below or within that risk appetite. This format will be used for presentation to all Standing Committees.	 Completed
3. Clinical Governance and Assurance re Services Delegated to the Integration Joint Board a. Regular reporting to the Clinical Governance Oversight Group (CGOG) providing assurance that recommendations made following external body visits are being progressed through service action plans to completion. b. Reporting on risk associated with Adult and Child Protection to the CGOG. ***Action Owner: Director of Health and Social Care Partnerships*** **Original target implementation dates a - 30 April 2023 & b – 31 July 2023.**	a. Inspections and methodology reported to CGOG on 18 April 2023 and future reporting scheduled in CGOG 2023/24 workplan. b. Report on risk 10 regarding Adult and Child Protection was presented to the CGOG meeting on 20 June 2023.	 Completed
4. Clinical Governance Strategic Framework & Clinical Governance Risk Management a. The Clinical Governance Strategic Framework (CGSF) to be presented to Fife NHS Board for approval. b. Adult and Child Protection and the latest guidance (Scottish Government's NHS Public Protection Accountability and Assurance Framework to be considered as part of the 2023/24 workplan for the Clinical Governance Strategic Framework. c. The Terms of Reference for the CGOG to be amended to include a specific responsibility regarding consideration of external reviews and whether appropriate action has been undertaken to address any recommendations made. d. A meeting of the Organisational Learning Group (OLG) to be held focused on how to build in the consideration of issues identified in external reports into future OLG agendas and the analysis that would need to be undertaken to provide the OLG with the information to discharge their responsibility as per its Terms of Reference item 2.4 regarding consideration of whether internal controls and associated reporting mechanisms need to be improved if they did not identify issues highlighted in inspections undertaken by external regulators/auditors. e. Minutes of OLG meetings to be routinely presented to the CGOG.	a. The CGSF was approved by Fife NHS Board on 28 March 2023. b. The Mid-Year Update on the Clinical Governance Strategic Framework presented to CGOG on 24 October 2023 and CGC on 3 November 2023 includes reference to the Scottish Government's NHS Public Protection Accountability and Assurance Framework. c. CGOG Terms of Reference was appropriately updated and was noted by CGOG on 24 October 2023 acknowledging their acceptance of the changes made. d. A review of the OLG commissioned by the Chief Executive has concluded and the recommendations made supersede this recommendation. e. The minutes of the OLG meeting held on 18 August 2023 were included on the CGOG Agenda for its meeting on 24 October 2023. f. The updated CRR presented to EDG on 17 August 2023 includes the revised wording of the risk. The Director of Acute Services advised that the scoring is reviewed regularly and was last updated at the end of April. The risk	 Completed

f. The description of risk 7 on the CRR to be updated to more accurately describe the risk associated with deferred treatment due to late presentation due to the pandemic (eg: changing the '*could*' in 'This time delay could impact clinical outcomes for the population of Fife' to '*will*'). and the scoring of this risk to be revised to take account of the related performance information. g. The anticipated deep dive analysis to be undertaken on risk 7 to be prioritised and to be undertaken in a manner that clearly explains the scale of the risk and better describes the controls in place. h. The alignment of Risk 7 to be reconsidered with specific consideration given to whether assurance on its management should be provided to the CGC. i. The difficulties in meeting targets for Serious Adverse Events Reviews to be reported to the CGC. ***Action Owner: Medical Director*** **Original target implementation date 31 August 2023.**	was scored at 16 High when reported to FPRC in November 2022 and is reported as 20 High to FPRC in May 2023. g. The deep dive into risk 7 has been undertaken and was presented to FPRC on 14 March 2023 and CGC on 7 July 2023. The deep dive into the related CRR 5 was undertaken and presented to EDG on and was presented to CGC on 5 May 2023. h. The alignment of risk 7 is to continue to be to FPRC but it was presented to CGC on 7 July 2023. i. The narrative included in the IPQR presented to CGC on 3 March 2023 highlighted the performance issues regarding the Adverse Events Management Process and the action being taken to address this.	
10. IG&S Incident Reporting to CGC The IG&S update report for the Clinical Governance Committee to be updated to include a section for IG Incident Management including: ○ Reasons for any instances of non-compliance with the 72-hour statutory timescale for reporting to the ICO and what has been done to prevent this from happening in future. ○ Sufficient information to allow an opinion on whether any of the incidents reported to date should be considered for disclosure within the Board's Governance statement. ***Action Owner: Associate Director of Digital and Information*** **Original target implementation date 31 May 2023.** **Extended to 29 February 2024 (TBC)**	IG&SSG Updates to CGC on 3 March and 8 September 2023 – (both Item 9.1) - Summary of Incident Reporting in the period including assurance regarding compliance with the 72-hour timescale for reporting to the ICO but does not include a statement regarding whether or not any of the incidents will warrant disclosure in the Board's Governance statement. This is to be included in the update presented to CGC on 12 January 2024.	 Minor slippage on agreed timelines
11. D&I Strategy Risk • D&I Workforce Plan to be added to the Corporate Risk Register as a mitigation to risk 18 – regarding the D&I Strategy to allow assessment of its implementation and effectiveness. ***Action Owner: Associate Director of Digital and Information*** **Original target implementation date 31 May 2023.** **Extended to 30 November 2023**	The risk report presented to CGC on 8 September 2023 includes the following as mitigation against corporate risk 18: '*Active review of the Strategy deliverables against current strategic objectives. This includes financial and workforce planning*'.	 Complete

CORPORATE GOVERNANCE

Corporate Risks:

Risk 1 – Population Health and Wellbeing Strategy – Moderate (12); Target (12) Moderate by March 2024 - Below Risk Appetite

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

Risk 2 – Health Inequalities – High Risk (20); Target (10) Moderate by March 2024 - Within Risk Appetite

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

Governance Arrangements

The Code of Corporate Governance was updated and approved at the May 2023 Board meeting.

Board and Committee Development Sessions covered a diverse range of topics and are critical for gaining further insight into key areas. The Annual Internal Audit Report 2022/23 (B06/24) highlighted that learning and key actions from these sessions should be recorded with formal outputs to ensure that actions are taken forward. The Board Secretary has advised that notes are taken on Development Sessions where appropriate and these used as part of the planning and design of topics under development.

The ARC members attended training sessions on the Annual Accounts, the role & function of the ARC and Risk Management. The CGC have considered Medical Education, Addiction Services, the Research relationship between NHS Fife and the University of St Andrews and Optimal Clinical Outcomes. The Public and Wellbeing Committee has considered topics which include Child and Adolescent Mental Health Service and Psychological therapies and Integrated Screening. The Staff Governance Committee has considered continuously improving a safe working environment, promoting the health and wellbeing of staff, and iMatters.

Self- Assessment

The second edition (November 2022) of the Blueprint for Good Governance was presented to the March 2023 ARC. It describes the latest good governance practice including active and collaborative governance. A National survey for Board members, (self-assessment) is closing on 1 December 2023 and a Development Session will be held in February 2024 to reflect on the outcomes of the National Survey.

In March 2023 Governance Committees completed self-assessments and identified improvements which are being progressed within the Committee Action Lists. We will review the progress of the identified improvements and comment in the Internal Audit Annual Report 2023/24 (B06/25).

Committee Assurance

Standing Committees review their Terms of References annually. Internal audit review of Standing Committee papers found that where serious issues are reported, for example adverse findings from an inspection by a regulator, the papers do not conclude on whether the issue is likely to warrant disclosure in the Board's Governance Statement. A process should be introduced to prompt consideration by committee members, throughout the year, of issues that may warrant disclosure in the Board's Governance Statement.

Policies

A General Policies and Procedures paper presented to the 2 November 2023 EDG provided an update of the status of policies as at October 2023. 36 (64%) of the 56 General Policies were up to date, 12 (21%) were beyond their due date and review work was underway within departments for 8 (14%) of General Policies. We noted good practice in that the paper reported the potential risk management implications of overdue policies and the EDG will take a risk-based approach to prioritise out-of-date policies that are significantly beyond their due date.

Internal Audit will undertake a review of Policies and Procedures as part of the 2023/24 audit plan, to ensure that the update of policies is risk-assessed, delivered and monitored appropriately and that updated policies are published effectively, and superseded versions removed from circulation.

Culture and Values

A Board Development Session in April 2023 focussed on Culture, Values and the Role of the Board. The NHS Fife Code of Corporate Governance refers to culture and values, and we have evidenced examples of the Board and its officers embracing and promoting these values.

Strategy

The Public Health & Wellbeing Strategy (PHWS) was approved at the March 2023 Board meeting. The Public Health and Wellbeing Committee (PHWC) has oversight of the delivery of the PHWS and a Mid-Year Report to the November 2023 meeting provided a six-monthly update on delivery. Progress during the first 6 months was provided (to September 2023) with planned activity to the end of March 2024 highlighted. The report uses the three-horizons framework to plan the first year, medium-term and longer-term objectives, to describe how ongoing work will collectively contribute to the system change required.

The internal audit B14/23 on Strategic Planning, will evaluate the development of the Strategic Plan.

Operational Planning

The draft ADP 2023-24 is in line with SG guidance and was presented to the Board before submission to SG by end of July 2023, and subsequent approval on 11 August 2023. It was approved by the Board in September 2023. There are three ADP related submissions: the draft ADP1, the draft ADP2 (spreadsheet with detailed actions, milestones and risks) and the draft Medium-Term Plan (MTP) 2023/26, which was submitted to Scottish Government on 7 July 2023. Quarterly updates on ADP delivery are reported to the FPRC.

We commended the OPEL tool within our B08/23 Internal Control Evaluation report. OPEL supports management of increased activity, and the related impact on capacity and flow and scores continue to be reported on a daily basis on Stafflink to provide organisational awareness of the extreme pressures within the system and the high-risk environment the Board operates within.

Assurance Mapping

Committee Assurance Principles were endorsed by the NHS Fife ARC in May 2021. Internal Audit will continue to promote the use of the assurance principles through continued leadership of the Assurance Mapping Group, chaired by the Chief Internal Auditor, attendance at the Risks and Opportunities Group, and though internal audits.

Integration

The Integration Scheme was reviewed and approved by NHS Fife Board in September 2021. A Ministerial Strategic Group (MSG) published a report in 2019 outlining proposals to develop the features of good Integration. An MSG self-assessment was carried out by the Fife Health and Social Care Partnership and reported to the NHS Fife Finance, Performance and Resources Committee (PRC)

in January 2023. Sixteen key features were established, 6 were partially established. Internal Audit would expect an update report is provided to a future NHS Fife Finance, PRC meeting.

Performance

The Integrated Performance & Quality Report (IPQR) has continued to be reviewed and enhanced by the IPQR group, which was set up following the Board's Active Governance Workshop held in November 2021. The IPQR report now provides a Public Health and Wellbeing section and Statistical Process Control charts where relevant. This demonstrates improved connectivity through inclusion of Corporate Risks aligned to strategic priorities. Providing extracts of the IPQR for each Standing Committee has facilitated focussed scrutiny of the performance areas most relevant to each. The November 2023 IPQR included uptake of Covid and Flu winter vaccination programme and staff vacancies.

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

The latest IPQR presented to the November 2023 Board meeting highlighted:

- Eight indicators are on schedule to meet Standard/Delivery trajectory: Inpatient Falls, Inpatient Falls with Harm; Pressure Ulcers; SAB HAI/HCAI; C Diff; IVF Treatment Waiting Times; Freedom of Information Requests and Antenatal access.
- The Cancer 31 Day DTT current performance is at 90.6% with a target of 95%, which is a decrease in performance from last year.
- The Cancer 62 Day DTT current performance is 77.1% against a target of 95%, which has decreased in performance since last year.
- The following indicators show an Amber status, which is behind the target but within 5% of the Standard/Delivery trajectory: Cancer 31 Day DTT; Major/Extreme Adverse Events - % Closed on Time; Detect Cancer Early; Immunisation 6 in 1 at Age 12 months and Immunisation MMR2 AT 5 Years.
- Twelve indicators are not achieving target but are performing within the Mid-Range quartile for benchmarking: Cancer 62 Day RTT, S1 Complaints Closed in Month on Time, S2 Complaints Closed in Month on Time; 4-Hour Emergency Access (A&E) & (ED); Patient TTG%; New Outpatients; Diagnostics; Sickness Absence; CAMHS Waiting Times; Psychological Therapies Waiting Times (Statistical Process Control has identified this as an outlier and negatively outside the control limits) and Drugs & Alcohol Waiting Times.
- Performance in September for the 4-Hour Emergency Access decreased from 79% to 73.3%, significantly below the 95% national target and just below the 24-month average of 73.9%.

The pressures on the system are making performance against a range of targets challenging for NHS Fife in common with the entirety of NHSScotland.

Risk Management

The Risk Management Framework 2023-2025 was approved at the September 2023 Board meeting, following consideration by the ARC in August 2023. A delivery plan is being developed to support the implementation of the Framework.

More than 60% of the Corporate Risk scores are above risk appetite, meaning that action to bring risk scores within appetite and within a short timeframe are required. The annual review of risk appetite

has not yet taken place. Within the context of the unprecedented challenging external environment we are of the opinion that risk appetite needs to be revisited.

The implementation of Deep Dive risk reviews is designed to provide Governance Committees with assurance on the appropriate management of risk. We commend the paper to the 2 November 2023 EDG, where recommended criteria for undertaking a Deep Dive review was agreed. The triggers for invoking a Deep Dive review were outlined as, Proposed New, Deteriorating and Static, Corporate Risks, and Proposed De-escalation of a risk. Internal Audit will review these arrangements, including a review the full Deep Dive process, within B14/24 Risk Management this year.

The Risk and Opportunities Group (ROG) continues to meet to provide leadership and promote and embed an effective risk management culture.

Risk management dashboard operational guidance and a demonstration of the Risk Summary Dashboard was provided to the 2 November 2023 EDG. The dashboard is designed to guide risk owners through a series of activities to facilitate effective risk management. The implementation approach for the ROG to take this forward was agreed by the EDG. KPIs for operational risks have been developed and will continue to be refined as part of the ROG agenda.

Action Point Reference 1 – Governance Statement Disclosures

Finding:

Papers have been presented to each standing committee that highlight serious issues, but they have not concluded on, or prompted discussion on, whether these issues are likely to require disclosure in the Board's Governance Statement.

Audit Recommendation:

A process should be implemented that ensures serious issues are highlighted to all Standing Committees and members are prompted to agree if the issue warrants disclosure in the Board's Governance Statement. This may include a direction in the SBAR supporting the relevant paper, along with providing members with the key considerations for deciding upon disclosures from the relevant section of the Scottish Public Finance Manual:

- '*might the issue prejudice achievement of the business plan or other priorities?*
- *could the issue undermine the integrity or reputation of the organisation?*
- *what view does the audit committee take on the issue?*
- *what advice or opinions have internal audit and/or external audit given?*
- *might the issue make it harder to resist fraud or other misuse of resources?*
- *does the issue put a significant programme or project at risk?*
- *could the issue divert resources from another significant aspect of the business?*
- *could the issue have a material impact on the accounts?*
- *might financial stability, security or data integrity be put at risk?*'

A register of potential disclosures should be maintained and considered at year-end when preparing the Board's Governance Statement.

Assessment of Risk:

Merits attention		There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**

Management Response/Action:

Standing Committees each reflect on their year's business at the point of reviewing their annual assurance report. Significant work has been taken forward in recent years to enhance the content and detail of these reports, ensuring that the information provided within is comprehensive, robust and relevant for the purpose of providing assurance to the Board. It is at that point where committees discuss and decide on any potential disclosures, reflecting on the year's business overall and the movement of potential disclosure issues throughout the year (some in-year issues can be satisfactorily resolved by year-end, for instance).

In totality, the consideration of each Standing Committee's assurance statement influences the content and conclusions of the Governance Statement, which is discussed in draft and agreed with the Audit & Risk Committee. We believe the process in place at present is robust and appropriately reflective, without the need for a rolling issue list to be created, or additional changes to the SBAR template.

Action by:	Date of expected completion:
Head of Corporate Governance & Board Secretary	**N/A**

CLINICAL GOVERNANCE

Corporate Risks:

Risk 3 – COVID-19 Pandemic – Moderate (9); Target (12) Moderate by October 2023 – Below Risk Appetite

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

Risk 5 - Optimal Clinical Outcomes – High Risk (15);Target (10) Moderate by March 2024 – Within Risk Appetite

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

Risk 9 - Quality & Safety – High Risk (15);Target (10) Moderate by March 2024 – Above Risk Appetite

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

Risk 16 - Off-Site Area Sterilisation and Disinfection Unit Service – Moderate Risk (12);Target (6) Low by April 2026 – Within Risk Appetite

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

Risk 17 & 18 are aligned with the Clinical Governance Committee but are considered under the Information Governance section below.

Risk 7 is aligned with the Finance Performance and Risk Committee. We recommended that consideration be given to aligning this risk to the Clinical Governance Committee. This was considered but it was felt appropriate that the risk remained aligned to the FP&RC. The Clinical Governance Committee was updated on the deep dive into this risk at its 7 July 2023 meeting.

Risk 7 - Access to Outpatient, Diagnostic and Treatment Services - High Risk (20);Target No target due to uncertainty over level of funding – Above Risk Appetite

There is a risk that due to demand exceeding capacity, compounded by unscheduled care pressures, NHS Fife will see deterioration in achieving waiting time standards. This time delay will impact clinical outcomes for the population of Fife.

Clinical Governance Framework

The Clinical Governance Strategic Framework was approved by Fife NHS Board on 28 March 2023 and the annual delivery plan and progress update was presented to the Clinical Governance Oversight Group (CGOG) in October 2023, setting out the workstreams, objectives, leads, timescales and their status.

The only item reported as having slipped was the Risk Management Policy which is being revised following Board approval of the NHS Fife Risk Management Framework at the end of August 2023.

A Fife Health and Social Care Partnership (HSCP) Clinical & Care Governance Strategic Framework is in development and is to be presented to the IJB for approval by January 2024. This will outline arrangements for providing strategic direction and assurance on health and social care to the IJB, Fife Council and NHS Fife. This framework will complement the existing NHS Fife Clinical Governance Strategic Framework which describes HSCP Clinical and Care Governance Assurance Arrangements.

Fife IJB report F06/22 - Clinical and Care Governance was issued on 31 October 2023 and provided reasonable assurance on developments to Clinical and Care Governance Assurance processes and made two significant and three moderate recommendations. The significant findings related to the reporting of assurance regarding the management of the corporate risk recorded regarding Child and Adult Protection and establishing regular reporting on Adult and Child Protection to Fife Council's People and Communities Scrutiny Committee and the IJB's Quality and Communities Committee and SLT Governance and Assurance.

Clinical Governance Committee

Updated CGC Terms of Reference (ToR) were included in the Code of Corporate Governance approved by Fife NHS Board on 30 May 2023 and include a membership change related to patients' representative, responsibility for oversight of patient experience and feedback mechanisms and other administrative items.

The CGC 2023/24 annual workplan is presented to each CGC meeting with the latest update indicating that CGC should receive all items in 2023/24.

Clinical Risk Management

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

Risk 7 - Access to Outpatient, Diagnostic and Treatment Services is aligned to the Finance Performance and Risk Committee. Internal audit previously recommended this risk should be aligned to the CGC, but we were advised that the risk would remain aligned to the FPRC. However, the CGC was updated on the deep dive into this risk on 7 July 2023.

The CGC has also considered deep dive assurance reports for risks 9, 16 and 18 in 2023/24 and reviewed the corporate risks aligned to the Committee on 8 September 2023 and 3 November 2023.

Clinical Performance Reporting

The latest IPQR presented to CGC on 3 November 2023 highlighted the following areas which are not achieving target, with the SBAR providing detailed narrative and actions to improve:

- Adverse Events - August 2023 – 48.4% LAER/SAERs closed on time against a target of 50%:
- Escherichia Coli Bacteraemia (ECB) (HAI/HCAI) - August 2023 – 38.4 HAI/HCAI per 100,000 Occupied Bed Days against a target of 33.0
- Complaints (Stage 1 & Stage 2) - August 2023 - Stage 1 closed in month on time 42.6% against a target of 80% & Stage 2 closed in month on time 11.1% against a target of 50%. (A project and improvement plan is being developed by the Patient Experience Team in conjunction with a Senior Project Manager to improve performance in this area).

Quality Performance Indicators (QPIs) included in the Clinical Governance Strategic Framework are reported to the CGC along with details of remedial action being taken to address any indicators that were performing below target with the exception of:

- Adverse Events Improvement Actions (70% target for closure of actions within timescales)

- Complaint Closed- Stage 1 (80% target) – The summary table on the IPQR reported 42% for this, significantly below the target of 80% but there is no narrative included in the Clinical Governance section and any remedial action being taken (there is narrative regarding Stage 2 performance and improvement actions).

External Review

External Inspection Reports are included on an Activity Tracker document routinely considered by the Clinical Governance Oversight Group (CGOG).

In response to a recommendation in our 2022/23 ICE report (B08/23) a HSCP Inspection Update is presented to each CGOG meeting as a standing agenda item.

We commend the presentation of the papers on the HIS inspection and the Fatal Accident Enquiry to the CGC. These papers highlighted the serious issues raised to CGC members but, in common with other standing committees, did not include a conclusion on whether they require to be included as disclosures in the Board's Governance Statement at year-end and the members of the CGC were not asked to consider this. A recommendation relevant to this is included in the Corporate Governance section above at Action Plan Point 1.

The Cabinet Secretary requested all Boards in Scotland provide assurance that their processes and systems for the early identification, reporting and robust timely investigation of patient and staff safety concerns are fully effective. The NHS Fife Chief Executive commissioned a review of the Organisational Learning Group (OLG) which had a remit to ensure that the learning gained from events is used to optimise patient safety, outcomes and experience and to enhance staff wellbeing and job satisfaction. Our 2022/23 ICE report recommended that the OLG need to consider the effectiveness of internal control and reporting systems in relation to adverse findings in external reports.

Healthcare improvement Scotland (HIS) Inspection Report

HIS undertook an unannounced inspection on Acute Hospital Safe Delivery of Care at Victoria Hospital between 31 July and 2 August 2023 and reported serious concerns about the condition of the healthcare-built environment within the older building of the hospital and stated nine requirements and made two recommendations. The initial findings from the inspection were reported to CGC in September 2023 ahead of the publication of the final report on 26 October 2023. This update informed CGC that NHS Fife took immediate action to address issues identified by relocating a ward to another area in the hospital and bringing forward a planned programme of ward refurbishment. The timing of the publication of the final report did not allow enough time for an update to be provided to the CGC meeting in November 2023 but an update on progress to address the findings in the report is to be provided to the January 2024 CGC meeting. We are advised by the Director of Nursing that this update will consider the effectiveness of internal control and reporting systems (ie why corrective action wasn't undertaken before the issues were highlighted by HIS and what improvements need to be made to ensure that should similar issues occur, Senior Management are promptly notified).

Fatal Accident Enquiry

CGC were updated on the outcome of the fatal accident enquiry into death of a patient in the intensive care unit (ICU) at Victoria Hospital in October 2019. The report identified three specific shortcomings in the care of the patient and stated that had any one of the three been undertaken properly this might realistically have resulted in the death being avoided. The action plan to address the 8 recommendations made in the report was presented to CGC and the status of the actions is to be monitored by the Acute Services Division CGC which reports into CGOG.

Significant Adverse Events

The revised Adverse Events Policy (reviewed February 2023) is available on Stafflink and includes a flowchart of the revised process which links to further Adverse Events Management Resources on Stafflink.

The target related to closing SAERs within timescale has only been achieved in 1 month of the 5 reported to date. Actions designed to improve this are being implemented and are reported as being on track for implementation by 31 March 2024.

Duty of Candour (DoC)

The latest DoC Annual Report presented to the CGC on 3 March 2023 related to the financial year 2021/22 and included an update on DoC activity in 2022/23 to date. We have been advised by management that the 2022/23 DoC annual report for presentation to CGC in March 2024 will include an update on DoC activity in 2023/24.

Action Point Reference 2 – Performance Monitoring

Finding:

Quality Performance Indicators (QPIs) included in the Clinical Governance Strategic Framework should be reported to the CGC along with evidence of review and remedial action. We confirmed that reporting on QPIs to CGC or CGOG is evident in 2023/24 and that remedial action was reported where required, with the following exceptions:

- Adverse Events Improvement Actions (70% target for closure of actions within timescales) – not included in the IPQR or the Adverse Events reporting to CGOG
- Complaint Closed- Stage 1 (80% target) – the summary table on the IPQR reported 42% for this significantly below the target of 80% but there is no narrative on this and on remedial action included in the Clinical Governance section.

Audit Recommendation:

Performance reporting for the Clinical Governance Strategic Framework QPIs referred to in the finding above should be added to the performance reporting to CGC.

Assessment of Risk:

Moderate  Weaknesses in design or implementation of controls which contribute to risk mitigation.
Requires action to avoid exposure to moderate risks to achieving the objectives for area under review.

Management Response/Action:

Adverse Events:

The action closure rate was added to IPQR from January 2023. The initial target was set at 70%, however it quickly became apparent that we would not be able to meet this until improvements were made to the actions module on Datix and some training and education was devised and delivered. This was escalated through to CGOG on 20 June along with an overview of the short and long term goal for the improvements required. There was agreement to have a staggered approach to achieving the target. The target was reduced to 50% to be achieved by March 2024, at which time it would be reassessed and increased to the 70% if appropriate. An update on the short term goals was provided in August 2023, both of which will have been captured in the minutes.

Actions on Stage 1 Complaints:

The Patient Experience Team (PET) are working with services to improve the compliance of Stage 1 complaints, focusing on ensuring these are resolved locally at the service level via telephone or face-to-face, aiming to reduce the number of Stage 1 written complaint responses required. A new Stage 1 template has been created and tested within Acute to raise awareness of these complaints being resolved locally and highlight lessons learned.

The PET dashboard has been launched, raising awareness and providing up-to-date data regarding all open, Stage 1, Stage 2, enquiries and concerns.

A new weekly complaint report has been created and highlights the compliance target of 80% for Stage 1s and the previous month's data for Acute and H&SCP and whether the target has been achieved. A PET staff page has been created on Blink to raise awareness of the PET and the complaints process. There is greater engagement with PET and Services, focusing on open complaints, providing support, advice, and training. Roles and responsibilities with PET have been streamlined, releasing time for the support officers to focus on stage 1 complaints, concerns, and enquiries. PET will link with Planning and Performance Team to include narrative in IPQR.

Action by:	Date of expected completion:
Director of Nursing / Planning & Performance Team	**31 December 2023**

STAFF GOVERNANCE

Corporate Risks:

Risk 11 - Workforce Planning and Delivery – High Risk (16); Target (8) Moderate by March 2025 – Above Risk Appetite

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

Risk 12 - Staff Health and Wellbeing – High Risk (16);Target (8) Moderate by March 2025 – Above Risk Appetite

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

Risk 19 – Implementation of Health and Care (Staffing) (Scotland) Act 2019 [HCSA] – Moderate (12); Target (9) Moderate (no date given) – Within Risk Appetite

Taking account of ongoing preparatory work, there is a risk that the current supply and availability of trained workforce nationally, will influence the level of compliance with HCSA requirements. While the consequences of not meeting full compliance have not been specified, this could result in additional Board monitoring /measures.

Governance Arrangements

The SGC approved revised Terms of Reference in March 2023 and updates on the progress of the 2023/24 SGC workplan are reported to each meeting.

Workforce Strategy/Planning

The NHS Fife Workforce Plan 2022-2025, agreed by the Board and Scottish Government (SG), was published in November 2022. Internal Audit will comment on the plan within internal audit B17/23 – Workforce Planning, which will be presented to the SGC once finalised. Work to capture information on the identifying and meeting future workforce requirements is ongoing, with the granular information to be obtained by service-based workforce plan templates.

An update on the Three-Year Workforce Plan 2022-25 was presented to the September 2023 SGC meeting with an action plan to address both SG feedback and the recommendations from the Internal Audit Annual Report 2022/23 (B06/24). The majority of the actions are scheduled for completion by March 2024, with the timescale for one action to be confirmed.

The Workforce Plan should provide an opportunity to identify strategic solutions to critical workforce risks and a coherent, cohesive and proportionate response to extreme pressures is needed. The Medium Term Plan 2023-26 highlights the positive steps being taken by NHS Fife to develop and sustain its workforce.

Risk Management

The SGC has oversight of the Workforce Delivery & Planning and Staff Health & Wellbeing corporate risks, both of which have a current high rating. The planned date to reduce the risk score from high to moderate for both risks has been changed to the end of March 2025 (previously March 2023). Whilst these target dates are more realistic, due to the pressures within the system achievability of these dates may need to be reconsidered over time.

A paper on implementation of the Health & Care (Staffing) (Scotland) Act 2019 (Safe Staffing Legislation) was presented to the 14 September 2023 SGC meeting, to update it on the action being

taken to comply with this legislation, which has to be fully implemented by 1 April 2024. To help manage this a new corporate risk has been created, which will be reported to the SGC.

Staff Governance Standards

The SG do not require a staff governance action plan for 2023/24 and no further guidance on Staff Governance Standard (SGS) monitoring procedures has been issued. NHS Fife does ensure the principles of the SGS are followed through:

- SGC workplan reports on the strands of the SGS are presented.
- Signposting other papers to the strand of the SGSs to which they relate.
- Board Development Days.

A date for reporting on the Well-Informed strand has yet to be confirmed.

The Internal Audit Annual Report 2022/23 concluded that further improvements could be made to monitoring and reporting on compliance with the SGS with progress on track for financial year end reporting.

A copy of the 2022/23 Annual Monitoring Return was presented to the 9 November 2023 SGC meeting prior to submission to the SG. For 2021/22 the SG provided feedback on suggested topics for further consideration, which were highlighted to the SGC. The SGC has not been provided with an update on whether action was taken in response to them, and we recommend that this is done.

A workforce policy update to the November 2023 SGC covered development and maintenance of local HR policies and Once for Scotland Workforce Policies. To raise awareness of workforce policies a number of briefing sessions have been held across various sites and virtually over the month of October 2023 with more scheduled for November 2023.

Staff Experience

An update paper on the Annual Delivery Plan (ADP) 2023/24 was presented to the 14 September 2023 SGC meeting to enable monitoring of workforce aspects, with the ADP a standing agenda item at the SGC. Nursing and midwifery staffing issues including the number of registered nurses needed and those entering the workforce, a decrease in for nursing courses in Scotland in 2023 and significant vacancy challenges within NHS Fife.

The September 2023 SGC was informed that iMatters engagement for 2023 had improved and was 66% compared to a national figure of 59%.

Whistleblowing

Implementation of whistleblowing arrangements and reporting was reviewed in Internal Audit Report B18-23. Steps are being taken to fully implement the directives of the Independent National Whistleblowing Officer, including quarterly and annual reporting of whistleblowing instances, investigation and implementation of lessons learned.

Recommendations made by Internal Audit have yet to be fully implemented and are being monitored through the Audit Follow-Up Protocol. This includes a recommendation that the SGC Annual Statement of Assurance 2023/24 includes an overt opinion on the adequacy of existing whistleblowing arrangements, supported by a concluding statement from the Whistleblowing Champion.

Remuneration Committee

The Remuneration Committee (RC) reviewed its terms of reference at its March 2023 meeting and completed a self-assessment of its performance.

Appraisals

The RC reviewed the completion of the 2022/23 performance appraisal process for the Executive and Senior Manager Cohort at its May and June 2023 meetings. The RC approved the 2022/23 objective setting process for the Executive and Senior Management Cohort at its June 2023 meeting. The RC agreed the Chief Executive's 2023/24 objectives at its May 2023 meeting and the 2023/24 Executive Cohort objectives at its July 2023 meeting. The RC also agreed that, due to the importance of ensuring that there is sufficient robust evidence to support the performance rating applied to each member of staff, the RC would further consider the appraisal process at a future date. We recommend this is built into the RC workplan.

The completion of annual Agenda for Change appraisals was 40% as at 31 October 2023, demonstrating a slight continuous improvement (38% at 31 March 2023 and 33% at 31 October 2022), but highlighting that more action to improve staff engagement is required. The SGC was advised that the appraisal performance is being monitored and actions to support staff engagement continue, with current initiatives to increase the focus on this process and sustain improvement ongoing.

Presentation of the 2022/23 Annual Report on Medical Consultant and GP appraisals to the November 2023 SGC has been delayed until the January 2024 meeting, due to the need to collate additional information on the appraisal strategic framework.

Core Skills Training

Core training compliance at 31 October 2023 was 63% (57% in May 2023) against the target of 80%, as reported to the November 2023 SGC meeting.

The SGC was advised of work to increase compliance to the 80% target by 31 March 2024, including:

- Developing compliance improvement trajectories across services to target and prioritise activity.
- Further engagement with training owners to establish delivery plans and improve levels of staff attendance/completion.
- The roll out of enhanced manager reporting to support compliance monitoring activity.
- Completion of a full core training compliance review to develop and refine the programme to improve role specific training requirement.

Sickness Reporting

Sickness absence is now reported to the SGC on a regular basis through the Promoting Attendance update reports, which detailed work being undertaken towards improving attendance and wellbeing. This is supplemented by summary data in the IPQR presented to each SGC. The absence rate at 30 September 2023 was 6.93%, which compares with a Scottish average of 5.94% and the target of 4%. The committee was advised that a range of support packages are being made available to help support the mental health of staff, including resources available on the Healthy Working Lives website, plus the Live Positive - Stress Management Toolkit. An Attendance Management training programme continues to be delivered in partnership to groups of managers within NHS Fife.

Action Point Reference 3 – SG Annual Monitoring Return	
Finding:	
The Scottish Government (SG) Annual Monitoring Return update to the 20 July 2023 SGC advised that the same 'streamlined' approach would be adopted for the 2022/23 return as in 2021/22, with the SG providing feedback on topics it feels Boards should concentrate on. The SGC was advised of SG feedback on the 2021/22 Return and areas that NHS Fife may wish to feed into the Staff Governance Plan and subsequent Return for 2022/2023. An example included feedback received from iMatter roadshows 'Have a natter because iMatter'. The SGC has not been advised as to whether the reported matters have been progressed and these areas do not feature specifically in the 2022/23 Annual Monitoring return presented to the 9 November 2023 SGC meeting.	
Audit Recommendation:	
Future updates to the SGC within the Annual Monitoring Return should include an update on action to address SG feedback from previous years.	
Assessment of Risk:	
Merits attention 	There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**
Management Response/Action:	
We note the recommendations and will work with the Staff Governance Committee chair to progress the necessary updates	
Action by:	**Date of expected completion:**
Director of Workforce	**31 March 2024**

FINANCIAL GOVERNANCE

Corporate Risks:

Risk 13 Delivery of a Balanced In-Year Financial Position – High Risk (16); Target (8) Moderate by March 2025 – Above Risk Appetite

There is a risk that due to the ongoing impact of the pandemic combined with the very challenging financial context both locally and nationally, the Board will not achieve its statutory financial revenue budget target in 2023/24 without further planned brokerage from Scottish Government.

Risk 14 Delivery of Recurring Financial Balance over the Medium-Term – High Risk (16); Target (12) Moderate by March 2024 – Above Risk Appetite

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

Risk 15 Prioritisation & Management of Capital Funding – Moderate (12); Target (8) Moderate by April 2026 – Within Risk Appetite

There is a risk that lack of prioritisation and control around the utilisation of limited capital and staffing resources will affect our ability to deliver the PAMS and to support the developing Population Health and Wellbeing Strategy.

Medium Term Financial Plan (MTFP)

The SG issued formal guidance on financial planning covering the financial years 2023/24 to 2025/26 with final plans to be submitted to SG by 16 March 2023. The guidance required that Boards currently unable to deliver financial balance in 2022-23 without support from SG develop a Financial Recovery Plan to demonstrate how balance will be achieved within three years.

In agreement with SG, NHS Fife developed a 5-year plan on the basis that it provides a more realistic and credible timescale within which NHS Fife can achieve financial sustainability and commence brokerage repayments for the financial support received in the years 2022/25.

The MTFP was endorsed by the FPRC (Reserved Business) on 14 March 2023, followed by Board approval (Reserved Business) on 28 March 2023. It provides clarity on funding and expenditure assumptions with areas of greatest risk and uncertainty highlighted. It presents a range of potential scenarios which demonstrate the impact of changes to key parameters, with a £10.9m financial gap identified for 2023/24.

MFTP – SG Response and Brokerage Required

The SG acknowledged the position outlined in the MTFP in March 2023, with the Board advised to undertake the following actions:

- Provide an update on progress against actions set out in the financial recovery plan, including the work carried out in collaboration with the IJB and regional partners.
- Develop a plan to deliver 3% recurring savings in 2023-24 and develop options to meet any unidentified or high-risk savings balance.
- Develop other measures to be taken to further reduce the financial gap.
- Review key underlying drivers of the deficit and specific risks as presented within the Financial Plan.
- Focus on addressing Covid-19 legacy costs, including additional bed capacity.

The NHS Fife Financial Improvement and Sustainability Programme aims to mitigate the financial gap and deliver against the SG actions. Financial reporting to the Board and FPRC has highlighted that currently there is a high possibility that NHS Fife will require a level of brokerage from the SG

to deliver the identified financial gap of £10.9m it is however now clear that the in-year financial gap is materially increasing, the latest forecast is £23m, this position has been reported to NHS Fife Board and SG. The Board will work towards reducing the final level of brokerage where that is possible.

Internal Audit Annual Report 2022/23 (B06/24) previously highlighted that "*NHS Fife Board needs to assure itself that it has the capacity and capability sufficient to drive strategy, and the associated transformation programme as well as delivering savings of £15m a year*." NHS Fife needs to ensure it has the capacity to drive forward required savings, if it is to have any chance of avoiding the use of further brokerage in 2023/24 and onwards.

Current Financial Position for the period to 30 September 2023

Finance reporting to Board and FPRC has been transparent, and the Director of Finance and Strategy has consistently and clearly articulated financial challenges through EDG, Standing Committees and the Board.

The MTFP reports an underlying deficit of £25.9m with a £15m cost improvement plan and a projected residual gap of £10.9m for 2023/24. A £15.9m revenue overspend was reported for the six months to the end of September 2023. The financial report reflects the continuing impact of the historic and emerging financial pressures set out in the medium-term financial plan and, more importantly, reflects the limited progress to deliver against the agreed £15m cost improvement programme.

The overall financial overspend of £15.9m incudes extra funding allocations of £7.5m pro rata for the period to September 2023 (full year £15.1m) which, if they had not been received, would have substantially impacted the current overspend.

The SG has highlighted in recent letters to NHS Fife, following Quarter 1 results and the forecast year end position, that NHS Fife need to identify more actions between now and the financial year end to improve the forecast outturn and move towards break even.

Cost Improvement Plans (Savings)

In line with national expectations and highlighted above, a 3% cost reduction target was allocated across the Board core revenue resource limit which included the funds delegated to the Fife H&SCP. A cost improvement target of £4.6m was delegated to the partnership and the remaining £15m is the responsibility of NHS Fife to deliver.

The Financial Improvement and Sustainability (FIS) Board meets monthly. The update on the status of the FIS Programme to the end of September 2023 noted that £5.38m of cost improvement plans was confirmed as delivered, however only £2.56m is confirmed on a recurring basis. The absence of recurring savings will impact on subsequent years.

The MTFP savings identified £10m of temporary staff reduction and £5m of surge capacity reduction. The spend on temporary staffing has remained high and as highlighted in financial reports spending this year, this is more than last year, with only £0.31m confirmed savings. Initial plans to reduce surge capacity have not materialised and the Director of Finance has reported that savings will not be made in this area due to ongoing pressures within Acute Services. Other areas have been identified as providing savings but as of September 2023, £9.62m remains as unconfirmed.

The FIS report to the November 2023 FPRC refocused the approach to recovery options in 2023/24 (Horizon 1), for example, introducing a different approach to achieve supplementary staffing reduction with a "*focus on determining the impact and effectiveness of the additional measures taken over the past 12 months to increase substantive staffing to enable a reduction in premium cost agency staffing*". Further work (Horizon 2) is planned to assess the viability of a range of other options to deliver greater value and, where possible, achieve cost reductions over the medium

term, with options including Service Redesign, Estates Review, Reducing Corporate Overheads, Optimising Digital Opportunities and review of Waste systems. Horizon 3 will aim to drive forward the Values Based Healthcare discussion with clinicians to determine whether there are opportunities to realise greater value from the c£900m revenue budget based on considering how services might be delivered in the future.

Savings identified within the FIS Programme are currently operational rather than strategic in nature. Now that the PHWS has been approved and in-year and medium term plans are in place, the linkage of future cost improvement programmes to the operational delivery of the PHWS should be made explicit within future reporting.

Finance Risk Reporting Revenue

There are two corporate financial risks, one for in year delivery of the financial plan and the second related to the longer-term financial plan.

The update provided to the FPRC in November 2023 for Risk 13 - Delivery of a balanced in-year financial position noted the position '*has materially deteriorated in Q2 with very limited progress against the in-year cost reduction target. This position has been reviewed to determine actions which can be taken to reduce the level of forecast overspend. Despite ongoing attempts to reduce costs and a commitment to avoid any additional investment in our services, it is highly likely that the Board will require significant financial brokerage to break-even*'.

We commend the openness of the reporting of the financial position and the forewarning that brokerage will likely be required. We recommend that both target and actual risk scores are reviewed, to ensure they fully reflect the deterioration in the financial position and the challenging environment. The target risk scores due to be achieved by 31 March 2024 appear to be optimistic in the circumstances.

We reiterate our view from the Internal Audit Annual Report 2022/23 (B06/24) that the organisation must assure itself that it has both capacity and can affect cultural change sufficient to deliver the required level of savings in addition to business as usual. Key actions should follow from the production of the PHWS in terms of prioritisation and service change.

Property Asset Management, Net Zero and Capital Risk

In September 2023 NHS Fife Board approved the Whole System Property and Asset Management Strategy, developed from the previous Property Asset Management Strategy. This new Strategy demonstrates links to the PHWS. It is anticipated that the SG will request a 'Whole System Initial Agreement' and this new Property Strategy provides the strategic direction to develop this approach.

The capital plan for 2023/24 was approved in March 2023 as part of the MTFP. Reporting of the capital plan to the FPRC is frequent, with the latest report in November 2023 highlighting no significant risks but issues remain with long lead in times within the supply chain and continued inflationary challenges.

The new strategy highlights the importance of Net Zero, having started the process of creating net-zero carbon road maps for all NHS Fife sites as part of its building energy transition programme. This will show what NHS Fife needs to do to achieve net-zero emissions and the costs associated with that.

The Prioritisation & Management of Capital funding risk is reported to the FPRC, and a Deep Dive is due to be presented to the January 2024 meeting. As part of this we would expect an assessment is provided on the adequacy and effectiveness of key controls and actions.

Asset Verification

Physical checking of a sample of assets is a management requirement within the NHS Fife Financial Operating Procedures. Internal Audit have been provided with evidence that physical checking of equipment has been undertaken during the financial year to date.

INFORMATION GOVERNANCE

Information Governance

Corporate Risks:

Risk 17 – Cyber Resilience – High Risk (16); Target (12) Moderate by September 2024 – Above Risk Appetite

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

Risk 18 – Digital and Information – High Risk (15);Target (8) Moderate by April 2025 – Above Risk Appetite

There is a risk that the organisation maybe unable to sustain the financial investment necessary to deliver its D&I Strategy and as a result this will affect our ability to enable transformation across Health and Social Care and adversely impact on the availability of systems that support clinical services, in their treatment and management of patients.

Governance and Assurance

The Information Governance and Security Steering Group (IG&SSG) and Digital and Information Board (D&IB) continue to provide assurance to the CGC. The latest IG&S update was presented to CGC in September 2023, with a further update scheduled for March 2023. Updates on the D&I Strategy were provided to CGC in July and November 2023.

The IGS Accountability and Assurance Framework Report has been developed following a mapping exercise between the Scottish Public Sector Cyber Resilience framework and the ICO Accountability Framework and is presented to each meeting of the IG&SSG. Whilst we commend this approach, further development is required as only three of the 10 categories reported have fully defined performance metrics defined and only one of the 10 categories includes cross reference to the risks associated with it. The IG&SSG has been informed that work is underway to address these issues, but no definitive timeline has been communicated.

The Terms of Reference for both the IG&SSG and D&I Board require papers to be issued at least 5 clear days before the meetings but this has not been happening. Some papers have been delivered as presentations at the meeting without having been sent to members in advance. This should be remedied to ensure compliance with the ToR.

Risk Management – IG&SSG and D&I

The management of IG&S risks is reported to each IG&SSG meeting within the IGS Accountability and Assurance Framework Report and is included in the updates to CGC twice a year. A risk report is also presented to each D&IB and there is some commonality of risks in the reports presented to IG&SSG and D&IB.

The latest risk reporting to IG&SSG and D&IB shows that there are a total of 48 risks with 11 scored as high, 27 as medium and 10 scored as low. The graphical representations showed that 23 risks had improved scores since the last report, 24 had remained static and 1 had deteriorated.

Summary information is also provided indicating the total number of risks in each category across D&I with the number within (35%) and outwith (65%) the risk appetite highlighted. The report does not currently include commentary on whether the actions underway and planned will be sufficient to bring these risks within the risk appetite in an acceptable timescale.

Corporate Risks

The two Information Governance corporate risks have been aligned to the CGC for scrutiny and Deep Dives are reported. A deep dive into risk 18 – D&I Strategy was presented to CGC on 3 November 2023 and a deep dive into risk 17 Cyber Resilience is to be presented to the 12 January 2024 meeting. In common with other areas of risk management the format of the deep dives should be improved to address our annual report (B06/24) recommendations.

Although the scores on the corporate risks associated with IG&S have remained static in the year to date, there is evidence of actions being progressed to reduce these towards their target scores and the latest reporting includes a timescale for reaching the target level.

Digital and Information Strategy

The D&I Strategy update to the CGC on 3 November 2023 included analysis of delivery and clearly shows items partially or not delivered. It also identified themes for the next iteration of the strategy and confirmed that this will be supported by a financial framework.

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

Information Governance Responsibilities

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

Information Governance Policies and Procedures

The status of IG related policies is reported to IG&SSG in the IGS Accountability and Assurance Framework Report with the most recent report presented in October 2023 indicating that all 7 of the 8 policies were within their review date (87.5%). The exception being GP/D3 – NHS Fife Information Governance and Data Protection Core Policy which has a review date August 2023. The IGS Accountability and Assurance Framework Report states that this policy has been reviewed and is available for consultation.

Information Governance Incidents and Reporting

Updates on IG&S incident management are reported to each IG&SSG meeting and to the CGC twice per year. The most recent update to CGC on 3 November 2023 included:

- the number of IG&S incidents reported via DATIX
- the number of IG&S incidents reported to the ICO or Competent Authority, the number of these reported within the required 72-hour timescale and the number that required follow-up by the ICO.

At its meeting on 10 October 2023 the IG&SSG received an update on an incident where an imposter obtained personal identifiable information. This resulted in a reprimand from the ICO, which is the tier of ICO enforcement action below monetary penalties and can include publication of the reprimand on the ICO website. The IG&SSG agreed that the reports from the SAER would be provided to the IG&SSG for consideration before this incident would be highlighted to CGC outlining the issue would warrant disclosure in the Board's Governance Statement.

Action Point Reference 4 – Assurance Reporting to IG&SSG

Finding:

The IGS Accountability and Assurance Framework Report includes ten categories but while the IG&SSG have been advised that performance metrics are being developed for these, the group have not been informed of a timescale for completion of this and to date only three of the categories have fully established performance metrics defined.

Papers to the IG&SSG and the D&I Board has not always been timely and some papers have been delivered as presentations at the meeting without being distributed. The terms of reference for both IG&SSG and D&I Board state that the papers will be issued at least 5 clear days before the meetings, but this has not been happening in practice.

Audit Recommendation:

IG&SSG should be provided with a timescale by which the IGS Accountability and Assurance Framework Report will be improved to include:

- fully established performance measures for each category reported in the framework
- completed risk sections for each category in framework report including cross referencing to the ID of risk in DATIX and to the improvement actions that will reduce the risk score.

The timing of the issue of papers to IG&SSG and D&I Board members should be monitored, and action taken to ensure that the papers are provided to members at least 5 days before the meeting dates.

Assessment of Risk:

Merits attention		There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**

Management Response/Action:

The performance measures will be established throughout the remainder of 2023-24. While the measures can be developed the ability to report on these in a consistent and efficient manner will need to be established.

The IG&S Accountability Framework will be updated to include the relevant risk summary.

The timing of the issue of papers will be monitored.

Action by:	Date of expected completion:
Associate Director of Digital and Information	**30 April 2024**

Action Point Reference 5 – IG&S Incident Management Assurance

Finding:

At its meeting on 10 October 2023 the IG&SSG received an update on an incident where an imposter obtained personal identifiable information. This resulted in a reprimand from the ICO, which is the tier of ICO enforcement action below monetary penalties and can include publication of the reprimand on the ICO website. The IG&SSG agreed that this incident would warrant disclosure in the Board's Governance Statement, however, the report and findings from the SAER group would need to be issued to the IG&SSG prior to the item being highlighted to the CGC.

Audit Recommendation:

Our existing recommendation in ICE 2022-23 (B08/23 point 10) relates to including a conclusion in the incident management part of the update report to CGC from IG&SSG regarding whether any of the incidents being managed are likely to require a disclosure in the Board's Governance Statement. Having considered the breach referred to above the approach to reporting on information governance and security breaches should be strengthened to ensure that:

- The IG&SSG consider whether any of the breaches being reported are likely to require to be disclosed in the Board's Governance statement
- CGC are informed at the earliest opportunity regarding any breaches that are likely to require a disclosure in the Board's Governance Statement
- These steps are reflected in the relevant policies and procedures.

Assessment of Risk:

Merits attention		There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**

Management Response/Action:

The Incident reporting element to the IG&SSG will consider if any of the breaches are likely to require disclosure in the Board's Governance statement.

Through identification of these breaches the IG&SSG will consider the necessary escalation to the CGC.

Action by:	Date of expected completion:
Associate Director of Digital and Information	**30 April 2024**

Assessment of Risk

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

Fundamental		Non Compliance with key controls or evidence of material loss or error. **Action is imperative to ensure that the objectives for the area under review are met.**	**None**
Significant		Weaknesses in design or implementation of key controls i.e. those which individually reduce the risk scores. **Requires action to avoid exposure to significant risks to achieving the objectives for area under review.**	**None**
Moderate		Weaknesses in design or implementation of controls which contribute to risk mitigation. **Requires action to avoid exposure to moderate risks to achieving the objectives for area under review.**	**One**
Merits attention		There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**	**Four**

NHS Fife

External Audit Annual Plan

Year ended 31 March 2024

December 2023

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Introduction

Purpose

This audit plan highlights the key elements of our proposed audit strategy and provides an overview of the planned scope and timing of the statutory external audit of NHS Fife for the year ended 31 March 2024 for those charged with governance.

Our audit work will cover:

- the financial statements within the 2023/24 annual report and accounts
- the wider scope of public audit
- any other work requested by Audit Scotland.

Adding Value through the Audit

All of our clients demand of us a positive contribution to meeting their ever-changing business needs. Our aim is to add value to the Board through our external audit work by being constructive and forward looking, by identifying areas of improvement and by recommending and encouraging good practice. In this way, we aim to help the Board promote improved standards of governance, better management and decision making and more effective use of resources.

Feedback

If there are any elements of this audit plan to which you do not agree or you would like to discuss, please let us know as soon as possible.

Any comments you may have on the service we provide, the quality of our work, and our reports would be greatly appreciated at any time. Comments can be reported directly to any member of your audit team.

This plan has been prepared for the sole use of those charged with governance and management and should not be relied upon by third parties. No responsibility is assumed by Azets Audits Services to third parties**.**

Openness and transparency

This report will be published on Audit Scotland's website http://www.audit-scotland.gov.uk/

Audit scope and general approach

Responsibilities of the auditor and the Board

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

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

The Board has primary responsibility for ensuring the proper financial stewardship of public funds. This includes preparing a set of annual report and accounts that are in accordance with proper accounting practices. The Board is also responsible for complying with legislation and putting arrangements in place for governance and propriety that enable it to successfully deliver its objectives.

Appendix 3 provides further details of our respective responsibilities.

Risk-based audit approach

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

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

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

Communication with those charged with governance

Auditing standards require us to make certain communications throughout the audit to those charged with governance. These communications will be through the Audit and Risk Committee.

Partnership working

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

Our Audit Scotland appointments include Fife Integration Joint Board and Fife Council. Where practicable and appropriate we will share knowledge between our teams to generate efficiencies in the delivery of our audits.

Audit Scotland

Although we are independent of Audit Scotland and are responsible for forming our own views and opinions, we do work closely with Audit Scotland throughout the audit. This helps identify common priorities and risks, treat issues consistently across the sector, and improve audit quality and efficiency. We share information about identified risks, good practices and barriers to improvement so that lessons to be learnt and knowledge of what works can be disseminated to all relevant bodies.

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

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

Shared systems and functions

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

Delivering the audit

Hybrid audit approach

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

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

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

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

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

Secure sharing of information

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

Regular contact

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

Signing annual accounts

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

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

Approach to audit of the financial statements

Our objective when performing an audit is to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement and to issue an independent auditor's report that includes our auditor's opinion.

As part of our risk-based audit approach, we will:

- Perform risk assessment procedures including updating our understanding of the Board, including its environment, the financial reporting framework and its system of internal control;
- Review the design and implementation of key internal controls;

- Identify and assess the risks of material misstatement, whether due to fraud or error, at the financial statement level and the assertion level for classes of transaction, account balances and disclosures;
- Design and perform audit procedures responsive to those risks, to obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion; and
- Exercise professional judgment and maintain professional scepticism throughout the audit recognising that circumstances may exist that cause the financial statements to be materially misstated.

Materiality

"Reasonable assurance", referred to above, is a high level of assurance, but is not a guarantee that an audit will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. We include an explanation in the auditor's report of the extent to which the audit was capable of detecting irregularities, including fraud, and respective responsibilities for prevention and detection of fraud.

We apply the concept of materiality in planning and performing the audit, and in evaluating the effect of misstatements within the financial statements identified during the audit.

Judgments about materiality are made in the light of surrounding circumstances and are affected by our perception of the financial information needs of users of the financial statements, and by the size or nature of a misstatement, or a combination of both. The basis for our assessment of materiality for the year is set out in Appendix 1.

Any identified errors greater than £0.3million will be recorded and discussed with you and, if not adjusted, confirmed as immaterial as part of your letter of representation to us.

Accounting systems and internal controls

We will follow a substantive testing approach to gain audit assurance rather than relying on tests of controls. As part of our work, we consider certain internal controls relevant to the preparation of the annual accounts such that we are able to design appropriate audit procedures. However, this work will not cover all internal controls and is not designed for the purpose of expressing an opinion on the effectiveness of internal controls. If we identify significant deficiencies in controls, we will report these to you in writing.

Specialised skill or knowledge required to complete the audit

Our audit team will consult internally with our Technology Risk team in:

- Assessing the information technology general controls (ITGC)
- Reviewing the service auditor report findings and following up on any recommendations.

Going Concern

In most public sector entities (including health boards), the financial reporting framework envisages that the going concern basis for accounting will apply where the entity's services will continue to be delivered by the public sector. In such cases, a material uncertainty related to going concern is unlikely to exist.

For many public sector entities, the financial sustainability of the entity is more likely to be of significant public interest than the application of the going concern basis. Our wider scope audit work considers the financial sustainability of the Board.

Prevention and detection of fraud or error

In order to discharge our responsibilities regarding fraud and irregularity we require any fraud or irregularity issues to be reported to us as they arise. In particular we require to be notified of all frauds which:

- Involve the misappropriation of theft of assets or cash which are facilitated by weaknesses in internal control and;
- Are over £5,000.

We also require a historic record of instances of fraud or irregularity to be maintained and a summary to be made available to us after each year end.

National Fraud Initiative

The National Fraud Initiative (NFI) in Scotland is a biennial counter fraud exercise led by Audit Scotland working together with a range of Scottish public bodies, external auditors and overseen by the Cabinet Office for the UK as a whole. The most recent NFI exercise commenced in 2022 and most matches should have been investigated by 30 September 2023. As part of our 2023/24 audit, we will monitor the Board's participation and progress in the NFI.

Anti-money laundering

We require the Board to notify us on a timely basis of any suspected instances of money laundering so that we can inform Audit Scotland who will determine the necessary course of action.

Reporting our findings

At the conclusion of the audit we will issue:

- an independent auditor's report setting out our formal audit opinions within the annual report and accounts, and
- an annual audit report describing our audit findings, conclusions on key audit risks, judgements on the pace and depth of improvement on the wider scope areas, and any recommendations.

Definitions

We will use the following gradings to provide an overall assessment of the arrangements in place as they relate to the wider scope areas. The text provides a guide to the key criteria we use in the assessment, although not all of the criteria may exist in every case.


There is a fundamental absence or failure of arrangements
There is no evidence to support necessary improvement
Substantial unmitigated risks affect achievement of corporate objectives.
Arrangements are inadequate or ineffective
Pace and depth of improvement is slow
Significant unmitigated risks affect the achievement of corporate objectives
No major weaknesses in arrangements but scope for improvement exists
Pace and depth of improvement are adequate
Risks exist to the achievement of operational objectives
Effective and appropriate arrangements are in place
Pace and depth of improvement are effective
Risks to the achievement of objectives are managed

Financial statements - significant audit risks

Significant risks are risks that require special audit consideration and include identified risks of material misstatement that:

- Our risk assessment procedures have identified as being close to the upper range of the spectrum of inherent risk due to their nature and a combination of the likelihood and potential magnitude of misstatement; or
- Are required to be treated as significant risks due to requirements of ISAs (UK), for example in relation to management override of internal controls.

Significant risks at the financial statement level

The table below summarises significant risks of material misstatement identified at the financial statement level. These risks are considered to have a pervasive impact on the financial statements as a whole and potentially affect many assertions for classes of transaction, account balances and disclosures.

Management override of controls	Audit approach
Auditing Standards require auditors to treat management override of controls as a significant risk on all audits. This is because management is in a unique position to perpetrate fraud by manipulating accounting records and overriding controls that otherwise appear to be operating effectively. Although the level of risk of management override of controls will vary from entity to entity, the risk is nevertheless present in all entities. Due to the unpredictable way in which such override could occur, it is a risk of material misstatement due to fraud and thus a significant risk. Specific areas of potential risk include manual journals, management estimates and judgements and one-off	Procedures performed to mitigate risks of material misstatement in this area will include: • Documenting our understanding of the journals posting process and evaluating the design effectiveness of management controls over journals. • Analysing the journals listing and determining the criteria for selecting high risk and/or unusual journals. • Testing high risk and/or unusual journals posted during the year and after the draft accounts stage back to supporting documentation for appropriateness, corroboration and to ensure approval has been undertaken in line with the Board's journals policy.

Management override of controls	Audit approach
transactions outside the ordinary course of the business. **Risk of material misstatement: Very High**	• Gaining an understanding of the key accounting estimates and critical judgements made by management. We will challenge assumptions and consider for reasonableness and indicators of bias which could result in material misstatement due to fraud. • Evaluating the rationale for any changes in accounting policies, estimates or significant unusual transactions.

Significant risks at the assertion level for classes of transaction, account balances and disclosures

Fraud in revenue recognition	Audit approach
Material misstatement due to fraudulent financial reporting relating to revenue recognition is a presumed risk in ISA 240 (The Auditor's Responsibilities Relating to Fraud in an Audit of Financial Statements). The presumption is that the Board could adopt accounting policies or recognise income in such a way as to lead to a material misstatement in the reported financial position. Given the financial pressures facing the public sector as a whole, there is an inherent fraud risk associated with the recording of income around the year end. In respect of Scottish Government funding, however, we do not consider the revenue recognition risk to be significant due to a lack of incentive and opportunity to manipulate revenue of this nature. The risk of fraud in relation to revenue recognition is however present in all other income streams. **Inherent risk of material misstatement:** **Revenue (occurrence/completeness): High**	We will perform the below procedures based on their value within the financial statements: • Documenting our understanding of the Board's systems for income to identify significant classes of transactions, account balances and disclosures with a risk of material misstatement in the financial statements. • Evaluating the design of the controls in the key accounting systems, where a risk of material misstatement was identified, by performing a walkthrough of the systems. • Obtained evidence that income is recorded in line with appropriate accounting policies and the policies have been applied consistently across the year. • Substantively testing material income streams using analytical procedures and sample testing of transactions recognised for the year.

Fraud in non-pay expenditure	Audit approach
As most public sector bodies are net expenditure bodies, the risk of fraud is more likely to occur in expenditure. There is a risk that expenditure may be misstated resulting in a material misstatement in the financial statements. Given the financial pressures facing the public sector as a whole, there is an inherent fraud risk associated with the recording of expenditure around the year end leading to a material misstatement in the reported financial position. **Inherent risk of material misstatement:** • **Non-pay expenditure (occurrence/completeness): High** • **Accruals (existence/completeness): High**	We will perform the below procedures based on their value within the financial statements: • Documenting our understanding of the Board's systems for expenditure to identify significant classes of transactions, account balances and disclosures with a risk of material misstatement in the financial statements. • Evaluating the design of the controls in the key accounting systems, where a risk of material misstatement was identified, by performing a walkthrough of the systems. • Obtained evidence that expenditure is recorded in line with appropriate accounting policies and the policies have been applied consistently across the year. • Substantively testing material expenditure streams using analytical procedures and sample testing of transactions recognised for the year. • Reviewing accruals around the year end to consider if there is any indication of understatement of balances held through consideration of accounting estimates.

Refinancing of commitments under PFI contracts	Audit approach
The Board has two PFI contracts: 1.Community Hospital and Health Centre in St Andrews. The contract is for a period of 30 years commencing 31 July 2009. 2.Phase 3 of the Victoria Hospital site in Kirkcaldy. The contract is for a period of 30 years commencing 28 October 2011. These initiatives are recognised as non-current assets on the Board's balance sheet with net book value as at 31 March 2023 of £27million and £189million respectively. The Board identified PFI hospitals, which are inflation linked as a key cost pressure affecting the Board in 2022/23. In January 2023, a proposal for the re-financing of PFIs was approved as part of the Financial Improvement and Sustainability Programme. The deal on the re-financing agreement is expected to close in November 2023. Due to the complexity of accounting and the high value of the transactions, there is a risk that the Board's financial statements do not show the correct accounting entries and related commitments for the PFI refinancing, and that the unitary	Procedures performed to mitigate risks of material misstatement in this area will include: • Documenting our understanding of the structure of the Board's re-financed PFI contracts, including the models, and how these are accounted for. • Documenting our understanding of the wider financial implications which the re-financing decision has on the Board. • Reviewing the Board's calculation of unitary payments. • Reviewing the Board's compliance with the FReM and NHS Manual for Accounts regarding PFI contract re-financing.

Refinancing of commitments under PFI contracts	Audit approach
payments in relation to these facilities are not correctly accounted for. **Inherent risk of material misstatement:** • **PPP assets (valuation) : High** • **Lease liabilities (valuation): High** • **Expenditure (valuation): High**	

Valuation of land and buildings (key accounting estimate)	Audit approach
NHS Fife held land and buildings with a net book value of £507million at 31 March 2023, with external valuations on a five-year rolling basis. There is a significant degree of subjectivity in the measurement and valuation of land and buildings. This subjectivity and the material nature of the Board's asset base represents an increased risk of misstatement in the financial statements. **Inherent risk of material misstatement:** **Land & Buildings (valuation): Very High**	Procedures performed to mitigate risks of material misstatement in this area will include: • Evaluating management processes and assumptions for the calculation of the estimates, the instructions issued to the valuation experts and the scope of their work. • Evaluating the competence, capabilities and objectivity of the valuation expert. • Considering the basis on which the valuation is carried out and challenging the key assumptions applied. • Testing the information used by the valuer to ensure it is complete and consistent with our understanding. If there have been any specific changes to the assets in the year, we will ensure these have been communicated to the valuer. • Ensuring revaluations made during the year have been input correctly to the fixed asset register and the accounting treatment within the financial statements is correct.

IFRS 16 implementation for PPP- / PFI arrangements (key accounting estimate)	Audit approach
The mandatory adoption of IFRS 16 for PPP/PFI arrangements was implemented for NHS bodies from 1 April 2023. Under the new approach, there is an expectation that NHS bodies recognise variable lease payments, which are dependent on an index/ discount rate being applied on both transition and subsequent measurement, with changes needing to be accounted for appropriately. Therefore, there is an increased risk to the organisation that the incorrect rate is used when determining the lease payment. There is also an increased risk in respect of completeness of liabilities identified by the organisation on transition from IAS17 to IFRS16. **Inherent risk of material misstatement:** **Lease liabilities (valuation):High**	Procedures performed to mitigate risks of material misstatement in this area will include: • Reviewing the completeness and accuracy of the data collected by the Board and used as part of implementation of IFRS 16 for PPP/PFI arrangements. • Reviewing the appropriateness of the discount rate used in the calculation of the lease liability. • Reviewing the appropriateness of the remeasurement of the lease liability resulting from a change in an index/rate used to determine those payments. • Reperforming the calculation of the lease liability and right of use asset for PPP/PFI arrangements with aide from the NHS Bodies PFI Model. • Reviewing the accounting entries for both transition and subsequent measurement of the Board's PPP/ PFI arrangements to ensure they are in line with IFRS16 and the requirements of the Financial Reporting Manual (FReM), NHS Manual for Accounts and Scottish Government guidance. • Reviewing the accounting policy and related disclosures for IFRS 16 in line with the requirements of the Financial Reporting Manual (FReM), NHS Manual for Accounts and Scottish Government guidance.

Provisions – CNORIS (key accounting estimate)	Audit approach
The Board's financial statements include provision for legal obligations in respect of participation in CNORIS (Clinical Negligence and Other Risks Indemnity Scheme). There is a significant degree of subjectivity in the measurement and valuation of these provisions. This subjectivity represents an increased risk of misstatement in the financial statements. **Inherent risk of material misstatement:** **Provisions (Valuation): High**	Procedures performed to mitigate risks of material misstatement in this area will include: • Reviewing management's estimation for the provision and related disclosures. • Considering compliance with the requirements of the FreM and NHS Manual for Accounts. • Considering the competence, capability and objectiveness of the management expert.

The wider scope of public audit

Introduction

The Code of Audit Practice frames a significant part of our responsibilities in terms of four wider scope audit areas:

- Financial sustainability
- Financial management
- Vision, leadership and governance
- Use of resources to improve outcomes.

Our audit approach to the wider scope audit areas

Appointed auditors are required to consider the wider scope areas when:

- identifying significant audit risks at the planning stage of the audit
- reaching conclusions on those risks
- making recommendations for improvement
- where appropriate, setting out conclusions on the audited body's performance.

When reporting on such arrangements, the Code of Practice requires us to structure our commentary under the four areas identified above. Appendix 3 provides further detail on the definition, scope and audit considerations under each wider scope area.

Our planned audit work against these four areas is risk based and proportionate. Our initial assessment builds upon our understanding of the Board's key priorities and risks along with discussions with management and review of board and committee minutes and key strategy documents.

We have identified two significant risks in relation to financial sustainability and financial management as set out in the table below. At this stage, we have not identified any significant risks in relation to the other wider scope areas. Audit planning is a continuous process and we will report all identified significant risks, as they relate to the four wider scope areas, in our annual audit report.

Wider scope significant risks

Financial sustainability
The Board's medium term financial plan was approved by the Finance, Performance and Resources Committee and Board in March 2023. The plan shows a cumulative financial gap, before mitigations, of £73.195million over the period 2023/24 to 2027/28. A breakeven position for 2023/24 and 2024/25 and a surplus from 2025/26 onwards is forecast; however, this is subject to the delivery in full of challenging cost improvement plans and receipt of brokerage in 2023/24 and 2024/25. Work is currently ongoing to review planning assumptions to reflect the current financial environment which the Board operates in, as part of development of the 2024/25 budget and revised medium term financial plan. NHS Fife continues to face major risks to achieving financial balance while responding to the unprecedented challenges of recovering from the COVID-19 pandemic. Due to risk and uncertainty in relation to funding levels, workforce-related cost pressures and delivery of cost improvement programmes, the board's ability to deliver services in a sustainable manner remains a significant challenge and risk.
Our audit response: During our audit we will review whether the Board has appropriate arrangements in place to manage its future financial position. Our work will include an assessment of progress made in developing financially sustainable plans which reflect the medium and longer term impact of cost pressures and that continue to support the delivery of the Board's statutory functions and strategic objectives.

Financial management
Financial brokerage of £9.728million was required from the Scottish Government to allow NHS Fife to achieved its financial targets in 2022/23. In March 2023, the Board approved the 2023/24 financial plan which showed a projected budget gap of £10.9million after an ambitious cost improvement plan totalling £15million. The latest forecast (October 2023) projected a deficit of £22million, resulting from a high level of challenge associated with delivering the in-year savings target in full and an increasing level of spend on supplementary medical and nursing staff when compared to previous years. As at October 2023, only £5.608million of the £15million cost improvement plan had been delivered. There is a continued risk that the 2023/24 financial target will not be achieved and a higher level of brokerage than outlined in the approved financial plan will be required to achieve financial balance.
Our audit response: During our audit we will consider the Board's approach to identifying and responding to financial challenges that have occurred during the year.

In formulating our audit plan, we identified areas of possible significant risk in relation to vision, leadership and governance and use of resources to improve outcomes. Our audit approach will include reviewing and concluding on the following considerations to substantiate whether significant risks exist:

Vision, leadership and governance

- The progress made by the Board in implementing and delivering the Population Health and Wellbeing Strategy;
- Whether the Board can demonstrate that the governance arrangements in place are appropriate and operating effectively;
- Whether inductions and ongoing training arrangements for new board members support effective scrutiny and challenge;
- The transparency of decision-making, financial reporting and performance data and;
- Reasonableness and consistency of the governance statement in relation to other information gathered during our audit.

Use of resources to improve outcomes

- Whether the Board can evidence the achievement of value for money in the use of resources;
- How the Board demonstrates a focus on continuous improvement in the context of continuing and significant financial and operational challenge and;
- The Board's service recovery from the COVID-19 pandemic including pandemic related backlog challenges.

Audit team and timetable

Audit Team

Our audit team will be as follows:

Role	Name	Email
Key Audit Partner	Chris Brown	Chris.Brown@azets.co.uk
Engagement Manager	Andrew Ferguson	Andrew.Ferguson@azets.co.uk
Auditor in Charge	Amy Hughes	Amy.Hughes@azets.co.uk

Timetable

Please find below confirmation of our proposed timetable for the audit as previously discussed with management:

Role	Name
Audit planning meeting	24 November 2023
Audit Committee to consider audit plan	13 December 2023
Interim audit	February 2024
Receipt of draft accounts and commencement audit fieldwork	May 2024
Audit Committee to consider accounts and audit report	20 June 2024
Board meeting to approve accounts for signing	20 June 2024
Deadline for submission of signed accounts to SG	30 June 2024

Our Requirements

The audit process is underpinned by effective project management to co-ordinate and apply our resources efficiently to meet your deadlines. It is essential that the

audit team and the Board's finance team work closely together to achieve the above timetable.

In order for us to be able to complete our work in line with the agreed fee and timetable, we require the following:

- Draft financial statements of a good quality by the deadlines you have agreed with us. These should be complete including all notes, the performance report and the accountability report;
- Good quality working papers at the same time as the draft financial statements. These will be discussed with you in advance to ensure clarity over our expectations;
- Ensuring staff are available and on site (as agreed) during the period of the audit;
- Prompt and adequate responses to audit queries.

Audit independence and objectivity

Auditor Independence

We are required to communicate on a timely basis all facts and matters that may have a bearing on our independence.

In particular, FRC's Ethical Standard stipulates that where an auditor undertakes non audit work, appropriate safeguards must be applied to reduce or eliminate any threats to independence.

Azets has not been appointed to provide any non-audit services during the year. We confirm that we comply with FRC's Ethical Standard. In our professional judgement, the audit process is independent and our objectivity has not been compromised in any way. In particular there are and have been no relationships between Azets and the Board, its Board members and senior management that may reasonably be thought to bear on our objectivity and independence

We have considered our integrity, independence and objectivity in respect of audit services provided and we do not believe that there are any significant threats or matters which should be brought to your attention.

Other threats and safeguards

Other potential threats for which we have applied appropriate safeguards include:

Other threats to objectivity and independence	Safeguard
An Azets employee's father is a senior employee at NHS Fife (and disclosed in the Remuneration Report).	We confirm that we have implemented internal safeguards to ensure this employee has no involvement in our audit work and that no members of staff working on the audit discuss any aspects of the audit with them.

Appendices

Appendix 1: Materiality

Whilst our audit procedures are designed to identify misstatements which are material to our audit opinion, we also report to those charged with governance and management any uncorrected misstatements of lower value errors to the extent that our audit identifies these.

Under ISA (UK) 260 we are obliged to report uncorrected omissions or misstatements other than those which are 'clearly trivial' to those charged with governance. ISA (UK) 260 defines 'clearly trivial' as matters that are clearly inconsequential, whether taken individually or in aggregate and whether judged by any quantitative or qualitative criteria.

An omission or misstatement is regarded as material if it would reasonably influence the users of the financial statements. The assessment of what is material is a matter of professional judgement and is affected by our assessment of the risk profile of the Board and Group and the needs of the users.

When planning, we make judgements about the size of misstatements which we consider to be material, and which provide a basis for determining the nature and extent of our audit procedures. Materiality is revised as our audit progresses, should we become aware of any information that would have caused us to determine a different amount had we known about it during our planning.

Our assessment, at the planning stage, of materiality for the year ended 31 March 2024 was calculated as follows.

	Group £million	Board £million
Overall materiality for the financial statements	29.534	29.513
Performance materiality (75% of materiality)	22.151	22.134
Trivial threshold	0.300	0.300
Materiality	Our initial assessment is based on approximately 2% of gross revenue expenditure as disclosed in the 2022/23 audited annual report and accounts. We consider this to be the principal consideration for the users of the financial statements when assessing financial performance of the Group and Board.	
Performance materiality	Performance materiality is the working level of materiality used throughout the audit. We use performance materiality to determine the nature, timing and extent of audit procedures carried out. We perform audit procedures on all transactions, or groups of transactions, and balances that exceed our performance materiality. This means that we perform a greater	

	level of testing on the areas deemed to be at significant risk of material misstatement. Performance materiality is set at a value less than overall materiality for the financial statements as a whole to reduce to an appropriately low level the probability that the aggregate of the uncorrected and undetected misstatements exceed overall materiality.
Trivial misstatements	Trivial misstatements are matters that are clearly inconsequential, whether taken individually or in aggregate and whether judged by any quantitative or qualitative criteria. The lower of 5% of overall materiality for the Board and £0.300million. Individual errors above this threshold are communicated to those charged with governance.

The Remuneration & Staff Report and Related Parties disclosures are material by nature.

In performing our audit, we will consider any errors which cause result in a movement between the relevant bandings on the disclosure table to be material.

For Related Party transactions, in line with the standards we will consider the significance of the transaction with regard to both NHS Fife and the Counter party, the smaller of which will drive materiality considerations on a transaction by transaction basis.

Appendix 2: Group audit scope and risk assessment

As Group auditor under ISA (UK) 600 we are required to obtain sufficient appropriate audit evidence regarding the financial information of the components and the consolidation process to express an opinion on whether the group financial statements are prepared, in all material respects, in accordance with the applicable financial reporting framework.

Group audit scope

The Group consists of the following entities:

Component	Significant	Level of response required
NHS Fife	Yes	Comprehensive
Fife Integration Joint Board (IJB)	No	Analytical
Fife Health Board Endowment Fund (Fife Health Charity)	No	Analytical

Comprehensive - The component is of such significance to the group as a whole that an audit of the components financial statements is required for group reporting purposes.

Analytical - the component is not significant to the Group and audit risks can be addressed sufficiently by applying analytical procedures at the Group level.

Risks at the component-level

The risks identified at the Board are set out in this external audit plan. There are no other risks identified in any of the other components above in respect of the Group audit.

Appendix 3: Responsibilities of the Auditor and the Board

The Auditor General and Audit Scotland

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

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

Auditor responsibilities

Code of Audit Practice

The Code of Audit Practice (the 2021 Code) describes the high-level, principles-based purpose and scope of public audit in Scotland.

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

Our responsibilities

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

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

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

Wider scope audit work

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

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

Financial management

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

Auditor considerations

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

Financial sustainability

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

Auditor considerations

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

Vision, leadership and governance

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

Auditor considerations

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

Use of resources to improve outcomes

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

Auditor considerations

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

Best Value

Ministerial guidance to Accountable Officers for public bodies sets out their duty to ensure that arrangements are in place to secure Best Value in public services. Through our wider scope audit work, we consider the arrangements put in place by the Accountable Officer to meet these Best Value obligations.

Audit quality

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

of audit quality to the Auditor General and the Accounts Commission and provide regular reporting on audit quality and performance.

Audit Scotland maintains and delivers an Audit Quality Framework

The most recent audit quality report can be found at Quality of public audit in Scotland: Annual report 2022/23 | Audit Scotland (audit-scotland.gov.uk)

Board responsibilities

The Board has primary responsibility for ensuring the proper financial stewardship of public funds, compliance with relevant legislation and establishing effective arrangements for governance, propriety and regularity that enables it to successfully deliver its objectives. The features of proper financial stewardship include the following:

Area	Board responsibilities
Corporate governance	The Board is responsible for establishing arrangements to ensure the proper conduct of its affairs including the legality of activities and transactions, and for monitoring the adequacy and effectiveness of these arrangements. Those charged with governance should be involved in monitoring these arrangements.
Financial statements and related reports	The Board has responsibility for: • preparing financial statements which give a true and fair view of the financial position and its expenditure and income, in accordance with the applicable financial reporting framework and relevant legislation; • maintaining accounting records and working papers that have been prepared to an acceptable professional standard and support the balances and transactions in its financial statements and related disclosures; • ensuring the regularity of transactions, by putting in place systems of internal control to ensure that they are in accordance with the appropriate authority; and • preparing and publishing, along with the financial statements, an annual governance statement, management commentary (or equivalent) and a remuneration report in accordance with prescribed requirements. Management commentaries should be fair, balanced and understandable. Management is responsible, with the oversight of those charged with governance, for communicating relevant information to users about the entity and its financial performance, including providing adequate disclosures in accordance with the applicable financial reporting framework. The relevant information should be communicated clearly and concisely.

Area	Board responsibilities
	The Board is responsible for developing and implementing effective systems of internal control as well as financial, operational and compliance controls. These systems should support the achievement of its objectives and safeguard and secure value for money from the public funds at its disposal. The Board is also responsible for establishing effective and appropriate internal audit and risk-management functions.
Standards of conduct for prevention and detection of fraud and error	The Board is responsible for establishing arrangements to prevent and detect fraud, error and irregularities, bribery and corruption and also to ensure that its affairs are managed in accordance with proper standards of conduct by putting proper arrangements in place.
Financial position	The Board is responsible for putting in place proper arrangements to ensure the financial position is soundly based having regard to: • Such financial monitoring and reporting arrangements as may be specified; • Compliance with statutory financial requirements and achievement of financial targets; • Balances and reserves, including strategies about levels and their future use; • Plans to deal with uncertainty in the medium and long term; and • The impact of planned future policies and foreseeable developments on the financial position.
Best value	The Scottish Public Finance Manual sets out that accountable officers appointed by the Principal Accountable Officer for the Scottish Administration have a specific responsibility to ensure that arrangements have been made to secure Best Value. Accountable Officers are required to ensure accountability and transparency through effective performance reporting for both internal and external stakeholders.

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**13 December 2023**
Title:	**National Fraud Initiative Assignment 2023 Participation**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Kevin Booth, Head of Financial Services & Procurement**

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Government policy / directive

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

- Safe

2 Report summary

2.1 Situation

The paper confirms NHS Fife's participation in the NFI (National Fraud Initiative) 2022/23 assignment

2.2 Background

The NFI is an electronic data matching exercise that helps prevent and detect fraud across participating public and private sector bodies. There are over 1,100 participating authorities at present across the UK and in Scotland, Audit Scotland coordinates participation. As such NHS Fife's participation and successful interpretation and any subsequent actions in regards to its assigned matches is required to be reviewed as part of the Annual Accounts process.

The NFI process is normally run over a two year cycle with the most recent assignment commencing in 2022. Submission of specific data in relation to both Payroll and Creditors for a defined period is provided to the NFI. The data is then collated between participating organisations before a series of analytics is carried out to identify potential matches of data both within NHS Fife and across other participating organisations. A set of matched data is then provided to each organisation to carry out its own investigations into any identified

matches. Further matches can also be released by the NFI throughout the year depending on any late submissions or provision of further data from participating organisations.

2.3 Assessment

NHS Fife complied with the timeframe set by the NFI and provided the requested datasets for the 2022/23 assignment in November 2022.

A total of 2,469 matches have since been returned from NHS Fife to investigate and as of November 2023 the following table summarises the matches by category which have been investigated and closed.

2022/23 NFI Exercise Analysis

ID	Report	Matches	Closed	Ongoing
66	Payroll to Payroll - Multiple Employment	108	72	6
67.2	Payroll to Payroll - Email Address same, different name	1	1	
68	Payroll to Payroll - Multiple Employment, differing DOB	1	1	
68.2	Payroll to Payroll - Email Address same, different name	1	1	
78	Payroll to Pensions	20	20	
80	Payroll to Creditors (Linked Bank Account)	36	36	
81	Payroll to Creditors (Linked Address)	16	14	2
701	Duplicate Creditors by creditor name	153	153	
702	Duplicate Creditors by address detail	108	108	
703	Duplicate Creditors by bank account number	84	84	
708	Duplicate records by amount and creditor reference	1794	1794	
709	VAT Overpaid	53	53	
710	Duplicate Records by name, invoice number and amount but different creditor reference	18	15	
711	Duplicate Records by invoice number and amount but different creditor reference and name	25	25	
713	Duplicate Records by postcode, invoice number and amount but different creditor reference and invoice number and date	15	15	
750	Procurement - Payroll to Companies House (Director)	16	16	
752	Procurement - Payroll to Companies House (Director)	20	20	
		2469	2428	

Due to the significant volume of matches provided a risk based approach has been taken to the investigation of these prioritising those matches with the highest risk score as provided by the NFI.

There have been no significant findings to note following the investigations to date however there have been a number of positive outcomes to note:

- In respects of payroll a number of further information requests have been provided to other public sector bodies to support their concerns with sickness absence fraud.
- In respects of Creditors a number of duplicate supplier records have been closed reducing the future risk of posting errors.

- In respects of conflicts of interest, a number of employees were contacted in regards to the Boards Standards of Business Conduct policy and referred to its content around declarations of interest.

The participation in the NFI assignment contributes to the Boards objective of complying with the Counter Fraud Standards and in particular provides evidence of a proactive approach to undertaking detection activity when potential areas of fraud are identified.

2.3.1 Quality, Patient and Value-Based Health & Care

The NFI data matching assignments play an important role in protecting public funds against the risk of fraud and as such contributes to ensuring NHS Fife funds are protected to provide quality patient care.

2.3.2 Workforce

The data provided to the NFI includes payroll information covering the whole NHS Fife workforce.

2.3.3 Financial

With over 2,400 matches identified in the 2022/23 assignment, significant Financial Services staff hours are required to be committed to the analysis of the NHS Fife matched data to ensure effective utilisation and compliance with the process.

2.3.4 Risk Assessment / Management

NHS Fife provides the NFI with an annual privacy notice compliance declaration and a security compliance declaration to ensure that the security policy created and controlled by the Cabinet Office for the sharing of data is upheld and to ensure compliance with the Data Protection Act 2018.

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

N/A

2.3.6 Climate Emergency & Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

The NFI Data centres around both payroll and creditors information therefore the analysis is carried out by senior staff within both the Accounts Payable and Payroll Teams. Any applicable significant findings would potentially be referred to the Director of Workforce or the Head of Corporate Governance for support in resolution.

2.3.8 Route to the Meeting

This paper has been formed following discussions with the Boards External Auditors to provide assurance ahead of the Annual Accounts process for 2023/24 that effective participation has taken place with the NFI 2022/23 assignment.

2.4 Recommendation

Members are asked to take **assurance** from the report.

3 List of appendices

None.

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

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**13 December 2023**
Title:	**Losses and Special Payments Quarter 2**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Report Author:	**Kevin Booth, Head of Financial Services & Procurement**

1 Purpose

This is presented for:

- Assurance

This report relates to a:

- National policy

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

- Effective

2 Report summary

2.1 Situation

This paper presents a summary of the Board's Losses and Special Payments covering quarter to (01/07/23 – 30/09/23).

2.2 Background

The Boards Losses and Special Payments are controlled by the Financial Services Department and are reported to the Scottish Government as part of the Annual Accounts process.

As per section 16 of the Financial Operating Procedures, any potential losses or special payments are approved by the relevant Directorate/Department Head. The Loss, theft or damage paperwork is then provided to the Deputy Director of Finance for final approval.

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

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

2.3 Assessment

The attached appendix summarises the Boards losses and Special Payments for the period 01/07/23 – 30/09/23. The reports categorise the types of losses and special payments made in the period whilst also quantifying the number of cases of each and the total monetary value.

There were 229 Losses and Special Payments in the quarter which is a significant increase on the first quarter (100). The increase in number of payments however has not correlated however with an increased cost (£351,916) and instead has resulted in a reduction in cost when compared to the first quarter (£1,025,364). This decrease was predominantly as a result of the reduction in value of the clinical ex-gratia compensation payments (£235,558 down from £924,944). The total of Losses and Special Payments out with Clinical and Non-Clinical ex-gratia compensation payments was £11,738 which was a reduction in comparison to quarter one (£12,535).

The Treasury team carried out their quarterly analytical review to provide additional assurance and the following items were noted:

1 - There was a credit received for £151,583 against Clinical ex gratia payments (Section 26) in the quarter as a result of a return on a PPO annual settlement. This credit offset 39% of the spend in the quarter.

2 - Non-Clinical ex gratia payments (section 27) increased in the quarter (£104,620 from £87,885). The total for the quarter accounts for 41% of the total spend in 2022/23.

3– Compensation payments for Patients and Staff Financial Loss (Section 28) was higher than anticipated as a result of a significant historical claim for a patient's belongings

The above findings will be carried into the quarter three review to assist with the identification of any developing trends which may materially affect the Boards expected position at the end of 2023/24.

2.3.1 Quality, Patient and Value-Based Health & Care

The Losses and Special Payments require to be tightly controlled as they can have a material impact on the Boards financial position and ability to maintain budgets to ensure/enhance Patient Care.

2.3.2 Workforce

The procedural guidance for Managers to ensure the appropriate treatment for any losses or special payments is stated in the Financial Operating Procedures.

2.3.3 Financial

The Losses and Special Payments are included within the Boards Annual Accounts process, subject to external audit and submitted to the Scottish Government for oversight.

2.3.4 Risk Assessment/Management

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

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

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

2.3.6 Climate Emergency and Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

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

2.3.8 Route to the Meeting

This paper is brought to the members attention to give visibility of the Board's losses and special payments in the quarter to 30 September 2023.

2.4 Recommendation

Members are asked to take **assurance** from the report.

3 List of appendices

Appendix 1 - Summary of Losses and Special Payments 01/07/23 – 30/09/23.

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

FIFE HEALTH BOARD

SUMMARY OF LOSSES AND SPECIAL PAYMENTS

ITEM NO.	CATEGORY	JUL-SEP'23		OCT'22 - SEP'23	
	Miscellaneous / Theft / Arson / Wilful Damage				
1	Cash			1	125
2	Stores/procurement				
3	Equipment			1	1366
4	Contracts				
5	Payroll *Salary Overpayment Debtors Invoices*			43	34441
6	Buildings & Fixtures *Vandalism*	19	2516	50	6250
7	Other			1	355
	Fraud, Embezzlement & other irregularities (incl. attempted fraud)				
8	Cash				
9	Stores/procurement				
10	Equipment				
11	Contracts				
12	Payroll				
13	Other				
14	**Nugatory & Fruitless Payments**			1	70728
	Claims Abandoned:				
15	(a) Private Accommodation				
	(b) Other *Hardship Accounts / Insurance Excess / Debtors WO's*	175	2939	488	20636
	Stores Losses:				
16	Incidents of the Service :				
	- Fire				
	- Flood				
	- Accident				
17	Deterioration in Store				
18	Stocktaking Discrepancies				
19	Other Causes				
	Losses of Furniture & Equipment				
	and Bedding & Linen in circulation:				
20	Incidents of the Service :				
	- Fire				
	- Flood				
	- Accident *Loss / Damaged Equipment*	4	2203	17	12452
21	Disclosed at physical check				
22	Other Causes				
	Compensation Payments - legal obligation				
23	Clinical				
24	Non-clinical				
	Ex-gratia payments:				
25	Extra-contractual Payments				
26	Compensation Payments - ex-gratia - Clinical	13	235558	47	3896557
27	Compensation Payments - ex-gratia - Non Clinical	10	104620	26	296717
28	Compensation Payments - ex-gratia - Financial Loss	5	3396	17	6006
29	Other Payments				
	Damage to Buildings and Fixtures:				
30	Incidents of the Service :				
	- Fire				
	- Flood				
	- Accident *Vehicle Expenditure*	3	684	5	1205
	- Other Causes				
31	**Extra-Statutory & Extra-regulationary Payments**				
32	**Gifts in cash or kind**				
33	**Other Losses**				
		229	351917	697	4346838

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**13 December 2023**
Title:	**Procurement Tender Waivers Quarter 2**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Kevin Booth, Head of Financial Services & Procurement**

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Government policy / directive
- Legal requirement

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

- Safe

2 Report summary

2.1 Situation

In order to allow the Audit & Risk Committee to take assurance that the Boards Procurement Function is operating within the legal requirements of the Scottish Government. This paper presents oversight of the Contract Awards over £50,000 in the period July 2023 – September 2023 that were subject to a waiver of competitive tender.

2.2 Background

As per the Guidance in the Public Contracts Scotland Act 2015. Any non-competitive award of a contract with an anticipated value of £50,000 or more (inclusive of vat) must have a waiver of competitive tender completed prior to award and be signed off by both the Head of Procurement and then counter signed by both the Director of Finance & Strategy and the Chief Executive.

The waiver of competitive tender confirms the restricted conditions which when in existence, the Board is permitted to award the contract without following the existing procurement journey route 2 as prescribed in the Act.

The restricted, permitted conditions (as per the Code of Corporate Governance, appendix 3 Standing Financial Instructions, section 9.11) which must be in existence are as follows:

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

Any other justification including the unavailability of time should not be considered without the prior agreement with the Scottish Government.

2.3 Assessment

During the period July 2023 – September 2023 the Procurement Team awarded five contracts of £50,000 or above. Of these contracts one was subject to a waiver of competitive tender and the justification is summarised as follows:

Medtronic GI Manometry Equipment for £56,730.

The requirement to replace the equipment arose in quarter two due to the existing equipment failing and being beyond economical repair. This resulted in essential clinical services being suspended until such times as the equipment could be replaced.

On investigation it was identified that there were no available frameworks for NHSF to access to procure the replacement equipment and in addition and following discussions with the service, it was established that the replacement equipment would need to be compatible with the existing Medtronic Manoscan probes, otherwise the Board would need to incur significant further cost to replace additional equipment.

The waiver of competitive tender was approved based on points 2, 3 and 5 of the criteria above.

2.3.1 Quality, Patient and Value-Based Health & Care

A waiver of competitive tender will only ever be considered by Procurement where all applicable information is provided to a high quality, allowing for an effective decision to be made.

2.3.2 Workforce

The current guidance for the application of a waiver of competitive tender is contained within the Financial Operating Procedures section 11(a) for staff to refer to when consideration is required. The qualifying criteria contained mirrors that within the Boards Standing Financial Instructions.

2.3.3 Financial

As per the Public Contracts Scotland Act 2015 any procurement of £50,000 or above is subject to Procurement Journey Route 2 (or Route 3 if £138,760 or above), where a Tender would be posted through the Public Contracts Tender Portal. The implementation of the Tender Waiver negates the requirement for this process.

2.3.4 Risk Assessment / Management

The implementation of a Waiver of Competitive Tender needs to be robustly controlled to ensure the Board does not expose itself to challenge which could result in legally imposed financial penalties and reputational damage.

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

The governed application of the waiver of competitive tender ensures applicable treatment of suppliers across the marketplace.

2.3.6 Climate Emergency & Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

The consideration of the application of a waiver of competitive tender is considered by the Senior Procurement Team following discussions with the order requisitioner before being approved if applicable by the Head of Procurement and then issued to the Director of Finance & Strategy and the Chief Executive for final sign off.

2.3.8 Route to the Meeting

The Procurement Governance Board monitors the Procurement KPI's which includes the number of Competitive Tender Waivers implemented.

2.4 Recommendation

Members are asked to take **assurance** that the Procurement process for the waiver of competitive tenders was correctly applied in the period.

3 List of appendices

None.

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

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**13 December 2023**
Title:	**Financial Operating Procedures Review 2023**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Kevin Booth, Head of Financial Services & Procurement**

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Local policy

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

- Effective

2 Report summary

2.1 Situation

The review of the Boards Financial Operating Procedures (FOPS) has just been concluded and the revised (2023) version will shortly be distributed and communicated widely across applicable staff teams.

2.2 Background

The FOPS are the detailed financial processes that members of staff are required to follow when administering the Boards funds. The FOPS form part of the Boards internal control system and provide reference to both the Internal and External Auditors.

It is important that the FOPS are reviewed regularly to ensure they are reflective of current best practice, provide sufficient control and take account of any arising risks.

2.3 Assessment

The FOPS were last fully reviewed and presented to the ARC in December 2021.

The 2023 review was carried out and informed through the creation of a workplan to ensure that appropriate senior members of staff were consulted. Sections were allocated for review to relevant departments and senior members of staff based on their knowledge and

involvement with the working practices of these sections. The revised sections were then returned to the Head of Financial Services & Procurement for final review. The review ensured that the FOPS are both reflective of current practice whilst also ensuring that sufficient controls remain in place. During the review, discussions were held to consider the changing work practices following the post pandemic period, whilst any risks identified were discussed during the drafting of the revised sections to ensure appropriate actions were implemented.

The 2023 iteration of the FOPS encompasses the 2022 interim update that was made for the amendment to the Procurement section. In addition, the agreed actions from Internal Audit assignment B21/23 which is scheduled to be completed in December 2023 has been incorporated.

Moving forward Financial Services will ensure that the next revision of the FOPS is carried out by December 2025 and that any future Audit recommendations are acted on and any material revisions are implemented with specific sections being distributed on an interim basis.

2.3.1 Quality, Patient and Value-Based Health & Care

The distribution of the revised FOPS will ensure that the staff can consistently follow the approved process. Ensuring equality and improved transparency which will support the objective of quality patient care.

2.3.2 Workforce

The revised FOPS will be circulated widely to ensure applicable staff are aware of the updated procedures to be followed moving forward.

2.3.3 Financial

The revised FOPS provide an additional safeguard to the board's finances.

2.3.4 Risk Assessment / Management

The Head of Financial Services & Procurement consulted with members of staff who contributed to specific sections to ensure any applicable risks were considered and minimised where possible.

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

The FOPS provide a detailed operational guide to NHS Fife staff to ensure applicable financial process should be followed in a consistent manner.

2.3.6 Climate Emergency & Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

The review of the FOPS was informed by contributions from across the Finance team, along with colleagues from Estates and Digital & Information.

2.3.8 Route to the Meeting

The FOPS are scheduled for review on a 24-month basis, with conformation of the review scheduled within the workplan for the audit & Risk Committee.

2.4 Recommendation

Members are asked to take **assurance** from the report.

3 List of appendices

The FOPS are of significant size and a link to the 2023 version can be provided, if requested.

Report Contact
Kevin Booth
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PROPOSED AUDIT & RISK COMMITTEE

ANNUAL WORKPLAN 2024 / 2025

Governance – General						
	Lead	**16/05/24**	**20/06/24**	**12/09/24**	**12/12/24**	**13/03/25**
Minutes of Previous Meetings	**Chair**	✓	✓	✓	✓	✓
Action Plan	**Chair**	✓	✓	✓	✓	✓
Escalation of Issues to NHS Board	**Chair**	✓	✓	✓	✓	✓
Governance Matters						
	Lead	**16/05/24**	**20/06/24**	**12/09/24**	**12/12/24**	**13/03/25**
Audit Scotland Technical Bulletin	**Head of Financial Services**	✓ **2024/1**		✓ **2024/2**	✓ **2024/3**	✓ **2024/4**
Annual Assurance Statement 2023/24	**Board Secretary**	✓ Draft	✓ Final			
Annual Assurance Statements from Standing Committees 2023/24	**Board Secretary**		✓			
Annual Review of Code of Corporate Governance	**Board Secretary**	✓				
Committee Self-Assessment	**Board Secretary**					✓
Corporate Calendar / Committee Dates 2025/26	**Board Secretary**			✓		
Delivery of Annual Workplan 2024/25	**Director of Finance & Strategy**	✓	✓	✓	✓	✓
Financial Operating Procedures Review	**Head of Financial Services**	(Two yearly review. Next review due December 2025)				
Governance Statement	**Director of Finance & Strategy**	✓ Draft	✓ Final			
IJB Annual Assurance Statement 2023/24	**Board Secretary**		✓ TBC	✓ TBC		
Internal Audit Review of Property Transactions Report 2023/24	**Internal Audit**			✓ TBC		

Governance Matters (cont.)						
	Lead	**16/05/24**	**20/06/24**	**12/09/24**	**12/12/24**	**13/03/25**
Losses & Special Payments	**Head of Financial Services**	✓		✓	✓	✓
Procurement Tender Waivers Compliance 2024/25	**Head of Financial Services**	✓		✓	✓	✓
Review of Annual Workplan 2025/26	**Board Secretary**				✓ Draft	✓ Approval
Review of Terms of Reference	**Board Secretary**					✓ Approval
Risk						
	Lead	**16/05/24**	**20/06/24**	**12/09/24**	**12/12/24**	**13/03/25**
Annual Risk Management Report 2023/24	**Risk Manager**	✓ Draft	✓ Final			
Corporate Risk Register	**Director of Finance & Strategy/Risk Manager**	✓	✓	✓	✓	✓
Risk Management Key Performance Indicators 2024/25	**Risk Manager**			✓		
Risk & Opportunities Group and Progress Report	**Risk Manager**	✓		✓	✓	✓
Governance – Internal Audit						
	Lead	**16/05/24**	**20/06/24**	**12/09/24**	**12/12/24**	**13/03/25**
External Quality Assessment (5 yearly)	**Internal Audit**					✓
FTF Shared Service Agreement / Service Specification	**Internal Audit**				✓	
Internal Audit Progress Report	**Internal Audit**	✓		✓	✓	✓
Internal Audit Annual Plan 2024/25	**Internal Audit**	✓ Draft	✓ Final			
Internal Audit Annual Report 2023/24	**Internal Audit**		✓			
Internal Audit – Follow Up Report on Audit Recommendations 2023/24	**Internal Audit**	✓		✓	✓	✓

Governance – Internal Audit (cont.)						
	Lead	**16/05/24**	**20/06/24**	**12/09/24**	**12/12/24**	**13/03/25**
Internal Audit Framework	**Chief Internal Auditor**					✓
Internal Controls Evaluation Report 2023/24	**Internal Audit**				✓	
Governance – External Audit						
	Lead	**16/05/24**	**20/06/24**	**12/09/24**	**12/12/24**	**13/03/25**
Annual Audit Plan 2023/24	**External Audit**				✓	
External Audit – Follow Up Report on Audit Recommendations	**Director of Finance & Strategy**					✓
Patients' Private Funds - Audit Planning Memorandum	**Head of Financial Services**					✓
Service Auditor Reports on Third Party Services	**Head of Financial Services**		✓			
Annual Accounts						
	Lead	**16/05/24**	**20/06/24**	**12/09/24**	**12/12/24**	**13/03/25**
Annual Accounts Preparation Timeline	**Head of Financial Services**	✓ Follow Up				✓ Initial
External Auditors Annual Accounts Progress Update	**External Auditor**	✓				✓
Annual Accounts & Financial Statements 2023/24	**Director of Finance & Strategy / External Audit**		✓			
Annual Audit Report 2023/24	**External Audit**		✓			
Letter of Representation 2023/24	**Director of Finance & Strategy / External Audit**		✓			
Patients' Funds Accounts 2023/24	**Head of Financial Services**		✓			
Annual Statement of Assurance to the NHS Board 2023/24	**Board Secretary**		✓			
Counter Fraud						
	Lead	**16/05/24**	**20/06/24**	**12/09/24**	**12/12/24**	**13/03/25**
Counter Fraud Service – Quarterly Report (Alerts & Referrals)	**Head of Financial Services**	Private Session		Private Session	Private Session	Private Session
Counter Fraud Standards Assessment	**Head of Financial Services**					Private Session

Counter Fraud (cont.)						
	Lead	**16/05/24**	**20/06/24**	**12/09/24**	**12/12/24**	**13/03/25**
Counter Fraud Action Plan 2024/25	**Head of Financial Services**	✓				
Counter Fraud Annual Report 2023/24	**Head of Financial Services**	✓				
Adhoc						
	Lead	**16/05/24**	**20/06/24**	**12/09/24**	**12/12/24**	**13/03/25**
Private Meeting with Internal / External Auditors	**Committee**			Private Session		Private Session
Appointment of Patients' Private Funds Auditor	**Director of Finance & Strategy**	**As required**				
Legal & regulatory updates (e.g. Audit Scotland reports etc.)	**Head of Financial Services**					
Progress on National Fraud Initiative (NFI)	**Head of Financial Services**				✓	
Additional Agenda Items (Not on the Workplan e.g. Actions from Committee)						
	Lead	**16/05/24**	**20/06/24**	**12/09/24**	**12/12/24**	**13/03/25**
Training Sessions Delivered						
	Lead	**16/05/24**	**20/06/24**	**12/09/24**	**12/12/24**	**13/03/25**
Members' Training Session – the Annual Accounts: The Role & Function of the Audit & Risk Committee	**External Auditors**	✓				

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**13 December 2023**
Title:	**Audit Scotland Technical Bulletin 2023/3**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Kevin Booth, Head of Financial Services & Procurement**

1 Purpose

This is presented for:

- Assurance

This report relates to a:

- Emerging issue
- Government policy/directive
- Legal requirement

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

- Effective

2 Report summary

2.1 Situation

The Audit Scotland Technical Bulletin 2023/3 is a resource shared across members of the Finance Directorate and is provided to the Audit and Risk committee to raise awareness of emerging developments from an Audit perspective.

2.2 Background

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

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

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

2.3 Assessment

The Audit Scotland Technical Bulletin 2023/3 is arranged by sector with content applicable to specific sectors and also across the public sector as a whole. There is no specific section in relation to Health in quarter three with Audit Scotland's focus being on the Local Government and College sector audits.

Section five on professional matters to note, does draw reference to the recently issued consultation on a revised ethical standard, the thematic review of climate related disclosures and the new standards on the disclosure of sustainability-related financial information, all which will potentially influence Health Sector audits moving forward.

2.3.1 Quality, Patient and Value-Based Health & Care

N/A

2.3.2 Workforce

The Technical Bulletin is shared widely across the Finance Directorate.

2.3.3 Financial

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

2.3.4 Risk Assessment/Management

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

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

N/A

2.3.6 Climate Emergency and Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

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

2.3.8 Route to the Meeting

This paper has been provided to support the Audit & Risk Committee following discussions between the Head of Corporate Governance and the Head of Financial Services & Procurement

2.4 Recommendation

Members are asked to take **assurance** from the bulletin.

3 List of appendices

Appendix 1 - Audit Scotland Technical Bulletin 2023/3.

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Technical Bulletin 2023/3

Technical developments and emerging risks from July to September 2023

AUDIT SCOTLAND

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

27 September 2023

Contents

1: Introduction

Purpose

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

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

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

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

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

Highlighted items

Professional Support highlights in the following table a selection of the items in this Technical Bulletin that are of particular importance:

Highlighted items		
Treasury has issued guidance on preparing WGA returns [**paragraph 1**]	CIPFA/ LASAAC have issued an exposure draft of the accounting code for 2024/25 **[paragraph 10]**	CIPFA has issued draft guidance on applying IFRS16 leases to service concession arrangements **[paragraph 24]**
Professional Support has published Module 14 of TGN 2023/1 on the risks of misstatement specific to colleges **[paragraph 28]**	Professional Support has published TGN 2023/6(C) Model Independent Auditor's Reports for colleges **[paragraph 31]**	The SFC has issued the 2022/23 accounts direction **[paragraph 35]**
The SFC has issued guidance notes on completing the 2022/23 financial statements of colleges **[paragraph 37]**	The FRC has issued a consultation on a revised Ethical Standard **[paragraph 39]**	The FRC issued a thematic review of the Task Force on Climate-related Financial Disclosures **[paragraph 56]**

Consulting with Professional Support

Auditors should consult with Professional Support by sending an email to TechnicalQueries@audit-scotland.gov.uk.

2: All sectors

Guidance on 2022/23 WGA returns for preparers

1. HM Treasury has issued guidance on preparing the 2022/23 Whole of Government Accounts (WGA) returns for local government and for central government bodies. WGA is prepared by Treasury and consolidates the audited accounts of bodies in the UK that exercise functions of a public nature or are funded from public money. The process has been running significantly behind schedule over the last few years.

2. Paragraph 1.7.1 sets out the key dates for 2022/23 WGA as summarised in the following table:

Sector	Cycle	Return	Submission date
Central government	1	Unaudited	20 October 2023
	2	Audited	17 November 2023
Local Government	1	Unaudited	24 November 2023
	2	Audited	22 December 2023

3. Auditors are not expected by Professional Support to meet these dates if doing so would compromise audit quality.

4. Data is collected for the 2022/23 WGA by bodies inputting information directly to the Online System for Central Accounting and Reporting (OSCAR II). Bodies are exempt from the WGA process if their gross expenditure, gross income, gross assets, and gross liabilities are below £30 million for both 2021/22 and 2022/23.

5. A diagram at paragraph 4.2.2 of the guidance sets out the steps involved in the WGA submission process. The steps depend on whether the body is above the audit threshold. Section 1.7 advises that the threshold for audit is breached if any of total assets (excluding property, plant and equipment), total liabilities (less pension liabilities), total income or total expenditure is above £2 billion.

6. Annex A provides a summary of the proforma tabs used to input data. Chapter 7 provides more detailed guidance on inputting data into the tabs. Section 7.2 advises that the Audit Report is a view of all data submitted which can be shared with auditors. It may be appropriate to download the individual tabs instead, and also run the new primary financial statements report.

7. A key part of the WGA process is the elimination of transactions and balances between WGA bodies. Recording complete and accurate counter-

party identifier (CPID) information is the only way in which transactions and balances between WGA bodies can be identified and eliminated. Paragraph 6.3.4 explains how bodies can run a Matches Analysis Tool which allows them to see 'live' published data from other bodies. Central government bodies are required to formally agree transaction streams and balances that are above £5 million with central government counterparties.

8. A Technical Guidance Note (TGN) on the evaluation by auditors of the 2022/23 submissions will be provided by Professional Support.

Technical consultations with auditors

Professional Support responds to requests from auditors for technical consultations

9. The following table summarises requests from auditors for technical consultations with Professional Support in respect of issues arising from the audit of the 2022/23 annual accounts, along with the advice offered:

What are the accounting implications of the use of Reinforced Autoclaved Aerated Concrete in a body's buildings?
In December 2022, the UK government issued a notice regarding Reinforced Autoclaved Aerated Concrete (RAAC) with a guide for estates managers. RAAC was widely used in the construction of floors and roofs from the 1950s to early 1990s. However, recent investigations have identified that roof leaks could lead to the deterioration of RAAC planks. The Scottish Government are working in partnership with the UK Government on research into the extent of the use of RAAC in public buildings. The Local Government Association advised its members to check as a matter of urgency whether any buildings in their estates have roofs, floors, cladding or walls made of Reinforced Autoclaved Aerated Concrete (RAAC). A number of Scottish councils have identified buildings which contain RAAC. Bodies should be considering whether the use of RAAC in a building is an indication that the asset may be impaired.

3: Local government sector

Consultation on 2024/25 accounting code

10. CIPFA/LASAAC Local Authority Code Board has issued an exposure draft of the Code of Practice on Local Authority Accounting in the UK (the accounting code) for 2024/25. The Invitation to Comment (ITC) sets out:

- proposed revisions to the 2024/25 accounting code (Section A)
- the proposed approach to implementing IFRS 17 Insurance Contracts (Section B)
- proposals arising from CIPFA/LASAAC's strategic work plan (Section C)
- other financial reporting issues (Section D).

11. Responses to the consultation should be sent to cipfalasaac@cipfa.org by 17 October 2023.

Proposed revisions to the 2024/25 accounting code

12. The main proposed revisions to the 2024/25 accounting code relate to the implementation of IFRS 16 Leases. Implementation is mandatory in 2024/25 for any local authority that did not follow the recommendation to adopt in 2022/23 or 2023/24.

13. It is not expected that implementation will require any significant changes to the provisions set out in Appendix F to the 2023/24 accounting code. However, it is proposed to add paragraph 4.2.2.91 to reflect an amendment to IFRS 16 in respect of sale and leaseback. This will require the seller-lessee to determine 'lease payments' or 'revised lease payments' in a way that would not recognise any amount of the gain or loss that relates to the right of use retained by the seller-lessee.

14. There is also the following proposal on applying IFRS 16 to service concession arrangement liabilities in respect of first time application:

- The main difference from IAS 17 in respect of lease liabilities relates to variable payments that depend on an index or a rate. Instead of being expensed, IFRS 16 requires these to be incorporated into the liability (and subsequently amortised), based on the most recent index or rate. This applies to the extent that variable payments in the unitary charge are allocated to the asset rather than as payment for services.

- The proposal is that remeasurement should be required on the date of initial application, rather than allowing remeasurement to be deferred until the next change in payments. This would mean that, while the opening balance is initially calculated on an IAS 17 basis on 1 April, the liability would then be subject to immediate further remeasurement to reflect the effect of the index or rate on payments, based on the position at 31 March in the previous year.

15. Questions 2 and 3 in the ITC request local authority views on their readiness for IFRS 16 implementation and any further support that the Chartered Institute of Public Finance and Accountancy (CIPFA) might be able to provide.

Proposed approach to implementing IFRS 17

16. In respect of IFRS 17, it is proposed that:

- mandatory implementation will be deferred to 2025/26, with early adoption allowed
- the standard should be treated the same as the extant IFRS 4, i.e. a brief reference included in Section A of the accounting code as a standard with limited application.

CIPFA/LASAAC's strategic work plan

17. CIPFA/LASAAC has updated its strategic work plan with a focus on improving the presentation of the annual accounts and ensuring that they clearly present their key messages. Some aspects of the plan are briefly summarised in the following paragraphs.

Overview of performance and summary financial information

18. Questions 11 to 15 ask for views on proposals to add a new section to the Narrative Report to give an overview of performance and summary financial information. This would be on a voluntary basis for 2024/25.

19. This proposal is based on a requirement of the Government Financial Reporting Manual (FReM) for a performance overview. The aim is to provide users with a short summary that provides them with sufficient information to understand the body, its purpose and objectives, the outcomes it wants to achieve, its performance against delivering those outcomes and/or objectives, and the impact and management of key risks. The specific requirements are set out at paragraphs 3.1.1.5 to 3.1.1.7.

20. The required summary financial information would reconcile to the information produced in the financial statements, include key financial elements of performance, and demonstrate at a high level the authority's financial position. The detailed requirements are set out at paragraph 3.1.1.8 but in summary include the following:

- A summary of service outturn per service in comparison to the budget and reconciled to the amounts charged to revenue in accordance with statutory provisions in the Expenditure and Funding Analysis

- An analysis of outturn against spend for the Housing Revenue Account.
- A summary of the financial position based on the Balance Sheet
- An analysis of an authority's usable reserves.
- An authority's capital expenditure for the current and preceding year, forecast for the following three years, and a short explanation of the capital programme.
- The capital financing requirement, borrowing as a proportion of a council's total income for the current and preceding year and forecast for the following three years, and an explanation of what the trends indicate in terms of capital financing.
- A summary of any significant commercial activities and their risks.

Changes to the structure/format of the code

21. CIPFA/LASAAC is seeking views on restructuring the accounting code at questions 16 to 21 in the ITC. The main issues are summarised in the following table:

Issues	Views requested on whether the….
Accessibility	structure and format of the accounting code allows its provisions to be easily understood and usable.
Approach to content of IFRS	detailed provisions of standards should no longer be presented (similar to the approach adopted by the FReM).
Adaptations and interpretations	adaptations and interpretations are clearly presented and easily identified
Structure of the Code	structure of the accounting code should follow the order in which the financial statements are presented by local authorities (as set out in the table at paragraph 68 of the ITC).
Statutory accounting provisions	specifications for statutory adjustments should be brought together in one place, such as alongside the provisions for the Movement in Reserves Statement.

Sustainability reporting

22. CIPFA/LASAAC is considering whether sustainability reporting requirements should be explicitly included in the accounting code. It is of the view that the requirements should follow international and UK public sector best practice, but considers that in several areas it is not yet well developed. Question 22 therefore asks stakeholders what they consider is the best approach to the introduction of sustainability reporting in local government.

Other financial reporting issues

23. A new section has been introduced to the ITC which features issues which impact on local authority financial reporting or other emerging issues. These include asking stakeholders for views on:

- where the requirements of the accounting code might be changed to ease the burden on the local audit and accounts preparation system
- whether any additional specifications are required in the accounting code on the net defined benefit pensions asset and calculation of an asset ceiling
- the impact of new IPSASs 45 to 48 on the accounting code to the extent they augment the interpretations for the local government context.

Draft guidance on applying IFRS 16 to service concession arrangements

24. CIPFA has issued draft guidance on applying the requirements of IFRS 16 to service concession arrangements. It sets out the aspects of accounting which are different as a result of the change from IAS 17 to IFRS 16, and provides illustrative examples.

25. Where local authorities implement IFRS 16 in 2022/23 they can opt out of applying the standard to service concession arrangements. However, where IFRS 16 is implemented for leases in 2023/24, it must also apply to service concession arrangements. This is summarised in the following table:

Financial year	Application to leases	Application to service concession arrangements
2022/23	Voluntary	Voluntary
2023/24	Voluntary	Mandatory if applied to leases
2024/24	Mandatory	Mandatory

26. Auditors should refer to this guidance where a local authority applies IFRS 16 to service concession arrangements.

Technical consultations with auditors

Professional Support responds to requests from auditors for technical consultations

27. The following tables summarise requests from auditors for technical consultations with Professional Support in respect of issues arising from the audit of the 2022/23 annual accounts of local government bodies, along with the advice offered:

Should bodies recognise a net defined benefit asset when the pension fund reports a surplus as at 31 March 2023?

Where bodies can access the economic benefit arising from the asset in terms of reduced contributions or a refund, they should recognise the net defined benefit as an asset. The net defined benefit asset recognised should be the surplus, adjusted for the effect of any asset ceiling. The surplus is:

- the fair value of plan assets, less
- the present value of the defined benefit obligation.

The asset ceiling is the present value of any economic benefits available in the form of refunds from the plan or reductions in future contributions to the plan. Bodies should engage with their actuaries to help identify the asset ceiling. The emerging view is that that bodies participating in LGPS will have a minimum funding requirement as contribution rates are set in advance. In their report on IAS 19 reporting (paragraph 31), PWC comment that if a surplus arises for a scheduled body, given that this body is expected to participate in the LGPS indefinitely, it would be expected that this surplus will lead to lower future contributions by that body. They also expect employers to consider contributions in respect of future service to be a minimum funding requirement under IFRIC 14 as they are obligated to pay them.

Where there is a minimum funding requirement for contributions relating to future service, the economic benefit available as a reduction in future contributions is the sum of the estimated future service cost in each period, determined using assumptions consistent with those used to determine the defined benefit obligation, less the estimated minimum funding requirement contributions that would be required for future service in those periods adjusted for any prepayment made. The IFRS Interpretations Committee, in a decision in July 2015, conclude that when an entity estimates the future minimum funding requirement contributions, it should:

- include amounts in the schedule of contributions for the fixed period specified by the schedule; and
- beyond that period, make an estimate that assumes a continuation of those factors establishing the minimum funding basis as determined by the pension trustees.

An estimate cannot be determined to be accurate or inaccurate, but it can be considered reasonable if:

- the method used in making the accounting estimate is appropriate
- the underlying assumptions are sound
- the body has considered and addressed the effect of estimation uncertainty
- the amount is described clearly as being an estimate

Should bodies recognise a net defined benefit asset when the pension fund reports a surplus as at 31 March 2023?

- the nature and limitations of the estimating process are explained
- no errors have been made in selecting and applying an appropriate process for developing the estimate.

Where actuaries report that the present value of the minimum funding requirement contributions exceeds the future service cost, IFRIC 14 advises that no asset should be recognised. There is no requirement to recognise a liability for the difference.

4: College sector

TGN on risks of material misstatement in 2022/23

28. Professional Support has published Module 14 of TGNote 2023/1. The TGN is intended to inform auditors' judgement when identifying and assessing the risks of material misstatement in the 2022/23 annual report and accounts of central government bodies generally. Module 14 provides:

- guidance on applying the other modules to the audit of the 2022/23 annual report and accounts of colleges
- supplementary guidance on the risks of misstatements in areas specific to colleges

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

30. Auditors are expected to pay due regard to Module 14 and use it as a primary reference source when performing 2022/23 audits of colleges. Auditors should advise Professional Support of any intended departures from the guidance.

Independent auditor's reports for college accounts in 2022/23

31. Professional Support has published TGN 2023/6(C) to provide auditors with model forms of Independent Auditor's Reports (IAR) which should be used for the 2022/23 annual accounts of colleges in Scotland.

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

33. The model forms of IARs set out in the appendices of the TGNs have been tailored to reflect relevant legislation and augmented by the reporting requirements of the Auditor General.

34. There are a number of changes to the model forms of IAR and to the application guidance in 2022/23. These are summarised in the following table:

Area	Change
Model IARs	The description of the financial reporting framework has been removed from the 'true and fair' element of the opinion on the financial statements.
	The period of appointment disclosure has been simplified.
	The explanation of the extent to which the audit is capable of detecting irregularities has been enhanced with a view to reducing any perceived need for extensive local tailoring.
Application guidance	The guidance on the period of appointment disclosure has been revised to reflect the amendment in standard wording.
	Auditors should consult with Professional Support on any tailoring of the standard wording of the explanation of the extent to which the audit is capable of detecting irregularities.
	A new Auditor Action has been added in respect of identifying the audited parts of the Remuneration Report.

2022/23 accounts direction

35. The Scottish Funding Council (SFC) has issued their Accounts Direction for Scotland's Colleges 2022/23. The direction requires colleges to:

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

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

- Paragraph 11 confirms that the 2016 version of the Code of Good Governance for Scotland's Colleges continues to apply for 2022/23. The revised version issued in September 2022 will be adopted in 2023/24.
- References in the Performance Report and Governance Statement to COVID-19 have been removed. Disclosures should reflect the impact of current geopolitical issues and exceptional inflationary pressures on the sector.

Guidance on 2022/23 financial statements

37. The SFC has issued guidance notes on completion of the 2022/23 financial statements which are designed to supplement the accounts direction. The guidance covers key disclosures in the financial statements, including model disclosure notes set out at Annexes A to F.

38. There are no significant changes from 2021/22.

5 Professional matters

Proposed revisions to Ethical Standard

39. The Financial Reporting Council (FRC) has issued a consultation on a revised Ethical Standard. The purpose of this revision is to:

- take account of changes to the International Ethics Standards Board for Accountants (IESBA) Code of Ethics;
- respond to issues identified through audit inspection
- provide greater clarity in respect of specific prohibitions and requirements
- allow consultation on whether to withdraw the Other Entities of Public Interest category.

40. The key changes being consulted on are outlined in the following paragraphs.

Breaches

41. There is a proposed requirement for firms to design controls which effectively identify reportable breaches.

42. The concept of 'inadvertent' breaches (i.e. those which do not necessarily call into question the firm's ability to give an opinion) has been proposed. Clarification has been provided to explain which breaches cannot be inadvertent including:

- a deliberate breach either by an individual or a firm
- If a breach occurred due to a firm's ineffective policies or procedures.

43. When a requirement is breached, the engagement partner and ethics partner would need to consider the situation and actions required from the perspective of an objective, reasonable and informed third party. The proposed revised standard highlights examples where individual breaches should be reported outwith the normal timetable.

44. Other proposals include:

- requiring engagement partners to report the details and significance of any breaches to those charged with governance of each entity
- requiring a firm, in its assessment of whether to accept or continue any engagement, to document any breaches of the standard and actions taken in response.

Identification of safeguards

45. Paragraph 1.46 proposes additional requirements and prohibitions that would apply to specific categories of entity. The consultation seeks views on whether such enhancements could be made to other areas of the standard.

Financial relationships

46. Paragraphs 2.3 and 2.4 have been revised to clarify requirements set by the standard and those set by statute regarding personal financial independence for engagement teams and other staff.

47. Paragraphs 2.5 to 2.10 provide further guidance on financial interests, for example those held by trustees. Paragraph 2.9 and 2.10 have been clarified to explain the actions to be taken where financial interests are not permitted to be held.

Long association with engagements

48. Clarification has been provided in paragraphs 3.22 and 3.23 to explain that:

- once an engagement partner has completed the maximum allowed period, they cannot act as engagement quality reviewer for that engagement for another five years
- where an engagement partner rotates off an engagement after five years, the option to extend for an additional two years is no longer available.

49. A table setting out the rotation periods for key audit partners has been included at paragraph 3.23. Guidance has been provided detailing the impact that significant gaps of service have when calculating rotation periods.

Fees

50. Section 4 proposes enhancements to the prohibitions in relation to fees. Calculations used to determine whether an audit firm is over reliant on fees have been amended to include fees from entities that are connected in substance.

Non-audit/additional services

51. Changes to section 5 on non-audit/additional services are being proposed to align more closely with changes to the IESBA Code including:

- information technology services to reflect restrictions on audit firms providing hosting services to audited entities [paragraphs 5.53-5.54]
- enhanced tax service prohibitions [paragraph 5.67]
- recruitment and remuneration services, where audit firms provide related services [paragraph 5.89]
- corporate finance services relating to the provision of advice to audited entities on debt and financial instruments
- internal audit to provide examples of activity that would be classed as internal audit services.

52. An example of non-audit services has been provided to aid clarity.

53. Documentation requirements in respect of non-audit/additional services have been enhanced to require inclusion of:

- the safeguards adopted, and the reasons why they are considered to be effective, in responding to the specific threats identified
- any significant judgements concerning the potential threats and proposed safeguards
- how the objective and reasonable third-party test has been applied.

54. The proposed effective date of the revised standard will be for financial periods commencing on or after 15 December 2024. Comments on the consultation paper should be sent to: AAT@frc.org.uk by 31 October 2023.

Thematic review of climate related disclosures

55. The FRC has issued a thematic review of the Task Force on Climate-related Financial Disclosures (TCFD) mandated in the annual accounts of premium listed companies.

56. The overall conclusion of the review was that the availability and quality of climate-related data is still evolving. The review identified good practice as well as opportunities for improvement.

57. The review focused on the following four key questions:

Key question	Observations	Expectations/required improvements
Has reporting of climate-related metrics and targets improved since last year?	Entities' reporting of climate-related metrics has improved incrementally with greater consideration of cross-sector and sector-specific metrics. Due to the high volume of information to be presented, many entities are struggling to clearly present the material metrics and targets. The consistency with the TCFD framework including clearer statements about data that is not yet available improved.	The definition and reporting of entity-specific metrics and targets, beyond the headline 'net zero', should be disclosed. Better linkage is required between the climate-related metrics and targets and the risks and opportunities to which they relate. Explanation is required of year-on-year movements in metrics and performance against targets. Transparency is needed about internal carbon prices, where used. Better linkage is needed between climate-related targets in TCFD disclosures and other related targets disclosed.

Key question	Observations	Expectations/required improvements
Are entities adequately disclosing their plans for transition to a lower carbon economy, including interim milestones and progress?	Most entities have set net-zero or other climate-related targets, but the metrics used to track progress are unclear and explanations of performance are not always provided. It was unclear whether interim emission targets covered all business activities or how the entity planned to meet interim targets.	Disclosures should include the expected steps to meet targets, highlighting areas of judgement and uncertainties. A review should be undertaken of the Transition Plan Taskforce guidance and consideration given as to how best to articulate their targets and plans for transition.
Are entities using consistent and comparable metrics?	Some commonality was identified but methodological differences due to entity-specific adjustments made direct comparisons challenging.	TCFD cross-sector and industry-specific metrics should be used to aid comparability. Details of the methodology applied when calculating non-standard metrics should be provided to aid comparability.
Are entities explaining how their targets have affected the financial statements?	Most entities provided some explanation of how climate was considered in the financial statements. However, it was often difficult to determine the extent of the impact of targets on the financial statements, due to a lack of entity specific disclosures. The connectivity between information included in narrative reporting and financial statements disclosures was mixed.	Where climate-related targets and transition plans could impact the financial statements, entities should explain the assessments undertaken and any impacts on the financial statements.

58. Through their reviews of company reporting, the FRC have included some areas that entities should consider when reporting on metrics and targets. This includes clarity, balance and avoiding undue focus on immaterial areas of the business.

New standards on disclosure of sustainability-related financial information

59. The International Sustainability Standards Board (ISSB) has issued two financial reporting standards setting out the overall requirements for disclosing sustainability-related financial information.

60. IFRS S1* requires entities to disclose information about sustainability-related risks and opportunities that could impact on the entity's cash flows, access to finance or cost of capital over the short, medium and long term. It requires an entity to disclose material information about all of the significant sustainability-related risks and opportunities to which it is exposed.

61. Sustainability-related financial information should therefore include information about the entity's:

- governance processes, controls and procedures used to monitor and manage the risks and opportunities
- strategy and approach used to manage the risks and opportunities
- risk management processes used to identify, assess, prioritise and monitor risks and opportunities
- performance metrics and targets including progress towards any targets the entity has set or is required to meet by law or regulation.

62. IFRS S2* requires entities to disclose information about its climate-related risks and opportunities that is useful to users of the financial statements. The disclosures are summarised in the following table:

Area	Explanation
Governance	Processes, controls and procedures an entity uses to monitor and manage climate-related risks and opportunities. This includes disclosures on: • details of the governance body responsible for climate-related matters and, for example, how that body determines whether the skills and competencies are available or need to be developed in this area, how climate-related risks and opportunities are considered when making decisions, and how often it receives performance information. • management's role in the governance process including the controls and procedures used to support oversight of climate-relates risks and opportunities and how these integrate with other internal functions.
Strategy	Disclosures to explain the entity's strategy for managing climate-related risks and opportunities. This includes disclosure on: • climate-related risks and opportunities that are expected to affect the entity's prospects and the effect of the risks and opportunities on the business model, decision making, strategy, and financial position • the resilience of the entity's strategy and business model to climate-related risks and opportunities.

Area	Explanation
Risk management	Disclosure on the risk management arrangements and policies including how the entity identifies, assesses, prioritises, and monitors climate-related risks and opportunities and how these processes are integrated into the entity's overall risk management process. This includes disclosing information on: • climate-related scenario analysis used to inform the identification of risks and opportunities • how the entity assesses the nature, likelihood, and magnitude of the effect of risks • prioritisation of climate-related risks relative to other risks • the process for monitoring risks.
Metrics and targets	Performance information to allow users to understand progress made against climate-related targets set internally or required by law or regulations. Entities are required to disclose information on: • cross-industry metrics eg greenhouse gases • industry-based metrics where applicable • qualitative and quantitative climate-related targets.

63. Applying these standards, with additional disclosure when necessary, is presumed to result in a fair presentation.

Technical Bulletin 2023/3

Technical developments and emerging risks from July to September 2023

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AUDIT & RISK COMMITTEE

ANNUAL WORKPLAN 2023 / 2024

Governance – General		18/05/23 - Meeting Cancelled				
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Minutes of Previous Meetings	**Chair**	✓ Via email	✓	✓	✓	✓
Action Plan	**Chair**	✓ Via email	✓	✓	✓	✓
Escalation of Issues to NHS Board	**Chair**	✓ Via email	✓	✓	✓	✓
Governance Matters						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Audit Scotland Technical Bulletin	**Head of Financial Services**	✓ 2023/1 – Via email		✓ 2023/2	✓ 2023/3	✓ 2023/4
Annual Assurance Statement 2022/23	**Board Secretary**	✓ Via email	✓ Final			
Annual Assurance Statements from Standing Committees 2022/23	**Board Secretary**		✓			
Annual Review of Code of Corporate Governance	**Board Secretary**	✓ Via email				
Committee Self-Assessment	**Board Secretary**					✓
Corporate Calendar / Committee Dates 2024/25	**Board Secretary**			✓		
Delivery of Annual Workplan 2023/24	**Director of Finance & Strategy**	✓	✓	✓	✓	✓
Governance Statement	**Director of Finance & Strategy**	✓ Via email	✓ Final			
IJB Annual Assurance Statement 2022/23	**Board Secretary**		✓ Letter	Report (for 2024)		
Internal Audit Review of Property Transactions Report 2022/23	**Internal Audit**	No transactions to review for 2022/23				
Losses & Special Payments	**Head of Financial Services**	✓ Via email		✓	✓	✓

Governance Matters (cont.)						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Review of Annual Workplan 2024/25	**Board Secretary**				✓ Draft	✓ Approval
Review of Terms of Reference	**Board Secretary**					✓ Approval
Significant Issues of Wider Interest	**Director of Finance & Strategy**	**No separate letter required this year**				
Risk						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Annual Risk Management Report 2022/23	**Risk Manager**	✓ **Via email**	✓ Final			
Corporate Risk Register	**Director of Finance & Strategy/Risk Manager**	✓	✓	✓	✓	✓
Risk Management Key Performance Indicators 2022/23	**Risk Manager**			**Deferred to March**		✓
Risk & Opportunities Group and Progress Report	**Risk Manager**	✓ **Via email**		✓ **verbal**	✓	✓
Governance – Internal Audit						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
External Quality Assessment (5 yearly)	**Internal Audit**					✓
FTF Shared Service Agreement / Service Specification	**Internal Audit**				**Deferred to next mtg**	✓
Internal Audit Progress Report	**Internal Audit**	✓ **Via email**		✓	✓	✓
Internal Audit Annual Plan 2023/24	**Internal Audit**		✓ Final			
Internal Audit Annual Report 2022/23	**Internal Audit**		✓			
Internal Audit – Follow Up Report on Audit Recommendations 2022/23	**Internal Audit**	✓ **Via email**		✓	✓	✓
Internal Audit Framework	**Chief Internal Auditor**					✓
Internal Controls Evaluation Report 2023/24	**Internal Audit**				✓	

Governance – External Audit						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Annual Audit Plan 2023/24	**External Audit**				✓	
External Audit – Follow Up Report on Audit Recommendations	**Director of Finance & Strategy**					✓
Patients' Private Funds - Audit Planning Memorandum	**Director of Finance & Strategy**					✓
Service Auditor Reports on Third Party Services	**Director of Finance & Strategy**		✓			
Annual Accounts						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Annual Accounts Preparation Timeline	**Head of Financial Services**	✓ **Via email**				✓ Initial
Annual Accounts & Financial Statements 2022/23	**Director of Finance & Strategy / External Audit**		✓			
Annual Audit Report (including ISA 260) 2022/23	**External Audit**		✓			
Letter of Representation (ISA 580) 2022/23	**Director of Finance & Strategy / External Audit**		✓			
Patients' Funds Accounts 2022/23	**Head of Financial Services**		✓			
Annual Statement of Assurance to the NHS Board 2022/23	**Board Secretary**		✓			
Counter Fraud						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Counter Fraud Service – Quarterly Report (Alerts & Referrals)	**Head of Financial Services**	**Deferred to August**		Private Session	Private Session	Private Session
Counter Fraud Standards Update	**Head of Financial Services**	**Deferred to August**		Private Session		Private Session
Adhoc						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Private Meeting with Internal / External Auditors	**Committee**			Private Session		Private Session

Appointment of Patients' Funds Auditor	**Director of Finance & Strategy**	**As required**				
Legal & regulatory updates (e.g. Audit Scotland reports; Technical Bulletin etc)	**Head of Financial Services**					
Progress on National Fraud Initiative (NFI)	**Head of Financial Services**				✓	
External Auditors Annual Accounts Progress Update	**External Auditor**	**No update provided as mtg cancelled**				✓
Additional Agenda Items (Not on the Workplan e.g. Actions from Committee)						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Risk Management Framework and GP/R7 Risk Management Policy	**Director of Finance & Strategy**			✓ **Framework**	✓ **Update**	
Health Board Partnership Agreement April 2023 – March 2028	**Director of Finance & Strategy**		✓			
Procurement, Waiver of Competitive Tenders Q1	**Head of Financial Services**			✓		
Counter Fraud Standards Assessment 2022/23	**Head of Financial Services**			✓		
Training Sessions Delivered						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Members' Training Session – the Annual Accounts: The Role & Function of the Audit & Risk Committee	**External Auditors**	✓ **Held on 30/05/23**				
Review of the effectiveness of the new Corporate Risk Register process	**Director of Finance & Strategy**			**12/10/23**		