NHS Fife Audit & Risk Committee

Thu 09 December 2021, 14:00 - 16:00

MS Teams

Agenda

14:00 - 14:25
25 min

1. MEMBERS' TRAINING SESSION – CYBER SECURITY

Enclosed *(Alistair Graham, Associate Director, Digital & Information, in attendance)*

Item 1 - SBAR Cyber Security Risk Report.pdf (7 pages)

14:25 - 14:25
0 min

2. Apologies for Absence

Martin Black

14:25 - 14:25
0 min

3. Declaration of Members' Interests

Martin Black

14:25 - 14:25
0 min

4. Minutes of Previous Meeting held on Thursday 16 September 2021

Enclosed *Martin Black*

Item 4 - A&R Minutes 16 September 2021 Unconfirmed.pdf (10 pages)

14:25 - 14:25
0 min

5. Matters Arising / Action List

Enclosed *Martin Black*

Item 5 - A&R Action List - 9 December 2021.pdf (1 pages)

14:25 - 14:55
30 min

6. GOVERNANCE - GENERAL

6.1. Financial Operating Procedures Review 2021

Enclosed *Kevin Booth*

Item 6.1 - SBAR Financial Operating Procedures Review 2021 .pdf (3 pages)

6.2. Losses and Special Payments Overview

Enclosed *Kevin Booth*

Item 6.2 - SBAR Losses and Special Payments Overview.pdf (3 pages)
Item 6.2 - Appendix 1 Summary of Losses and Special Payments 1 Apr - 30 Jun 21.pdf (1 pages)
Item 6.2 - Appendix 2 Summary of Losses and Special Payments 1 Jul - 30 Sept 21.pdf (1 pages)

6.3. Revised Code of Corporate Governance

Enclosed *Dr Gillian MacIntosh*

- Item 6.3 - SBAR Revised Code of Corporate Governance.pdf (3 pages)
- Item 6.3 - Code of Corporate Governance.pdf (127 pages)

6.4. Update on Board Action Plan for the Implementation of the NHS Scotland 'Blueprint for Good Governance'

Enclosed *Dr Gillian MacIntosh*

- Item 6.4 - SBAR Blueprint for Good Governance.pdf (5 pages)
- Item 6.4 - Appendix 1 Blueprint Action Plan Update.pdf (4 pages)

14:55 - 15:15
20 min

7. GOVERNANCE - INTERNAL AUDIT

7.1. Internal Audit Progress Report

Enclosed *Tony Gaskin*

- Item 7.1 - SBAR Internal Audit Progress Report .pdf (3 pages)
- Item 7.1 - Appendix 1 Internal Audit Progress Report.pdf (11 pages)

7.2. Internal Audit – Follow Up Report on Audit Recommendations

Enclosed *Tony Gaskin*

- Item 7.2 - SBAR Internal Audit – Follow Up Report on Audit Recommendations .pdf (18 pages)

7.3. Internal Control Evaluation

Enclosed *Tony Gaskin*

- Item 7.3 - SBAR Internal Control Evaluation.pdf (3 pages)
- Item 7.3 - Internal Control Evaluation.pdf (39 pages)

15:15 - 15:30
15 min

8. GOVERNANCE - EXTERNAL AUDIT

8.1. Annual Accounts 2020/21 - Progress Update on External Audit Annual Report Recommendations

Enclosed *Margo McGurk*

- Item 8.1 - SBAR Progress Update on External Audit Annual Report Recommendations.pdf (6 pages)

15:30 - 16:00
30 min

9. RISK

9.1. Risk Management Key Performance Indicators (KPI) Report

Enclosed *Pauline Cumming*

- Item 9.1 - SBAR Risk Management Key Performance Indicator Report.pdf (3 pages)
- Item 9.1 - Appendix 1 Risk Management Key Performance Indicator Report .pdf (5 pages)

9.2. Board Assurance Framework (BAF)

Enclosed *Pauline Cumming*

- Item 9.2 - SBAR Board Assurance Framework (BAF).pdf (8 pages)
- Item 9.2 - Appendix 1 BAF Financial Sustainability - FPRC 091121.pdf (1 pages)
- Item 9.2 - Appendix 2 BAF Environmental Sustainability - FPRC 091121.pdf (2 pages)
- Item 9.2 - Appendix 3 BAF Workforce Sustainability - SGC 281021.pdf (2 pages)
- Item 9.2 - Appendix 4 BAF Quality & Safety - CGC 031121.pdf (2 pages)

- Item 9.2 - Appendix 5 BAF Strategic Planning - CGC 031121 FPRC 091121.pdf (1 pages)
- Item 9.2 - Appendix 6 BAF Integration Joint Board - IJB 161121.pdf (1 pages)
- Item 9.2 - Appendix 7 BAF Digital and Information - CGC 031121.pdf (2 pages)

9.3. Risk Management Arrangements – Reviewing our Approach

Presentation *Margo McGurk*

- Item 9.3 - Risk Management Arrangements – Reviewing our Approach Presentation.pdf (8 pages)

16:00 - 16:00
0 min

10. ESCALATION OF ISSUES TO NHS FIFE BOARD

16:00 - 16:00
0 min

11. ANY OTHER BUSINESS

16:00 - 16:00
0 min

12. DATE OF NEXT MEETING - THURSDAY 17 MARCH 2022 AT 2PM

NHS Fife Board

Meeting:	**Audit & Risk Committee**
Meeting date:	**9 December 2021**
Title:	**Cyber Security Resilience**
Responsible Executive:	**Dr Chris McKenna – Medical Director**
Report Author:	**Alistair Graham – Associate Director of Digital & Information**

1 Purpose

This is presented to the Audit & Risk Committee for:

- Assurance

This report relates to a:

- Emerging Issue

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

- Safe

2 Report summary

2.1 Situation

Given the rise in successful and significant targeted cyber intrusion activity within Public Sector organisations, the current threat level of a successful cyber-attack is high.

The Audit & Risk Committee have requested that an education session be provided to outlining the threats, risks and mitigations associated with a cyber attack and the Network and Information System Directive (NISD) Action Plan.

The information shared from the recent HSE incident identifies a change in the intrusion approach to be a "human-led" attack rather than one operated by programmed code alone. The attack was much more sophisticated and dynamic on HSE and continued to be human-led even through the response phases.

No organisation is immune to cyber-attack - it is a case of when not if. The complexity of modern digital networks and the applications they deliver are such that exploits will always be available for attackers to use and gain footholds in our digital estates.

The Audit & Risk Committee is provided this report to support the education session to be provideda the meeting on 9 December 2021.

2.2 Background

Cyber-attacks have become alarmingly sophisticated and, in 2021, have caused significant immediate and medium-term impact on organisations and their ability to provide services. (Scottish Environment Protection Agency (SEPA) & HSE in Ireland).

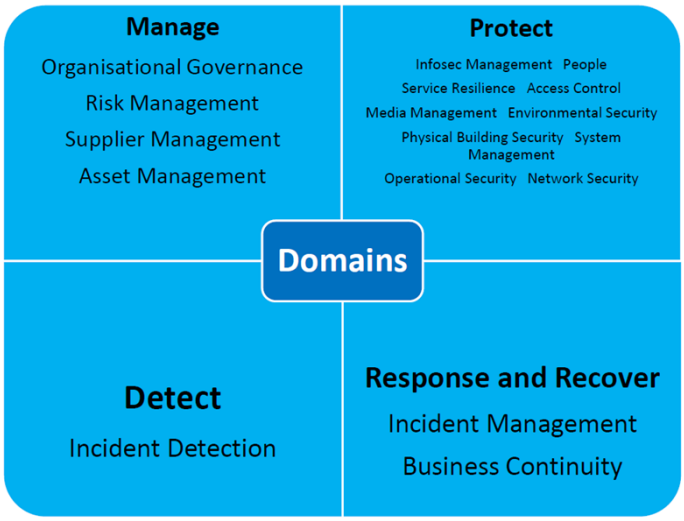
The most popular and successful type of attack is 'Ransomware', malicious software. When successful, these attacks threaten or cause reputational and physical damage to an organisation's data sources and seek to extort money to prevent or undo the damage.

These attacks use Email as the primary point of entry (94% in 2020). Users utilising Email platforms across a wide range of devices is our primary vulnerability. Cyber actors use increasingly effective methods to trick humans into downloading malicious tools designed to find and open other technical vulnerabilities deeper inside the network. Exposing these vulnerabilities to a human operator to continue their surveillance was the method used against HSE. NHS Fife also has elements of exposure from its use of legacy applications that operate on unsupported platforms. These systems are often consider critical to business and clinical functions.

Our responsibilities to manage the risks associated are primarily though activities contained within the Network & Information Systems (NIS) Regulations 2018, which came into force in May 2018. These regulations form a significant part of the Cyber Resilience Framework. The regulations require NHS Fife to:-

- Take appropriate technical and organisational measures to secure their network and information systems;
- Take into account the latest developments and consider the potential risks facing the systems;
- Take appropriate measures to prevent and minimise the impact of security incidents to ensure service continuity; and
- Notify the relevant supervisory authority of any security incident having a significant impact on service continuity without undue delay.

The NIS audit, that is conducted annual looks to cover the following domains:-



In our most recent audit (March 2021), the overall compliance to the NIS Regulations rose from 53% in 2020 to 69% in March 2021. With the work associated by the NIS Action plan, assured by the Information Goverance and Security Steering Group, the current estimated compliance is at 73%

2.3 Assessment

In the past, Ransomware attacks have followed a relatively simple automated lifecycle. The blanket canvassing using 'phishing' Emails will find victims, deploy automated tools and rely upon common business characteristics or features within popular systems to deliver their payload, usually preventing access to data by encryption. NHS Fife has been a victim of 3 ransomware attacks using this lifecycle in the last five years. Each time there was a level of impact whilst systems were isolated, cleansed or wiped clean, then recovered from backup.

Recent attacks have been human-operated, which significantly increases the risk of longer-term downtime or even unrecoverable damage.

The D&I department has spent considerable time during May & June assessing NHS Fife's resilience level against the types of cyber attacks outlined above. We have accelerated the delivery of some planned improvements, found additional quick wins to improve security and conducted exercises to model the impact of the attacks witnessed. These activities also included accelerating a previously planned series of workshops to service areas to ensure resilience and response plans are developed to handle this type of attack.

Additional awareness and education activity has been provided and particular focus has been given to Executive Director's and their PA support. An example of such materials is included in Appendix 1.

The current risks associated with NISD are summarised below:

Categorisation	Total Risks	Current Risk Level Breakdown
NISD Risks that inhibits the organisations ability to comply with the necessary security controls protecting access to data and digital assets including user behaviour	7	High Risk – 3 Moderate Risk – 4 Low Risk – 2

Of particular focus is Risk 1338, NHS Fife is at increase risk to a targeted cyber intrusion a risk that was recategorized to a High (20) risk assessment following the change in activity outlined in this paper. A summary of the risk, its root cause and associated management actions (mitigations) is included in Appedix 2 for members consideration.

Threats & Vulnerabilities

- Criminals are deliberately targeting healthcare.
- They have high capability and tools that are hard to detect.
- We have a vast and complex estate that is difficult to secure.
- We have a vast and complex supply chain.
- There are several legacy systems and technologies.
- Tolerate the adoption and use of technology that contain weaknesses as they are considered to be essential.
- Some NHS Scotland suppliers are heedless of the support lifecycle.

- There is limited ability for 'orchestrated' firmware level patching.
- Exposure is inevitable due to a significant digital presence.

Actions

- Heightened cyber awareness at all levels - ongoing
- Outstanding actions ‘sprint’ in May to clear off backlist of security driven work - complete
- User attended Cyber Attack DR exercises - ongoing.
- Technical Cyber Attack Exercise – using Human-Operated attack theme - complete.
- Reviewed the learnings and created 32-point action list - ongoing.
- Support for NISD audit action plan and cyber security roadmap - ongoing
- D&I BCDR Planning review/redesign - ongoing.
- Strengthening of the Cyber Security Team / IG Team - complete.

The threshold for technical and security compliance will be raised for all new devices and systems that require a connection to our network. This threshold will also be used to reassess compliance for all existing devices and systems. Consideration must also be given to data sharing arrangements particualalry in the area of research.

The other activity that would add significant value, particularly in the Respond and Recover domain, would be to exercise a cyber attack response as part of the major incident plan for Fife. Specifically this exercise would identify where the current major incident reponse relies on technology or network connectivity which may or may not be available due to the nature of the cyber attack or due to the mitigations to stop the spread of any attack.

2.3.1 Quality/ Patient Care

The impact to clinical activities, if the victim of a successful cyber attack, would be signficiant through the unavailability of key clinical system. These systems would be unavailable for length periods of time and the quality of care would be reliant on the robustness of services resilience plans.

2.3.2 Workforce

Flexible and dynamic working practices, well informed workforce of common threats and vulnerabilities. Documented and practised DR plans.

2.3.3 Financial

A reprioritisation of the Digital & Information Capital allocation, supported by FCIG, has allowed additional response technologies to be procured. This technology is planned to be in place by March 2022.

2.3.4 Risk Assessment/Management

The current risk management summary for this is area is as follows:-

Categorisation	Total Risks	Current Risk Level Breakdown
NISD Risks that inhibits the organisations ability to comply with the necessary security controls protecting access to data and digital assets including user behaviour	7	High Risk – 3 Moderate Risk – 4 Low Risk – 2

Appendix 2 outlines the key risk in this area.

2.3.5 Equality and Diversity, including health inequalities

N/A.

2.3.6 Communication, involvement, engagement and consultation

N/A

2.3.7 Route to the Meeting

- Presented to EDG on 2 December 2021.

2.4 Recommendation

- **Assurance** – For Members' information and assurance.

3 List of appendices

The following appendices are included with this report:

- **Appendix 1** – Info Graphic from National Cyber Security Centre
- **Appendix 2** – Risk Summary Report for Key Risk 1338 – NHS Fife is at increased risk to a targeted cyber intrusion

Report Contact
Alistair Graham
Associate Director of Digital & Information
Email alistair.graham1@nhs.scot

Appendix 1 – Info Graphic from National Cyber Security Centre

Appendix 2 – Risk Summary Report – Key Risk 1338

Risk Item - 1338

NHS Fife is at increased risk to a targeted cyber intrusion

There is a risk that NHS Fife is victim of a targeted cyber intrusion from adversaries, because Microsoft has stopped supporting all Office 2007 products, this effectively ends the lifecycle of this product and sub-products including: MS Word 2007, MS Excel 2007, MS Powerpoint 2007, MS Publisher 2007, MS Access 2007 (Also lighter MS Office 2007 products like Picturemaker, Groove, One Note and InfoPath), although these products will continue to function after this date, organisations will no longer receive patches for security vulnerabilities identified in these products, resulting in a successful cyber attach and data breach and the potential for a sustained period of system loss.

Risk Velocity Speed at which the risk will impact NHS Fife	Rapid

Current Risk Level	
High 20	
Likelihood 5 – Almost Certain	Consequence 4 - Major
Target Risk Level	
Low Risk 4	

Root Cause	Management Actions	Status
Health organisations have experienced successful attacks in recent months Attacks on HSE Ireland and other public agencies suggests the sustained targeting of public sector organisations by cyber criminals.	**Heightened cyber awareness at all levels** As well as a number of general communications a number of workshops (5 in total between June 21 – September 21) have been made available to staff and managers. Paper on current resilience position has also been presented to EDG, with further guidance to be provided through information and a response workshop being planned. Update on Cyber Resilience being presented to Audit and Risk Committee – December 2021	Ongoing December 2021
Wide and varied digital footprint makes us susceptible to a wide variety of attack types The scale and complexity of our digital footprint makes us more susceptible to different types of cyber attacks via multiple routes, increasing the risk of a successful intrusion	**Technical cyber attack exercise complete** A technical improvement sprint was undertaken following immediate review of the HSE Ireland attack. This was followed up a 2 part digital response exercise to simulate a human operated attack – 32 point actions plan produced – expected completion (non cost items) October 2021	Ongoing December 2021
The complexity of attack (human led) has changed recently resulting in a change to the level of impact likely to be experienced The attacks witnessed in recent months, if successful, would result in a more significant impact to services. The impact would limit our ability to respond in a timely manner and be able to restore critical systems in the short term (2-4 weeks)	**Threshold for technical and security compliance to be raised/adhered to** A range of legacy technologies are in place across NHS Fife. The security thresholds for new and existing technology requires to be established to remove the threat to cyber attack these technologies present. The area of medical devices and systems operating on legacy operating systems will be targeted for improvement. Item to be scoped and progressed.	Not Started
The number of users results in increased likelihood of a successful attack The number of users within NHS Fife represents the potential number of targets for a Phishing (mass targeting) or Spearing (social engineered) more targeted attempts to encourage users to expose vulnerabilities.	**Funding request required for tertiary backup option** As part of the technical action plan it has been identified that an alternative backup solution is required to prevent malicious or targeted destruction of data and system backups. Indicative costs are being sought and a representation to prioritise the Digital capital allocation for this purpose will be made.	Ongoing March 2022
It is challenging to retain Cyber specialists within the D&I team to allow consistent progress against NISD and be responsive to emerging threats The cyber team experiences significant turnover given the competitive nature of the Cyber and Security market. With large differences in pay and terms and conditions between the public and private sector and a limited pool of talent the ability to retain resource is limited. Progress against NISD is inconsistent.	**Ongoing recruitment to Cyber team** Recruitment to the lead Cyber Consultant role in NHS Fife is ongoing. While a limited response to advert, some quality candidates did present in the recruitment process. A more sustainable resource model will be considered on appointment to the lead role	**Complete**

MINUTE OF THE AUDIT & RISK COMMITTEE MEETING HELD ON THURSDAY 16 SEPTEMBER 2021 AT 2PM VIA MS TEAMS

Present:
M Black, Non-Executive Member (Chair)
S Braiden, Non-Executive Member
A Lawrie, Non-Executive Member
K MacDonald, Non-Executive Member

In Attendance:
K Booth, Head of Financial Services & Procurement
A Clyne, Audit Scotland
P Cumming, Risk Manager
P Fraser, Audit Scotland
T Gaskin, Chief Internal Auditor
A Graham, Associate Director of Digital & Information *(agenda item 9)*
B Howarth, Regional Audit Manager
B Hudson, Regional Audit Manager
Dr G MacIntosh, Head of Corporate Governance & Board Secretary
M McGurk, Director of Finance & Strategy
A Mitchell, Independent Auditor - Thomson Cooper *(agenda item 7.1)*
C Potter, Chief Executive
H Thomson, Board Committee Support Officer (Minutes)

1. Welcome / Apologies for Absence

The Chair welcomed everyone to the meeting, in particular, B Howarth, P Fraser and A Clyne from Audit Scotland. He noted that A Graham, Associate Director of Digital & Information, and A Mitchell, Auditor of the Patients Funds Accounts from Thomson Cooper, will be joining for specific agenda items.

Apologies were received from member Cllr D Graham (Non-Executive Member).

2. Declaration of Members' Interests

There were no declarations of interest made by members.

3. Minute of the last Meeting held on 17 June 2021

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

4. Action List / Matters Arising

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

5. GOVERNANCE – GENERAL

5.1 Audit & Risk Committee Final Annual Statement of Assurance 2020/21

The Head of Corporate Governance and Board Secretary provided background to the Audit & Risk Committee Final Annual Statement of Assurance 2020/21 and advised that this final draft now reflected the content within the IJB Statement of Assurance. It was noted the Committee has scrutinised previously the annual statement in depth.

The Audit & Risk Committee **approved** the Draft Audit & Risk Committee Final Annual Statement of Assurance, for onward submission to the Board.

5.2 Committee & Directors' Annual Assurances for 2020/21

The Head of Corporate Governance and Board Secretary introduced the Committee & Directors' Annual Assurances for 2020/21 and advised the Annual Assurance reports provide a comprehensive coverage of the responsibilities delegated to the Committees and provide assurance each Committee has undertaken and fulfilled their respective remits. The Executive Directors' Assurance Letters also provide assurance from a managerial perspective. The report included the following separate assurance statements from:

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

The Director of Finance & Strategy and Head of Governance & Board Secretary were commended by the Chief Executive for their efforts in providing the detailed Annual Assurances, which were a substantial improvement on previous years' submissions.

The Audit & Risk Committee **noted** the assurances provided within the report.

6. GOVERNANCE – INTERNAL AUDIT

6.1 Annual Internal Audit Report 2020/21

The Chief Internal Auditor reported on the Annual Internal Audit Report for 2020/21 and expanded on the key themes as outlined in the paper. Overall, it was reported that positive progress has been made by NHS Fife in a number of key areas, particularly in Information Security & Governance.

It was advised remaining risks will be identified in relation to clinical priorities as impacted by Covid-19, and this will be taken forward through the Clinical Governance Committee. It was noted progress is ongoing in relation to reviewing clinical risks as detailed in the Quality & Safety Board Assurance Framework.

It was agreed the Annual Internal Audit Report 2020/21 is to be circulated to the Board Committees at their next cycle of meetings, to enable committees to see clearly the progress in areas linked to their respective remits.

The Internal Audit Team were thanked for all their efforts in providing a comprehensive report.

The Audit & Risk Committee:

- **agreed** the internal audit annual report 2020/21 be distributed to Standing Committees for consideration at their next meetings;
- **noted** a final version will be reported to the next Audit and Risk Committee meeting, with a completed action plan; and
- **noted** a revised Internal Audit plan will be presented to the December Audit and Risk Committee

6.2 Review of Property Transactions

The Regional Audit Manager provided an update on the Review of Property Transactions paper.

The Audit & Risk Committee **noted** the requirements of the NHS Scotland Property Transactions Handbook have been complied with, that arrangements are in place to issue the Board's Annual Property Transactions Return to Scottish Government Health & Social Care Directorates by the deadline of 31 October 2021, and that the return be submitted with no significant issues identified.

7. ANNUAL ACCOUNTS

7.1 Patients' Private Funds – Receipts and Payments Accounts 2020/21

A Mitchell, Auditor of the Patients Funds Accounts from Thomson Cooper, joined the meeting for this item.

The Head of Financial Services & Procurement introduced the Patients' Private Funds – Receipts and Payment Accounts 2020/21.

The Independent Auditor advised that an Audit Planning Memorandum was issued to the Audit & Risk Committee at the start of the Audit process, which highlighted the main areas of risk: the security of assets and compliance with operating procedures for patients' funds.

The Audit Completion Memorandum reports an Audit visit was carried out, followed up with Ward visits at Lynebank and Queen Margaret Hospital, and no restrictions were reported in the scope of the Audit work carried out.

It was advised the Audit Completion Memorandum reports no significant issues identified throughout the Audit, and noted the main issues were minor in terms of compliance with the financial operating procedures.

A clean Audit report will be provided subject to the approval of the Annual Accounts by the NHS Fife Board for year ended 31 March 2021.

The Audit & Risk Committee:

- **reviewed** the Patients' Private Funds Accounts; and
- **recommended** that the accounts are approved by the NHS Board.

7.2 Service Auditor Reports on Third Party Services

The Director of Finance & Strategy provided an update on the key points within the Service Auditor Reports on Third Party Services and outlined the three key service audits provided on behalf of NHS Fife.

The Director of Finance & Strategy highlighted the key points in relation to the service audits and focussed specifically on describing the current status of the NSS Practitioner and Counter Fraud Services report which was qualified for the second consecutive year. A level of concern was reported with the audit findings due to weaknesses highlighted in four out of five control areas. Assurance was provided to the Audit & Risk Committee that a significant, senior level commitment had been given by NSS in responding to this audit. Detailed scrutiny has been carried out by the NSS Management Team and the NSS Audit & Risk Committee in relation to examining a range of required improvement actions. The Director of Finance & Strategy explained the background to previous unaddressed issues within the Report and noted an Independent Auditor had carried out an assessment at the request of NSS. It was noted that the matter is referenced for transparency within the NHS Fife Governance Statement.

It was reported NHS IT Services Audit has moved from unqualified to a qualified status this year, and the auditors had noted there had been significant improvements and controls operating within this area from 2020 to the current financial year.

Following a question on the four areas control areas where weaknesses were highlighted, it was advised the development and reporting of an action plan for these areas will be presented to the NHS Boards Directors of Finance national meeting. The Director of Finance & Strategy will report progress to the Audit & Risk Committee. It was noted the areas of concern are a priority for NSS and Audit Scotland are optimistic issues are being addressed.

The Audit & Risk Committee **noted** the reports and audit opinions of the independent service auditors in 2020/21 for each of the services hosted by NHS National Services Scotland and by NHS Ayrshire & Arran on behalf of NHS Fife.

7.3 Draft Annual Audit Report

B Howarth, Audit Director from Audit Scotland, provided an update on the Draft Annual Audit Report.

It was reported the Audit Report fieldwork was substantially complete by the end of August 2021, which is an improvement on the position from year.

The outcome was a clean Audit certificate, and it was noted that there were challenges very late in the year in relation to managing late allocations from Scottish Government,

changes to the accounting treatment for Personal Protective Equipment and the presentation of funding to the Integrated Joint Board.

B Howarth noted that non-delivery of planned savings remains an issue for NHS Fife in relation to future planning to deliver legacy savings.

The increase in staff turnover and pressure on capacity was highlighted across the system. In relation to financial services B Howarth noted that payroll services have been challenged in-year with recruitment to this key service proving very difficult. The ongoing proposal in relation to creating a shared service for payroll with a number of other NHS Boards may help to provide future resilience.

A large impact on service performance was reported, which was not unexpected.

It was advised that audit testing had revealed 2 payroll transactions from a sample of 10 where overpayments had occurred, both were quickly rectified, and recovery action taken. Further testing will be carried out by the finance team for assurance. It was also noted payroll have been working at 30% under capacity in terms of Payroll Officers and work is underway at a local level to address this issue.

An update was provided on the NSS Practitioner and Counter Fraud services audit and it was noted the approach to testing service controls and testing of financial transactions will be addressed going forward. It was also noted that an action plan is in place for this year. Assurance was provided from NSS auditors that payments made under all payment streams were appropriate.

The Audit & Risk Committee **noted** the Annual Audit Report.

7.4 NHS Fife Independent Auditors Report - Including Draft Letter of Representation

P Fraser from Audit Scotland advised the Draft Letter of Representation is provided for the Chief Executive and the Director of Finance & Strategy to sign following approval of the Annual Accounts by the NHS Fife Board.

P Fraser advised that the NHS Fife Independent Auditors Report highlighted there were no unadjusted errors in relation to the Accounts and that the Audit work is now complete. Final checks are still be carried out on the final version of the Annual Accounts document.

Audit Scotland were thanked for their hard work which was carried out virtually.

7.5 NHS Fife Annual Accounts for the Year Ended 31 March 2021

The Director of Finance & Strategy introduced the Annual Accounts for the Year Ended 31 March 2021.

Key areas of the Annual Report were highlighted. The Performance Report confirms the Board met all the key financial targets, and the Remuneration report covers a number

of required disclosures in relation to remuneration paid to staff of NHS Fife and NHS Board.

The Director of Finance & Strategy highlighted the importance of the Governance Statement and noted the Audit & Risk Committee had reviewed and endorsed a previous version. It was advised the Service Auditor Report narrative was the only addition to the version previously considered.

The Head of Financial Services & Procurement outlined the key statutory financial targets within the financial statements. It was noted the net expenditure for the year-end had increased by 10.6%, with the main driver being the £39m increase in employee expenditure; further detail is outlined in the Remuneration Report.

It was reported the Statement of Financial Position shows a slight decrease in taxpayers' equity as a result of a reduction in the value of the Board's total assets.

There was a significant reduction in provisions for the year, and it was advised this was as a result of the in-year settlement on a high value clinical negligence case.

It was confirmed the Annual Accounts also include the Consolidated Group Accounts, incorporating the Audited Accounts of the Fife Health Charity for the year ended 31 March 2021

It was reported there were no new accounting standards adopted this year, and no prior year adjustments in relation to the Board's figures to report.

It is anticipated the NHS Fife Annual Accounts 2021/22 will revert back to the June date of approval. Further detail on timings will be provided to the Committee in due course.

The team were congratulated for all their hard work. A particular thank you was extended by the Chief Executive to the Head of Financial Services & Procurement, who joined NHS Fife earlier in the year.

The Audit & Risk Committee:

- **reviewed** the draft Annual Accounts for the year ended 31 March 2021;
- **recommended** that the Board approve the Annual Accounts for the year ended 31 March 2021;
- **recommended** that the Board authorise the designated signatories (Chief Executive and Director of Finance) to sign the Accounts on behalf of the Board, where indicated in the document;
- **approved** the proposed arrangements for resolution of minor matters in relation to the accounts, and up to the date of submission to the Scottish Government Health and Social Care Directorate; and
- **noted** that the accounts are not placed in the public domain until they are laid in Parliament.

7.6 Annual Assurance Statement to the NHS Board

The Audit and Risk Committee **noted** the Chair's signed approval of the Committee's final version of the Committee Assurance Statement to the Board.

8. RISK

8.1 Report against Risk Management Workplan

The Risk Manager provided an update on the Risk Management Workplan.

The Report outlines the work done since the last Report in May 2021. Timescales identified in the last Report have been altered and amended in line with recommendation from Internal Audit and the current work underway in relation to the review of risk management arrangements. It was noted the latter review includes a baseline review of risk maturity.

The Digital & Information Board Assurance Framework (BAF), changes to the Strategic BAF and intended work on Quality & Safety was highlighted as part of the workplan. It was advised the Workforce Sustainability BAF is progressing with the Workforce Team.

It was advised the national Datix system continues to be developed and the timescale for completion is not yet available. A timescale will be shared when available.

Action: Risk Manager

The Audit & Risk Committee **approved** the workplan.

8.2 Risk Management Key Performance Indicators

The Risk Manager provided the Committee with an update on performance against indicators that are currently in place.

It noted a number of indicators relate to adverse events, and the appropriateness of this is being considered as part of the review of the risk management arrangements.

The Chair of the Committee asked on who within the organisation has the authority to determine that a risk can be removed from the register. It was advised that such decisions are made by the Management Team and reported back through the governance arrangements.

It was advised that a review of the Board Assurance Frameworks (BAFs) is required at Executive level and Board level to differentiate and define appropriately between operational service delivery risks and strategic & corporate level risks, as currently there are a combination of both within the BAFs. Consistency of risk scoring also needs to be considered.

The Audit & Risk Committee **noted** the Risk Management KPIs.

8.3 Update on Corporate Risk Register Arrangements

The Risk Manager provided an update on the Corporate Risk Register arrangements and advised the register is at a developmental stage.

The Chair of the Committee asked whether the Integrated Joint Board (IJB) directions could create risks for NHS Fife. It was noted that "delivery" against IJB Directions can create risks which would be noted in the appropriate BAF.

It was noted the Corporate Risk Register is unchanged since the last update in June 2021.

A full report will be provided on the outcomes of the review of the Corporate Risk Register at the December Committee meeting.

Action: Risk Manager

The Audit & Risk Committee **noted** the Corporate Risk Register arrangements.

8.4 NHS Fife Board Assurance Framework Update

The Risk Manager provided an update on the NHS Fife Board Assurance Framework (BAF), and noted the last report was provided in June 2021.

The Executive Directors' Workshop on Risk Management on 23 September will provide an opportunity to examine the effectiveness of the BAF process.

The Audit & Risk Committee **noted** the NHS Fife Board Assurance Framework update.

9. INTERNAL AUDIT REPORT

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

The Associate Director of Digital & Information joined the meeting for this item. He provided an update and commented on the report's findings, which are all being addressed.

The findings in the Internal Audit Report identified limited assurances in the ITIL area and recognised the increasing dependency NHS Fife on digital initiatives to support patient care.

The Committee **noted** the Internal Audit Report – Information Technology Infrastructure Library Audit – and the actions underway to address the recommendations therein.

10. STRATEGY / PLANNING

10.1 NHS Fife Population Health and Wellbeing Strategy Development Progress

The Director of Finance & Strategy gave an update on the progress with the development of the NHS Fife Population Health and Wellbeing Strategy.

The Executive Directors Group propose to take forward a portfolio approach to developing and delivering the strategy through a newly established Portfolio Delivery

Programme Board (PDPB). It is anticipated that the PDPB will report directly into the new Public Health & Wellbeing Governance Committee being set up by the Board.

The portfolio will be aligned directly to the four national care programmes that the Scottish Government have initiated.

It was advised that the first stage of the EQIA stage assessment has concluded and is now moving to stage two.

The design of the strategy is being progressed through communications and engagement with wider stakeholders and members of the public. A survey or poll will be carried out, which offers questions to the public and will be collated for feedback.

The Committee **noted** the establishment of the Population Health and Wellbeing Portfolio Board and progress of the development of the strategy.

10.2 Joint Remobilisation Plan 2021/22 (RMP)

The Director of Finance & Strategy provided an update on the Joint Remobilisation Plan 2021/22**.**

The Scottish Government (SG) have approved the RMP3 and have acknowledged that planning is an ongoing activity. A delivery planning template has been issued from the SG for completion by the end of September 2021 and this will be completed as part of the RMP4. The RMP4 will include key deliverables agreed within the RMP3, and any additional actions or material changes envisaged in terms of those being delivered towards the latter part of 2021.

SG have not requested a separate winter plan, and thus this will form part of the RMP4 submission.

An action tracker is being developed with key actions and progress on deliverables, and updates will be provided to the Executive Teams, Committees and to the Board (by exception only).

The Committee **noted** the process in place for production of the RMP4.

11. OTHER

11.1 Corporate Calendar – Committee Dates for 2022/23

It was requested to factor in a possible July/August meeting for Audit & Risk in 2022, due to the likely timings for the Annual Accounts and Audits, should the normal June timescale be extended.

The Committee **noted** the proposed meeting dates for 2022/23.

12. ESCALATION OF ISSUES TO NHS FIFE BOARD

There were no issues to highlight to the Board.

It was agreed to advise in the cover note of the Minutes to the Board, an acknowledgment of the unique circumstances this year and the efforts of the Finance Team and Auditors to deliver the accounts against a tight and challenging timescale.

13. ANY OTHER BUSINESS

There was no other business.

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

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

AUDIT & RISK COMMITTEE – ACTION LIST

Meeting Date: Thursday 9 December 2021

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	TIMESCALE	COMMENTS / PROGRESS	RAG
1.	16/09/2021	**National Datix System**	Continue to develop the Datix IT Risk Management system to ensure it remains fit for purpose and supports organisational requirements.	**PC**	When available	26/11/21 - Discussions are taking place at a national level around the procurement of risk management systems (of which Datix is one). Any developments and the related implications for NHS Fife will be reported back to the Committee.	In progress
2.	16/09/2021	**Corporate Risk Register**	A full report will be provided on the outcomes of the review of the Corporate Risk Register at a future Committee meeting.	**PC**	March 2021		
3.	17/06/2021	**Financial Operating Procedures**	The Head of Financial Services & Procurement advised a review on the Financial Operating Procedures is being carried out and an update will be provided later in the year, once the Audit process is complete.	**KB**	December 2021	Closed - on agenda for 9 December 2021 meeting.	Closed – on agenda
4.	17/06/2021	**Annual Risk Management Report 2020/21**	The Board will be requested to discuss risks, reporting mechanisms and continuous improvement at a future Board Development Session.	**MM**	A future Board Development Session	Closed - Board Development Session held on 2 November 2021.	Closed

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**9 December 2021**
Title:	**Financial Operating Procedures Review 2021**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Report Author:	**Kevin Booth, Head of Financial Services**

1 Purpose

This is presented to the Board for:

- Approval

This report relates to a:

- Local policy

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

- Effective

2 Report summary

2.1 Situation

The Boards Financial Operating Procedures (FOPS) were last reviewed in July 2018 and as such the Head of Financial Services has prioritised a review to ensure that a potential weakness in Internal Control could be safeguarded. It is good practice to regularly review the FOPS and this ideally should be done regularly as required and not exceeding a 24-month period.

There are also a number of Internal Audit Management Recommendations dating back to 2018 (17) that had been previously agreed but were yet to be included in the existing version of the FOPS for members of staff to follow.

2.2 Background

The FOPS are the standard financial processes that members of staff are required to follow when administering the Boards funds. The FOPS form part of the internal control system of the Board 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 audit recommendations.

2.3 Assessment

A workplan was created to ensure that appropriate senior members of staff were consulted during the review of the FOPS. Sections were allocated for review to specific departments and 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 for overview before a final review was held between the Head of Financial Services and the Deputy Director of Finance. The review ensured that the FOPS are both reflective of current practice whilst also ensuring that adequate controls remain in place. During the review discussions were held to consider the changing work practices following the onset of COVID-19 and any risks identified were discussed during the drafting of the revised sections to ensure any appropriate actions were implemented.

Discussions were held with members of the Internal Audit Team to ensure that the historic internal audit recommendations were clarified and incorporated in order that these recommendations can now be closed off.

It is planned that the revised FOPS will be made available on the staff Intranet and communications will also be made to the Directorate Heads for cascading to all appropriate staff within their areas of responsibility.

Going forward the Head of Financial Services will ensure that a further revision of the FOPS is carried out by December 2023 and that all 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 Care

The distribution of the revised FOPS will ensure that the staff can consistently follow the approved process. Ensuring equality and improved transparency.

2.3.2 Workforce

The distribution of the revised FOPS should reduce the potential for confusion and procedures not being followed consistently by the workforce.

2.3.3 Financial

The revised FOPS provide an additional safeguard to the Board's Finances

2.3.4 Risk Assessment/Management

The FOPS will need to be distributed down through the Directorates to ensure that the use of any historic, localised versions is reduced.

2.3.5 Equality and Diversity, including health inequalities

The FOPS provide an operational guide to staff to ensure that processes should be followed in a consistent manner.

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

In order to ensure a wide-reaching review of the FOPS were carried out, The Head of Financial Services consulted with a wide range of senior members of staff to ensure that accurate representation of processes could be recorded. Out with the Finance Team, colleagues from both Estates and Digital Information provided input.

2.3.8 Route to the Meeting

Following discussions with the Chair of the Audit and Risk Committee surrounding the outstanding Internal Audit Recommendations and action was created at the June committee meeting and this is reflected in the committees Action Log.

2.4 Recommendation

Members should take assurance that the FOPS have now been reviewed and the outstanding Internal Audit recommendations have all been incorporated.

This paper is presented for the Committee's Approval.

3 List of appendices

The following appendices are included with this report:

- Draft FOPS

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

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**9 December 2021**
Title:	**Losses and Special Payments Overview**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Report Author:	**Kevin Booth, Head of Financial Services**

1 Purpose

This is presented to the Audit & Risk Committee for:

- Assurance

This report relates to a:

- National policy

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

- Effective

2 Report summary

2.1 Situation

This paper presents a summary of the Board's Losses and Special Payments covering the periods 01/04/21 – 30/06/21 and 01/07/21 – 30/09/21. The attached appendices quantify the Board's Losses and Special payments into categories defined by the requirements of the Scottish Government. These categories include losses relating to fraud, damage to buildings and 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 legal claims that are negotiated on the Board's behalf by the Central Legal Office.

2.2 Background

The 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. All losses and Special Payments as per section 16 of the Financial Operating Procedures are to be approved by the relevant Directorate/Department Head. The Loss, theft or damage forms are then provided to the Deputy Director of Finance for final approval. The ex-gratia compensation payments for both clinical and non-clinical legal claims are agreed on the Boards behalf by the Central Legal Office. The Finance Business Partner for Corporate

Services liaises with the Central Legal Office to ensure that settlements are as communicated and recharged accordingly. The Losses and Special Payments are then collated in the prescribed categories/format presented as per the requirements of the Scottish Government.

2.3 Assessment

The attached appendices summarise the Boards losses and Special Payments for the periods 01/04/21 – 30/06/21 (Quarter 1) and 01/07/21 – 30/09/21 (Quarter 2). The reports categorise the types of losses and special payments made in the period while also quantifying the number of cases of each and also the total monetary value.

It should be noted that the significant increase in the total between quarter 1 (£222,238) and quarter 2 (£908,168), is as a result of significantly increased Ex-gratia Clinical legal settlements of £605,708 and an increase in both the numbers and value of Ex-gratia Non-Clinical legal settlements, an additional 5 claims totalling £69,037.

To identify and minimise areas or types of recurrent loss an annual analysis report is planned to be prepared and where required the Head of Financial Services will liaise with the relevant Directorate Manager/Department Head to consider and implement any changes to current working practices, which may reduce future losses.

2.3.1 Quality/ Patient Care

N/A

2.3.2 Workforce

N/A

2.3.3 Financial

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

2.3.4 Risk Assessment/Management

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

2.3.5 Equality and Diversity, including health inequalities

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

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

The Boards quarterly Losses and Special Payments are complied by the Treasury Team and are provided to the Head of Financial Services. These losses and Special Payments have already 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 was previously discussed with Margo McGurk, Director of Finance and Strategy.

2.4 Recommendation

This paper is brought to the members attention to give visibility of the Board's losses and special payments and also to discuss the frequency the Committee would like to be provided with this information and whether any further information could be provided to give members a better understanding of the underlying position?

- **Assurance**

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Summary of Losses and Special Payments 01/04/21 – 30/06/21
- Appendix No 2, Summary of Losses and Special Payments 01/07/21 – 30/09/21

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

FIFE HEALTH BOARD

FOR THE PERIOD 01.04.21 - 30.06.21

SUMMARY OF LOSSES AND SPECIAL PAYMENTS

ITEM NO.	CATEGORY	NO. OF CASES	TOTAL £
	Miscellaneous / Theft / Arson / Wilful Damage		
1	Cash		
2	Stores/procurement		
3	Equipment		
4	Contracts		
5	Payroll		
6	Buildings & Fixtures	6	1,360.83
7	Other		
	Fraud, Embezzlement & other irregularities (inc. attempted fraud-		
8	Cash		
9	Stores/procurement		
10	Equipment		
11	Contracts		
12	Payroll		
13	Other		
14	**Nugatory & Fruitless Payments**		
	Claims Abandoned:		
15	(a) Private Accommodation		
	(b) Other	158	1,216.79
	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	4	962.53
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	7	189,071.75
27	Compensation Payments - ex-gratia - Non Clinical	2	28,500.00
28	Compensation Payments - ex-gratia - Financial Loss	7	926.68
29	Other Payments		
	Damage to Buildings and Fixtures:		
30	Incidents of the Service :		
	- Fire		
	- Flood		
	- Accident	1	200.00
	- Other Causes		
31	**Extra-Statutory & Extra-regulationary Payments**		
32	**Gifts in cash or kind**		
33	**Other Losses**		
		185	222,238.58

FIFE HEALTH BOARD

FOR THE PERIOD 01.07.21 - 30.09.21

SUMMARY OF LOSSES AND SPECIAL PAYMENTS

ITEM NO.	CATEGORY	NO. OF CASES	TOTAL £
	Miscellaneous / Theft / Arson / Wilful Damage		
1	Cash		
2	Stores/procurement		
3	Equipment		
4	Contracts		
5	Payroll	1	1,604.00
6	Buildings & Fixtures	5	128.79
7	Other		
	Fraud, Embezzlement & other irregularities (inc. attempted fraud-		
8	Cash		
9	Stores/procurement		
10	Equipment		
11	Contracts		
12	Payroll		
13	Other		
14	**Nugatory & Fruitless Payments**		
	Claims Abandoned:		
15	(a) Private Accommodation		
	(b) Other	195	6,840.31
	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	8	3,260.06
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	8	794,779.16
27	Compensation Payments - ex-gratia - Non Clinical	7	97,537.60
28	Compensation Payments - ex-gratia - Financial Loss	10	3,200.03
29	Other Payments		
	Damage to Buildings and Fixtures:		
30	Incidents of the Service :		
	- Fire		
	- Flood		
	- Accident	5	818.50
	- Other Causes		
31	**Extra-Statutory & Extra-regulationary Payments**		
32	**Gifts in cash or kind**		
33	**Other Losses**		
		239	908,168.45

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**9 December 2021**
Title:	**Revised Code of Corporate Governance**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Gillian MacIntosh, Board Secretary**

1. Purpose

This is presented to the Audit & Risk Committee for:

- Assurance

This report relates to a:

- Local policy

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

- Effective

2. Report Summary

2.1 Situation

The Fife NHS Code of Corporate Governance is an all-encompassing suite of documents setting out the Board's Standing Orders, Committee Terms of Reference, Scheme of Delegation, Standing Financial Instructions and Code of Conduct for Board Members. It is therefore important that it remains current and correct.

An annual review of the Code of Corporate Governance is normally undertaken each spring, with an updated version approved previously in 2021 by Audit & Risk in April and by the Board in May. However, a recent change has been made to reflect the addition of the Terms of Reference of the new Public Health & Wellbeing Committee, following Board approval of this at its 30 November meeting. It was thought beneficial to reflect the existence of the new Committee in key governance documents immediately, rather than waiting until the next update, hence the in-year timing of this report.

2.2 Background

The most recent version of the Board's Code of Corporate Governance was formally approved by the Board in May 2021. At agreed previously, an annual update of the Code is considered by the Audit & Risk Committee and thence the Board, and this will be undertaken as scheduled in spring 2022. Therein, that update will also reflect, as normal, routine changes to all Board Committee remits and any recommended revisions to the Standing Financial Instructions.

2.3 Assessment

The version of the Code attached clearly reflects the establishment of the new Public Health & Wellbeing Committee, referencing this within the governance structural chart (p.15 of the document) and providing the approved Terms of Reference of the Committee itself (pp.33-35). Its remit is also summarised in the Scheme of Delegation, alongside existing Board governance committees (pp.83-84). Following Committee and Board approval, the online version of this key governance document will be updated to reflect the changes made.

2.3.1 Quality/ Patient Care

Delivering robust governance across the organisation is supportive of enhanced patient care and quality standards.

2.3.2 Workforce

N/A.

2.3.3 Financial

Ensuring appropriate scrutiny of NHS Fife's governance documents, and ensuring these remain up-to-date, is a core part of the Committee's remit.

2.3.4 Risk Assessment/Management

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

2.3.5 Equality and Diversity, including health inequalities

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

2.3.6 Other impact

N/A.

2.3.7 Communication, involvement, engagement and consultation

N/A.

2.3.8 Route to the Meeting

This paper has been considered in draft by the Director of Finance & Strategy and takes account of any initial comments thus received. It has also been reviewed by EDG at its meeting on 2 December.

The new Public Health & Wellbeing Committee reviewed and discussed their proposed Terms of Reference at their meeting on 15 October. NHS Fife Board approval of the included Terms of Reference was given at their meeting on 30 November.

2.4 Recommendation

The paper is provided for:

- **Recommending approval to the Board of the updated Code** – subject to members' comments regarding any further amendments necessary

3 List of appendices

The following appendices are included with this report:

- Appendix 1 – Revised Code of Corporate Governance

Report Contact
Dr Gillian MacIntosh
Head of Corporate Governance & Board Secretary
gillian.macintosh@nhs.scot

CODE OF CORPORATE GOVERNANCE

FIFE NHS BOARD

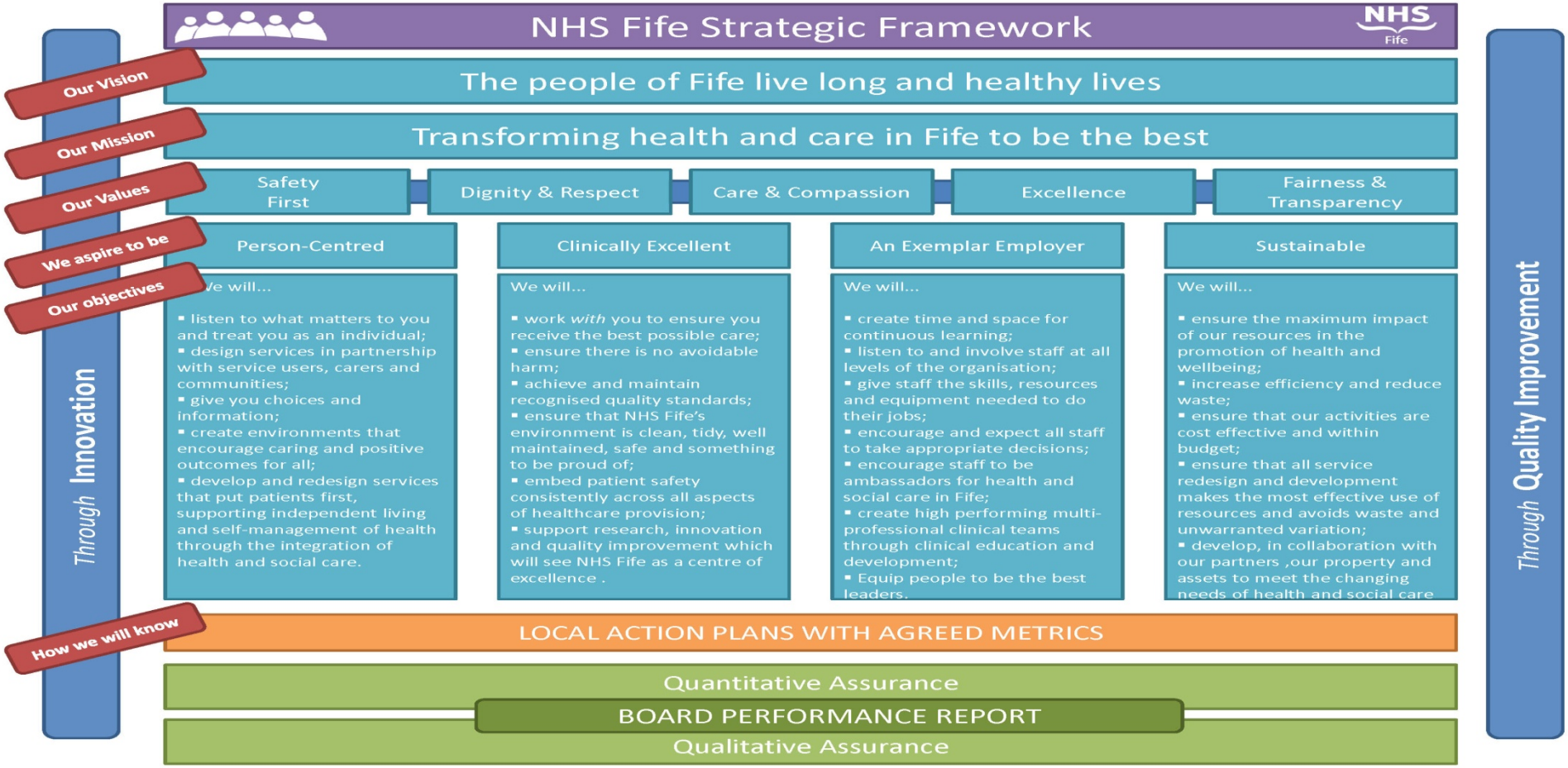
Reviewed by: Board Secretary
Date of Board Approval: *30 November 2021 (TBC)*
Next Review Date: April 2022

Issue no. 18 – Master

CONTENTS

NHS FIFE
STRATEGIC FRAMEWORK

The Strategic Framework underpins all that NHS Fife as an organisation does. It highlights NHS Fife's key principles and provides a basis for all strategies and plans - each strategy needs to wrap around the principles set out in the framework. The organisation has worked closely with staff to develop the Framework, and it has been endorsed by the NHS Fife Board and staff groups



STANDING ORDERS FOR THE PROCEEDINGS AND BUSINESS OF FIFE NHS BOARD

1 General

1.1 These Standing Orders for regulation of the conduct and proceedings of [Fife] NHS Board, the common name for Fife Health Board, [the Board] and its Committees are made under the terms of The Health Boards (Membership and Procedure) (Scotland) Regulations 2001 (2001 No. 302), as amended up to and including The Health Boards (Membership and Procedure) (Scotland) Amendment Regulations 2016 (2016 No. 3).

Healthcare Improvement Scotland and NHS National Services Scotland are constituted under a different legal basis, and are not subject to the above regulations. Consequently those bodies will have different Standing Orders.

The NHS Scotland Blueprint for Good Governance (issued through DL 2019) 02) has informed these Standing Orders. The Blueprint describes the functions of the Board as:

- Setting the direction, clarifying priorities and defining expectations.
- Holding the executive to account and seeking assurance that the organisation is being effectively managed.
- Managing risks to the quality, delivery and sustainability of services.
- Engaging with stakeholders.
- Influencing the Board's and the organisation's culture.

Further information on the role of the Board, Board members, the Chair, Vice-Chair, and the Chief Executive is available on the NHS Scotland Board Development website.

1.2 The Scottish Ministers shall appoint the members of the Board. The Scottish Ministers shall also attend to any issues relating to the resignation and removal, suspension and disqualification of members in line with the above regulations. Any member of the Board may on reasonable cause shown be suspended from the Board or disqualified for taking part in any business of the Board in specified circumstances.

1.3 Any statutory provision, regulation or direction by Scottish Ministers, shall have precedence if they are in conflict with these Standing Orders.

1.4 Any one or more of these Standing Orders may be varied or revoked at a meeting of the Board by a majority of members present and voting, provided the notice for the meeting at which the proposal is to be considered clearly states the extent of the proposed repeal, addition or amendment. The Board will annually review its Standing Orders.

1.5 Any member of the Board may on reasonable cause shown be suspended from the Board or disqualified for taking part in any business of the Board in specified circumstances. The Scottish Ministers may by determination suspend a

member from taking part in the business (including meetings) of the Board. Paragraph 5.4 sets out when the person presiding at a Board meeting may suspend a Board member for the remainder of a specific Board meeting. The Standards Commission for Scotland can apply sanctions if a Board member is found to have breached the Board Members' Code of Conduct, and those include suspension and disqualification. The regulations (see paragraph 1.1) also set out grounds for why a person may be disqualified from being a member of the Board.

Board Members – Ethical Conduct

1.6 Members have a personal responsibility to comply with the Code of Conduct for Members of Fife Health Board. The Commissioner for Public Standards can investigate complaints about members who are alleged to have breached their Code of Conduct. The Board will have appointed a Standards Officer. This individual is responsible for carrying out the duties of that role, however he or she may delegate the carrying out of associated tasks to other members of staff. The Board's appointed Standards Officer shall ensure that the Board's Register of Interests is maintained. When a member needs to update or amend his or her entry in the Register, he or she must notify the Board's appointed Standards Officer of the need to change the entry within one month after the date the matter required to be registered.

1.7 The Board's appointed Standards Officer shall ensure the Register is available for public inspection at the principal offices of the Board at all reasonable times and will be included on the Board's website.

1.8 Members must always consider the relevance of any interests they may have to any business presented to the Board or one of its committees. Members must observe paragraphs 5.6 - 5.10 of these Standing Orders, and have regard to Section 5 of the Code of Conduct (Declaration of Interests).

1.9 In case of doubt as to whether any interest or matter should be declared, in the interests of transparency, members are advised to make a declaration.

1.10 Members shall make a declaration of any gifts or hospitality received in their capacity as a Board member. Such declarations shall be made to the Board's appointed Standards Officer who shall make them available for public inspection at all reasonable times at the principal offices of the Board and on the Board's website. The Register of Interests includes a section on gifts and hospitality. The Register may include the information on any such declarations, or cross-refer to where the information is published.

1.11 The Board's Secretary shall provide a copy of these Standing Orders to all members of the Board on appointment. A copy shall also be held on the Board's website.

2 Chair

2.1 The Scottish Ministers shall appoint the Chair of the Board.

3 Vice-Chair

3.1 The Chair shall nominate a candidate or candidates for vice-chair to the Cabinet Secretary. The candidate(s) must be a Non-Executive member of the Board. A member who is an employee of a Board is disqualified from being Vice-Chair. The Cabinet Secretary will in turn determine who to appoint based on evidence of effective performance and evidence that the member has the skills, knowledge and experience needed for the position. Following the decision, the Board shall appoint the member as Vice-Chair. Any person so appointed shall, so long as he or she remains a member of the Board, continue in office for such a period as the Board may decide.

3.2 The Vice-Chair may at any time resign from that office by giving notice in writing to the Chair. The process to appoint a replacement Vice-Chair is the process described at paragraph 3.1.

3.3 Where the Chair has died, ceased to hold office, or is unable for a sustained period of time to perform his or her duties due to illness, absence from Scotland or for any other reason, then the Board's Secretary should refer this to the Scottish Government. The Cabinet Secretary will confirm which member may assume the role of interim chair in the period until the appointment of a new chair, or the return of the appointed chair. Where the Chair is absent for a short period due to leave (for whatever reason), the Vice-Chair shall assume the role of the Chair in the conduct of the business of the Board. In either of these circumstances references to the Chair shall, so long as there is no Chair able to perform the duties, be taken to include references to either the interim chair or the Vice-Chair. If the Vice-Chair has been appointed as the Interim Chair, then the process described at paragraph 3.1 will apply to replace the Vice-Chair.

4 Calling and Notice of Board Meetings

4.1 The Chair may call a meeting of the Board at any time and shall call a meeting when required to do so by the Board. The Board shall meet at least six times in the year and will annually approve a forward schedule of meeting dates.

4.2 The Chair will determine the final agenda for all Board meetings. The agenda may include an item for any other business, however this can only be for business which the Board is being informed of for awareness, rather than being asked to make a decision. No business shall be transacted at any meeting of the Board other than that specified in the notice of the meeting except on grounds of urgency.

4.3 Any member may propose an item of business to be included in the agenda of a future Board meeting by submitting a request to the Chair. If the Chair elects to agree to the request, then the Chair may decide whether the item is to be considered at the Board meeting which immediately follows the receipt of the request, or a future Board meeting. The Chair will inform the member which meeting the item will be discussed. If any member has a specific legal duty or

responsibility to discharge which requires that member to present a report to the Board, then that report will be included in the agenda.

4.4 In the event that the Chair decides not to include the item of business on the agenda of a Board meeting, then the Chair will inform the member in writing as to the reasons why.

4.5 A Board meeting may be called if one third of the whole number of members signs a requisition for that purpose. The requisition must specify the business proposed to be transacted. The Chair is required to call a meeting within 7 days of receiving the requisition. If the Chair does not do so, or simply refuses to call a meeting, those members who presented the requisition may call a meeting by signing an instruction to approve the notice calling the meeting provided that no business shall be transacted at the meeting other than that specified in the requisition.

4.6 Before each meeting of the Board, a notice of the meeting (in the form of an agenda), specifying the time, place and business proposed to be transacted at it and approved by the Chair, or by a member authorised by the Chair to approve on that person's behalf, shall be circulated to every member so as to be available to them at least three clear days before the meeting. The notice shall be distributed along with any papers for the meeting that are available at that point.

4.7 With regard to calculating clear days for the purpose of notice under 4.6 and 4.9, the period of notice excludes the day the notice is sent out and the day of the meeting itself. Additionally only working days (Monday to Friday) are to be used when calculating clear days; weekend days and public holidays should be excluded.

Example: If a Board is meeting on a Wednesday, the notice and papers for the meeting should be distributed to members no later than the preceding Thursday. The three clear days would be Friday, Monday and Tuesday. If the Monday was a public holiday, then the notice and papers should be distributed no later than the preceding Wednesday.

4.8 Lack of service of the notice on any member shall not affect the validity of a meeting.

4.9 Board meetings shall be held in public. A public notice of the time and place of the meeting shall be provided at least three clear days before the meeting is held. The notice and the meeting papers shall also be placed on the Board's website. The meeting papers will include the minutes of committee meetings which the relevant committee has approved. The exception is that the meeting papers will not include the minutes of the Remuneration Committee. The Board may determine its own approach for committees to inform it of business which has been discussed in committee meetings for which the final minutes are not yet available. For items of business which the Board will consider in private session (see paragraph 5.22), only the Board members will normally receive the meeting papers for those items, unless the person presiding agrees that others may receive them.

4.10 Any individual or group or organisation which wishes to make a deputation to the Board must make an application to the Chair's Office at least 21 working days before the date of the meeting at which the deputation wish to be received. The application will state the subject and the proposed action to be taken.

4.11 Any member may put any relevant question to the deputation, but will not express any opinion on the subject matter until the deputation has withdrawn. If the subject matter relates to an item of business on the agenda, no debate or discussion will take place until the item is considered in the order of business.

4.12 Any individual or group or organisation which wishes to submit a petition to the Board will deliver the petition to the Chair's Office at least 21 working days before the meeting at which the subject matter may be considered. The Chair will decide whether or not the petition will be discussed at the meeting.

5 Conduct of Meetings

Authority of the Person Presiding at a Board Meeting

5.1 The Chair shall preside at every meeting of the Board. The Vice-Chair shall preside if the Chair is absent. If both the Chair and Vice Chair are absent, the members present at the meeting shall choose a Board member who is not an employee of a Board to preside.

5.2 The duty of the person presiding at a meeting of the Board or one of its committees is to ensure that the Standing Orders or the committee's terms of reference are observed, to preserve order, to ensure fairness between members, and to determine all questions of order and competence. The ruling of the person presiding shall be final and shall not be open to question or discussion.

5.3 The person presiding may direct that the meeting can be conducted in any way that allows members to participate, regardless of where they are physically located, e.g. video-conferencing, teleconferencing. For the avoidance of doubt, those members using such facilities will be regarded as present at the meeting.

5.4 In the event that any member who disregards the authority of the person presiding, obstructs the meeting, or conducts himself/herself inappropriately the person presiding may suspend the member for the remainder of the meeting. If a person so suspended refuses to leave when required by the person presiding to do so, the person presiding will adjourn the meeting in line with paragraph 5.12. For paragraphs 5.5 to 5.20, reference to 'Chair' means the person who is presiding the meeting, as determined by paragraph 5.1.

Quorum

5.5 The Board will be deemed to meet only when there are present, and entitled to vote, a quorum of at least one third of the whole number of members, including at least two members who are not employees of a Board. The quorum for

committees will be set out in their terms of reference, however it can never be less than two Board members.

5.6 In determining whether or not a quorum is present the Chair must consider the effect of any declared interests.

5.7 If a member, or an associate of the member, has any pecuniary or other interest, direct or indirect, in any contract, proposed contract or other matter under consideration by the Board or a committee, the member should declare that interest at the start of the meeting. This applies whether or not that interest is already recorded in the Board Members' Register of Interests. Following such a declaration, the member shall be excluded from the Board or committee meeting when the item is under consideration, and should not be counted as participating in that meeting for quorum or voting purposes.

5.8 Paragraph 5.7 will not apply where a member's, or an associate of theirs, interest in any company, body or person is so remote or insignificant that it cannot reasonably be regarded as likely to affect any influence in the consideration or discussion of any question with respect to that contract or matter. In March 2015, the Standards Commission granted a dispensation to NHS Board members who are also voting members of integration joint boards. The effect is that those members do not need to declare as an interest that they are a member of an integration joint board when taking part in discussions of general health & social care issues. However members still have to declare other interests as required by Section 5 of the Board Members' Code of Conduct.

5.9 If a question arises at a Board meeting as to the right of a member to participate in the meeting (or part of the meeting) for voting or quorum purposes, the question may, before the conclusion of the meeting be referred to the Chair. The Chair's ruling in relation to any member other than the Chair is to be final and conclusive. If a question arises with regard to the participation of the Chair in the meeting (or part of the meeting) for voting or quorum purposes, the question is to be decided by the members at that meeting. For this latter purpose, the Chair is not to be counted for quorum or voting purposes.

5.10 Paragraphs 5.6-5.9 shall equally apply to members of any Board committees, whether or not they are also members of the Board, e.g. stakeholder representatives.

5.11 When a quorum is not present, the only actions that can be taken are to either adjourn to another time or abandon the meeting altogether and call another one. The quorum should be monitored throughout the conduct of the meeting in the event that a member leaves during a meeting, with no intention of returning. The Chair may set a time limit to permit the quorum to be achieved before electing to adjourn, abandon or bring a meeting that has started to a close.

Adjournment

5.12 If it is necessary or expedient to do so for any reason (including disorderly conduct or other misbehaviour at a meeting), a meeting may be adjourned to

another day, time and place. A meeting of the Board, or of a committee of the Board, may be adjourned by the Chair until such day, time and place as the Chair may specify.

Business of the Meeting

The Agenda

5.13 If a member wishes to add an item of business which is not in the notice of the meeting, he or she must make a request to the Chair ideally in advance of the day of the meeting and certainly before the start of the meeting. The Chair will determine whether the matter is urgent and accordingly whether it may be discussed at the meeting.

5.14 The Chair may change the running order of items for discussion on the agenda at the meeting. Please also refer to paragraph 4.2.

5.15 For Board meetings only, the Chair may propose within the notice of the meeting "items for approval" and "items for discussion". The items for approval are not discussed at the meeting, but rather the members agree that the content and recommendations of the papers for such items are accepted, and that the minutes of the meeting should reflect this. The Board must approve the proposal as to which items should be in the "items for approval" section of the agenda. Any member (for any reason) may request that any item or items be removed from the "items for approval" section. If such a request is received, the Chair shall either move the item to the "items for discussion" section, or remove it from the agenda altogether.

Decision-Making

5.16 The Chair may invite the lead for any item to introduce the item before inviting contributions from members. Members should indicate to the Chair if they wish to contribute, and the Chair will invite all who do so to contribute in turn. Members are expected to question and challenge proposals constructively and carefully to reach and articulate a considered view on the suitability of proposals.

5.17 The Chair will consider the discussion, and whether or not a consensus has been reached. Where the Chair concludes that consensus has been reached, then the Chair will normally end the discussion of an item by inviting agreement to the outcomes from the discussion and the resulting decisions of the Board.

5.18 As part of the process of stating the resulting decisions of the Board, the Chair may propose an adaptation of what may have been recommended to the Board in the accompanying report, to reflect the outcome of the discussion.

5.19 The Board may reach consensus on an item of business without taking a formal vote, and this will be normally what happens where consensus has been reached.

5.20 Where the Chair concludes that there is not a consensus on the Board's position on the item and/ or what it wishes to do, then the Chair will put the decision to a vote. If at least two Board members ask for a decision to be put to a vote, then the Chair will do so. Before putting any decision to vote, the Chair will summarise the outcome of the discussion and the proposal(s) for the members to vote on.

5.21 Where a vote is taken, the decision shall be determined by a majority of votes of the members present and voting on the question. In the case of an equality of votes, the Chair shall have a second or casting vote. The Chair may determine the method for taking the vote, which may be by a show of hands, or by ballot, or any other method the Chair determines.

5.22 While the meeting is in public the Board may not exclude members of the public and the press (for the purpose of reporting the proceedings) from attending the meeting.

Board Meeting in Private Session

5.23 The Board may agree to meet in private in order to consider certain items of business. The Board may decide to meet in private on the following grounds:

- The Board is still in the process of developing proposals or its position on certain matters, and needs time for private deliberation.
- The business relates to the commercial interests of any person and confidentiality is required, e.g. when there is an ongoing tendering process or contract negotiation.
- The business necessarily involves reference to personal information, and requires to be discussed in private in order to uphold the Data Protection Principles.
- The Board is otherwise legally obliged to respect the confidentiality of the information being discussed.

5.24 The minutes of the meeting will reflect when the Board has resolved to meet in private.

Minutes

5.25 The names of members present at a meeting of the Board, or of a committee of the Board, shall be recorded in the minute of the meeting. The names of other persons in attendance shall also be recorded.

5.26 The Board's Secretary (or his/her authorised nominee) shall prepare the minutes of meetings of the Board and its committees. The Board or the committee shall review the draft minutes at the following meeting. The person presiding at that meeting shall sign the approved minute.

6 Matters Reserved for the Board

Introduction

6.1 The Scottish Government retains the authority to approve certain items of business. There are other items of the business which can only be approved at an NHS Board meeting, due to either Scottish Government directions or a Board decision in the interests of good governance practice.

6.2 This section summarises the matters reserved to the Board:

a) Standing Orders
b) The establishment and terms of reference of all its committees, and appointment of committee members
c) Organisational Values
d) The strategies for all the functions that it has planning responsibility for, subject to any provisions for major service change which require Ministerial approval.
e) The Annual Operational Plan for submission to the Scottish Government for its approval. (Note: The Board should consider the draft for submission in private session. Once the Scottish Government has approved the Annual Operational Plan, the Board should receive it at a public Board meeting.)
f) Corporate objectives or corporate plans which have been created to implement its agreed strategies.
g) Risk Management Policy.
h) Financial plan for the forthcoming year, and the opening revenue and capital budgets.
i) Standing Financial Instructions and a Scheme of Delegation.
j) Annual accounts and report. (Note: Note: This must be considered when the Board meets in private session. In order to respect Parliamentary Privilege, the Board cannot publish the annual accounts or any information drawn from it before the accounts are laid before the Scottish Parliament. Similarly the Board cannot publish the report of the external auditors of their annual accounts in this period.)
k) Any business case item that is beyond the scope of its delegated financial authority before it is presented to the Scottish Government for approval. The Board shall comply with the Scottish Capital Investment Manual.
l) The Board shall approve the content, format, and frequency of performance reporting to the Board.
m) The appointment of the Board's chief internal auditor. (Note: This applies either when the proposed chief internal auditor will be an employee of the Board, or when the chief internal auditor is engaged through a contract with an external provider. The audit committee should advise the Board on the appointment, and the Board may delegate to the audit committee oversight of the process which leads to a recommendation for appointment.)
n) The contribution to Community Planning Partnerships through the associated improvement plans.
o) Health & Safety Policy
p) Arrangements for the approval of all other policies.
q) The system for responding to any civil actions raised against the Board.
r) The system for responding to any occasion where the Board is being investigated and / or prosecuted for a criminal or regulatory offence.

6.3 The Board may be required by law or Scottish Government direction to approve certain items of business, e.g. the integration schemes for a local authority area.

6.4 The Board itself may resolve that other items of business be presented to it for approval.

7 Delegation of Authority by the Board

7.1 Except for the Matters Reserved for the Board, the Board may delegate authority to act on its behalf to committees, individual Board members, or other Board employees. In practice this is achieved primarily through the Board's approval of the Standing Financial Instructions and the Scheme of Delegation.

7.2 The Board may delegate responsibility for certain matters to the Chair for action. In such circumstances, the Chair should inform the Board of any decision or action subsequently taken on these matters.

7.3 The Board and its officers must comply with the NHS Scotland Property Transactions Handbook, and this is cross-referenced in the Scheme of Delegation.

7.4 The Board may, from time to time, request reports on any matter or may decide to reserve any particular decision for itself. The Board may withdraw any previous act of delegation to allow this.

8 Execution of Documents

8.1 Where a document requires to be authenticated under legislation or rule of law relating to the authentication of documents under the Law of Scotland, or where a document is otherwise required to be authenticated on behalf of the Board, it shall be signed by an executive member of the Board or any person duly authorised to sign under the Scheme of Delegation in accordance with the Requirements of Writing (Scotland) Act 1995. Before authenticating any document the person authenticating the document shall satisfy themselves that all necessary approvals in terms of the Board's procedures have been satisfied. A document executed by the Board in accordance with this paragraph shall be self-proving for the purposes of the Requirements of Writing (Scotland) Act 1995.

8.2 Scottish Ministers shall direct which officers of the Board can sign on their behalf in relation to the acquisition, management and disposal of land.

8.3 Any authorisation to sign documents granted to an officer of the Board shall terminate upon that person ceasing (for whatever reason) from being an employee of the Board, without further intimation or action by the Board.

9 Committees

9.1 Subject to any direction issued by Scottish Ministers, the Board shall appoint such committees (and sub-committees) as it thinks fit. NHS Scotland Board

Development website will identify the committees which the Board must establish.

9.2 The Board shall appoint the chairs of all committees. The Board shall approve the terms of reference and membership of the committees. The Board shall review these as and when required, and shall review the terms within 2 years of their approval if there has not been a review.

9.3 The Board shall appoint committee members to fill any vacancy in the membership as and when required. If a committee is required by regulation to be constituted with a particular membership, then the regulation must be followed

9.4 Provided there is no Scottish Government instruction to the contrary, any Non-Executive Board member may replace a Committee member who is also a Non-Executive Board member, if such a replacement is necessary to achieve the quorum of the committee.

9.5 The Board's Standing Orders relating to the calling and notice of Board meetings, conduct of meetings, and conduct of Board members shall also be applied to committee meetings where the committee's membership consist of or include all the Board members. Where the committee's members includes some of the Board's members, the committee's meetings shall not be held in public and the associated committee papers shall not be placed on the Board's website, unless the Board specifically elects otherwise. Generally Board members who are not members of a committee may attend a committee meeting and have access to the meeting papers. However if the committee elects to consider certain items as restricted business, then the meeting papers for those items will normally only be provided to members of that committee. The person presiding the committee meeting may agree to share the meeting papers for restricted business papers with others.

9.6 The Board shall approve a calendar of meeting dates for its committees. The committee chair may call a meeting any time, and shall call a meeting when requested to do so by the Board.

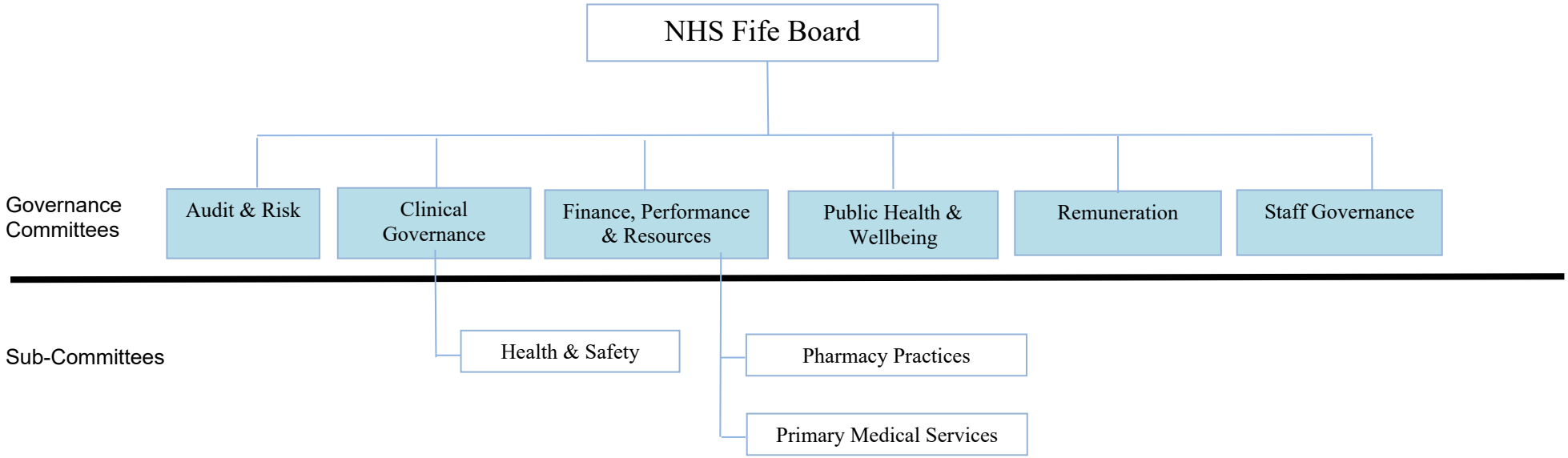
9.7 The Board may authorise committees to co-opt members for a period up to one year, subject to the approval of both the Board and the Accountable Officer. A committee may decide this is necessary to enhance the knowledge, skills and experience within its membership to address a particular element of the committee's business. A co-opted member is one who is not a member of Fife NHS Board and is not to be counted when determining the committee's quorum.

List of Appendices

Appendix 1 – Board Committee Structure
Appendix 2 – Terms of Reference for Board Committees
Appendix 3 – Standing Financial Instructions
Appendix 4 – Scheme of Delegation
Appendix 5 – SEAT Framework of Governance
Appendix 6 – Code of Conduct for Board Members

NHS Fife

NHS FIFE BOARD COMMITTEE STRUCTURE



TERMS OF REFERENCE FOR BOARD COMMITTEES

AUDIT AND RISK COMMITTEE
CONSTITUTION AND TERMS OF REFERENCE

Date of Board Approval: 25 May 2021

1. PURPOSE

1.1 To provide the Board with the assurance that the activities of Fife NHS Board are within the law and regulations governing the NHS in Scotland and that an effective system of internal control is maintained. The duties of the Audit and Risk Committee shall be in accordance with the Scottish Government Audit & Assurance Handbook, dated April 2018.

2. COMPOSITION

2.1 The membership of the Audit and Risk Committee will be:

- Five Non-Executive or Stakeholder members of Fife NHS Board (one of whom will be the Chair). (A Stakeholder member is appointed to the Board from Fife Council or by virtue of holding the Chair of the Area Partnership Forum or the Area Clinical Forum).

2.2 The Chair of Fife NHS Board cannot be a member of the Committee.

2.3 In order to avoid any potential conflict of interest, the Chair of the Audit and Risk Committee shall not be the Chair of any other governance Committee of the Board.

2.4 Officers of the Board will be expected to attend meetings of the Committee when issues within their responsibility are being considered by the Committee. In addition, the Committee Chair will agree with the Lead Officer to the Committee which Directors and other Senior Staff should attend meetings, routinely or otherwise. The following will normally be routinely invited to attend Committee meetings:

- Chief Executive
- Director of Finance (who is also Executive Lead for Risk Management)
- Chief Internal Auditor or representative
-
- Statutory External Auditor
- Head of Financial Services & Procurement
- Board Secretary

2.5 The Director of Finance shall serve as the Lead Executive Officer to the Committee.

2.6 The Board shall ensure that the Committee's membership has an adequate range of skills and experience that will allow it to effectively discharge its responsibilities. With regard to the Committee's responsibilities for financial reporting, the Board shall ensure that at least one member can engage

competently with financial management and reporting in the organisation, and associated assurances.

3. QUORUM

3.1 No business shall be transacted at a meeting of the Committee unless at least three Non-Executive or Stakeholder members are present. There may be occasions when due to the unavailability of the above Non-Executive members, the Chair will ask other Non-Executive members to act as members of the committee so that quorum is achieved. This will be drawn to the attention of the Board.

4. MEETINGS

4.1 The Committee shall meet as necessary to fulfil its remit but not less than four times a year.

4.2 The Chair of Fife NHS Board shall appoint a Chair who shall preside at meetings of the Committee. If the Chair is absent from any meeting of the Committee, members shall elect from amongst themselves one of the other Committee members to chair the meeting.

4.3 The agenda and supporting papers will be sent out at least five clear days before the meeting.

4.4 If necessary, meetings of the Committee shall be convened and attended exclusively by members of the Committee and, if relevant, the External Auditor and/or Chief Internal Auditor.

4.5 If required, the Chairperson of the Audit and Risk Committee may meet individually with the Chief Internal Auditor, the External Auditor and the Accountable Officer.

5. REMIT

5.1 The main objective of the Audit and Risk Committee is to support the Accountable Officer and Fife NHS Board in meeting their assurance needs. This includes:

- Helping the Accountable Officer and Fife NHS Board formulate their assurance needs, via the creation and operation of a well-designed assurance framework, with regard to risk management, governance and internal control;

- Reviewing and challenging constructively the assurances that have been provided as to whether their scope meets the needs of the Accountable Officer and Fife Health Board;

- Reviewing the reliability and integrity of those assurances, i.e. considering whether they are founded on reliable evidence, and that the conclusions are reasonable in the context of that evidence;

- Drawing attention to weaknesses in systems of risk management, governance and internal control, and making suggestions as to how those weaknesses can be addressed;

- Commissioning future assurance work for areas that are not being subjected to significant review

- Seeking assurance that previously identified areas of weakness are being remedied.

The Committee has no executive authority, and is not charged with making or endorsing any decisions. The only exception to this principle is the approval of the Board's accounting policies and audit plans. The Committee exists to advise the Board or Accountable Officer who, in turn, makes the decision.

5.2 The Committee will keep under review and report to Fife NHS Board on the following:

Internal Control and Corporate Governance

5.3 To evaluate the framework of internal control and corporate governance comprising the following components, as recommended by the Turnbull Report:

- control environment;
- risk management;
- information and communication;
- control procedures;
- monitoring and corrective action.

5.4 To review the system of internal financial control, which includes:

- the safeguarding of assets against unauthorised use and disposition;
- the maintenance of proper accounting records and the reliability of financial information used within the organisation or for publication.

5.5 To ensure that the activities of Fife NHS Board are within the law and regulations governing the NHS.

5.6 To monitor performance and best value by reviewing the economy, efficiency and effectiveness of operations.

5.7 To review the disclosures included in the Governance Statement on behalf of the Board. In considering the disclosures, the Committee will review as necessary and seek confirmation on the information provided to the Chief Executive in support of the Governance Statement including the following:

- Annual Statements of Assurance from the main Governance Committees and the conclusions of the other sub-Committees, confirming whether they have fulfilled their remit and that there are adequate and effective internal controls operating within their particular area of operation;

- Annual Statement of Assurance from the Integration Joint Board, confirming all aspects of clinical, financial and staff governance have been fulfilled, with appropriate and adequate controls and risk management in place;

- Details from the Chief Executive on the operation of the framework in place to ensure that they discharge their responsibilities as Accountable Officer as set out in the Accountable Officer Memorandum;

- Confirmation from Executive Directors that there are no known control issues nor breaches of Standing Orders/Standing Financial Instructions other than any disclosed within the Governance Statement;

- Summaries of any relevant significant reports by Healthcare Improvement Scotland (HIS) or other external review bodies.

5.8 To present an annual statement of assurance on the above to the Board, to support the NHS Fife Chief Executive's Governance Statement.

Internal Audit

5.9 To review and approve the Internal Audit Strategic and Annual Plans having assessed the appropriateness to give reasonable assurance on the whole of risk control and governance.

5.10 To monitor audit progress and review audit reports.

5.11 To monitor the management action taken in response to the audit recommendations through an appropriate follow-up mechanism.

5.12 To consider the Chief Internal Auditor's annual report and assurance statement.

5.13 To approve the Fife Integration Joint Board Internal Audit Output Sharing Protocol.

5.14 To review the operational effectiveness of Internal Audit by considering the audit standards, resources, staffing, technical competency and performance measures.

5.15 To ensure that there is direct contact between the Audit and Risk Committee and Internal Audit and that the opportunity is given for discussions with the Chief Internal Auditor at least once per year (scheduled within the timetable of business) and, as required, without the presence of the Executive Directors.

5.16 To review the terms of reference and appointment of the Internal Auditors and to examine any reason for the resignation of the Auditors or early termination of contract/service level agreement.

External Audit

5.16 To note the appointment of the Statutory Auditor and to approve the appointment and remuneration of the External Auditors for Patients' Funds and Endowment Funds.

5.17 To review the Audit Strategy and Plan, including the Best Value and Performance Audits programme.

5.18 To consider all statutory audit material, in particular:

- Audit Reports;
- Annual Reports;
- Management Letters

relating to the certification of Fife NHS Boards Annual Accounts and Annual Patients' Funds Accounts.

5.19 To monitor management action taken in response to all External Audit recommendations, including Best Value and Performance Audit Reports.

5.20 To hold meetings with the Statutory Auditor at least once per year and as required, without the presence of the Executive Directors.

5.21 To review the extent of co-operation between External and Internal Audit.

5.22 To appraise annually the performance of the Statutory and External Auditors and to examine any reason for the resignation or dismissal of the External Auditors.

Risk Management

5.23 The Committee has no executive authority, and has no role in the executive decision-making in relation to the management of risk. The Committee is charged with ensuring that there is an appropriate publicised Risk Management Framework with all roles identified and fulfilled. However the Committee shall seek assurance that:

- There is a comprehensive risk management system in place to identify, assess, manage and monitor risks at all levels of the organisation;

- There is appropriate ownership of risk in the organisation, and that there is an effective culture of risk management;

- The Board has clearly defined its risk appetite (i.e. the level of risk that the Board is prepared to accept, tolerate, or be exposed to at any time), and that the executive's approach to risk management is consistent with that appetite;

- A robust and effective Board Assurance Framework is in place.

5.24 In order to discharge its advisory role to the Board and Accountable Officer, and to inform its assessment on the state of corporate governance, internal control and risk management, the Committee shall:

- Receive and review a quarterly report summarising any significant changes to the Board's Corporate Risk Register, and what plans are in place to manage them;

- Assess whether the Corporate Risk Register is an appropriate reflection of the key risks to the Board, so as to advise the Board;

- Consider the impact of changes to the risk register on the assurance needs of the Board and the Accountable Officer, and communicate any issues when required;

- Receive and review a quarterly update on the Board Assurance Framework;

- Assess whether the linkages between the Corporate Risk Register and the Board Assurance Framework are robust and enable the Board to identify gaps in control and assurance;

- Reflect on the assurances that have been received to date, and identify whether entries on the Board's risk management system requires to be updated;

- Receive an annual report on risk management, confirming whether or not there have been adequate and effective risk management arrangements throughout the year, and highlighting any material areas of risk;

- The Committee shall seek assurance on the overall system of risk management for all risks and risks pertinent to its core functions.

- The Committee may also elect to request information on risks held on any risk registers within the organisation.

Standing Orders and Standing Financial Instructions

5.25 To review annually the Standing Orders and associated appendices of Fife NHS Board and advise the Board of any amendments required.

5.26 To examine the circumstances associated with any occasion when Standing Orders of Fife NHS Board have been waived or suspended.

Annual Accounts

5.27 To review and recommend approval of draft Fife NHS Board Annual Accounts and Patient Funds Accounts to the Board.

5.28 To review the draft Annual Report and Financial Review of Fife NHS Board as found within the Directors Report incorporated within the Annual Accounts.

5.29 To review annually (and approve any changes in) the accounting policies of Fife NHS Board.

5.30 To review schedules of losses and compensation payments where the amounts exceed the delegated authority of the Board prior to being referred to the Scottish Government for approval.

Other Matters

5.31 The Committee has a duty to review its own performance, effectiveness, including its running costs, and terms of reference on an annual basis.

5.32 The Committee has a duty to keep up-to-date by having mechanisms to ensure topical legal and regulatory requirements are brought to Members' attention.

5.33 The Committee shall review the arrangements for employees raising concerns, in confidence, about possible wrongdoing in financial reporting or other matters. The Committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow-up action.

5.34 The Committee shall review regular reports on Fraud and potential Frauds.

5.35 The Chairperson of the Committee will submit an Annual Report of the work of the Committee to the Board following consideration by the Audit and Risk Committee in June.

5.36 The Chairperson of the Committee should be available at Fife NHS Board meetings to answer questions about its work.

5.37 The Committee shall draw up and approve, before the start of each financial year, an Annual Workplan for the Committee's planned work during the forthcoming year.

5.38 The Committee shall provide assurance to the Board on achievement and maintenance of Best Value standards, relevant to the Committee's area of governance as set out in Audit Scotland's baseline report "Developing Best Value Arrangements".

5.39 The Committee shall seek assurance that the Board has systems of control to ensure that it discharges its responsibilities under the Freedom of Information (Scotland) Act 2002.

5.40 The Committee shall review the Board's arrangements to prevent bribery and corruption within its activities. This includes the systems to support Board members' compliance with the NHS Fife Board Code of Conduct (Ethical Standards in Public Life Act 2000), the systems to promote the required standards of business conduct for all employees and the Boards procedure to prevent Bribery (Bribery Act 2000).

6. AUTHORITY

6.1 The Committee is authorised by the Board to investigate any activity within its Terms of Reference, and in doing so, is authorised to seek any information it requires from any employee or external experts.

6.2 In order to fulfil its remit, the Audit and Risk Committee may obtain whatever professional advice it requires, and may require Directors or other officers of the Board to attend meetings.

6.3 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

6.4 The Committee's authority is included in the Board's Scheme of Delegation and is set out in the Purpose and Remit of the Committee.

7. REPORTING ARRANGEMENTS

7.1 The Audit and Risk Committee reports directly to the Fife NHS Board on its work. Minutes of the Committee are presented to the Board by the Committee Chairperson, who provides a report, on an exception basis, on any particular issues which the Committee wishes to draw to the Board's attention.

7.2 The Audit and Risk Committee will advise the Scottish Parliament Public Audit Committee of any matters of significant interest as required by the Scottish Public Finance Manual.

CLINICAL GOVERNANCE COMMITTEE
CONSTITUTION AND TERMS OF REFERENCE

Date of Board Approval: 25 May 2021

1. PURPOSE

1.1 To oversee clinical governance mechanisms in NHS Fife.

1.2 To observe and check the clinical governance activity being delivered within NHS Fife and provide assurance to the Board that the mechanisms, activity and planning are acceptable.

1.3 To oversee the clinical governance and risk management activities in relation to the development and delivery of the Clinical Strategy.

1.4 To assure the Board that appropriate clinical governance mechanisms and structures are in place for clinical governance to be supported effectively throughout the whole of Fife NHS Board's responsibilities, including health improvement activities.

1.5 To assure the Board that the Clinical and Care Governance Arrangements in the Integration Joint Board are working effectively.

1.6 To escalate any issues to the NHS Fife Board, if serious concerns are identified about the quality and safety of care in the services across NHS Fife, including the services devolved to the Integration Joint Board.

2. COMPOSITION

2.1 The membership of the Clinical Governance Committee will be:

- Six Non-Executive or Stakeholder members of the Board (one of whom will be the Chair). (A Stakeholder member is appointed to the Board from Fife Council or by virtue of holding the Chair of the Area Partnership Forum or the Area Clinical Forum)
- Chief Executive
- Medical Director
- Nurse Director
- Director of Public Health
- One Staff Side representative of NHS Fife Area Partnership Forum
- One Representative from Area Clinical Forum
- One Patient Representative

2.2 Officers of the Board will be expected to attend meetings of the Committee when issues within their responsibility are being considered by the Committee. In addition, the Committee Chair will agree with the Lead Officer to the Committee which other Senior Staff should attend meetings, routinely or otherwise. The following will normally be routinely invited to attend Committee meetings:

- Director of Acute Services
- Director of Health & Social Care
- Director of Pharmacy & Medicines
- Associate Medical Director, Acute Services Division
- Associate Medical Director, Fife Health & Social Care Partnership
- Associate Medical Director, Women & Children's Services
- Head of Quality & Clinical Governance
- Board Secretary

2.3 The Medical Director shall serve as the lead officer to the Committee.

3. QUORUM

3.1 No business shall be transacted at a meeting of the Committee unless at least three Non-Executive members or Stakeholder members are present. There may be occasions when due to the unavailability of the above Non- Executive members, the Chair will ask other Non-Executive members to act as members of the Committee so that quorum is achieved. This will be drawn to the attention of the Board.

4. MEETINGS

4.1 The Committee shall meet as necessary to fulfil its remit but not less than six times a year.

4.2 The Chair of Fife NHS Board shall appoint a Chair who shall preside at meetings of the Committee. If the Chair is absent from any meeting of the Committee, members shall elect from amongst themselves one of the other Committee members to chair the meeting.

4.3 The agenda and supporting papers will be sent out at least five clear days before the meeting.

5. REMIT

5.1 The remit of the Clinical Governance Committee is to:

- monitor progress on the health status targets set by the Board.

- provide oversight of the implementation of the Clinical Strategy in line with the NHS Fife Strategic Framework and the Care and Clinical Governance Strategy.

- receive the minutes of meetings of:
  - Acute Services Division Clinical Governance Committee
  - Area Clinical Forum
  - Area Drug & Therapeutics Committee
  - Area Radiation Protection Committee
  - Digital & Information Board
  - Fife Research Committee
  - Health & Safety Sub Committee

- H&SCP Clinical & Care Governance Committee
- H&SCP Integration Joint Board
- Infection Control Committee
- Information Governance & Security Group
- Integrated Transformation Board Public Health Assurance Committee
- NHS Fife Clinical Governance Steering Group
- NHS Fife Resilience Forum

- The Committee will produce an Annual Report incorporating a Statement of Assurance for submission to the Board, via the Audit and Risk Committee. The proposed Annual Report will be presented to the first Committee meeting in the new financial year or agreed with the Chairperson of the respective Committee by the end of May each year for presentation to the Audit and Risk Committee in June.

- Receive updates on and oversee the progress on the recommendations from relevant external reports of reviews of all healthcare organisations, including clinical governance reports and recommendations from relevant regulatory bodies which may include Healthcare Improvement Scotland (HIS) reviews and visits.

- Issues arising from these Committees will be brought to the attention of the Chair of the Clinical Governance Committee for further consideration as required.

- To provide assurance to Fife NHS Board about the quality of services within NHS Fife.

- To undertake an annual self-assessment of the Committee's work and effectiveness.

- The Committee shall review regularly the sections of the NHS Fife Integrated Performance & Quality Report relevant to the Committee's responsibility.

5.2 The Committee shall provide assurance to the Board on achievement and maintenance of Best Value standards, relevant to the Committee's area of governance as set out in Audit Scotland's baseline report "Developing Best Value Arrangements".

5.3 The Committee shall draw up and approve, before the start of each financial year, an Annual Workplan for the Committee's planned work during the forthcoming year.

6. AUTHORITY

6.1 The Committee is authorised by the Board to investigate any activity within its Terms of Reference, and in so doing, is authorised to seek any information it requires from any employee.

6.2 In order to fulfil its remit, the Clinical Governance Committee may obtain whatever professional advice it requires, and require Directors or other officers of the Board to attend meetings.

7. REPORTING ARRANGEMENTS

7.1 The Clinical Governance Committee reports directly to Fife NHS Board. Minutes of the Committee are presented to the Board by the Committee Chair, who provides a report, on an exception basis, on any particular issues which the Committee wishes to draw to the Board's attention.

7.2 Each Committee of the Board will scrutinise relevant risks on the Corporate Risk Register on a bi-monthly basis.

7.3 Each Committee of the Board will scrutinise the Board Assurance Framework risk(s) aligned to it on a bi-monthly basis.

FINANCE, PERFORMANCE AND RESOURCES COMMITTEE CONSTITUTION AND TERMS OF REFERENCE

Date of Board Approval: 25 May 2021

1. PURPOSE

1.1 The purpose of the Committee is to keep under review the financial position and performance against key non-financial targets of the Board, and to ensure that suitable arrangements are in place to secure economy, efficiency and effectiveness in the use of all resources, and that the arrangements are working effectively.

2. COMPOSITION

2.1 The membership of the Finance, Performance and Resources Committee will be:

- Six Non-Executive or Stakeholder members of the Board (one of whom will be the Chair). (A Stakeholder member is appointed to the Board from Fife Council or by virtue of holding the Chair of the Area Partnership Forum or the Area Clinical Forum)
- Chief Executive
- Director of Finance
- Medical Director
- Director of Public Health
- Director of Nursing

2.2 The Chair of the Audit and Risk Committee will not be a member of the Finance, Performance and Resources Committee.

2.3 Officers of the Board will be expected to attend meetings of the Committee when issues within their responsibility are being considered by the Committee. In addition, the Committee Chair will agree with the Lead Officer to the Committee which other Senior Staff should attend meetings, routinely or otherwise. The following will normally be routinely invited to attend Committee meetings:

- Director of Acute Services
- Director of Property & Asset Management
- Director of Health & Social Care
- Director of Pharmacy & Medicines
- Board Secretary

2.4 The Director of Finance shall serve as the Lead Executive Officer to the Committee.

3. QUORUM

3.1 No business shall be transacted at a meeting of the Committee unless at least three Non-Executive members or Stakeholder members are present. There

may be occasions when due to the unavailability of the above Non-Executive members, the Chair will ask other Non-Executive members to act as members of the committee so that quorum is achieved. This will be drawn to the attention of the Board.

4. MEETINGS

4.1 The Committee shall meet as necessary to fulfil its remit but not less than four times per year.

4.2 The Chair of Fife NHS Board shall appoint a Chair who shall preside at meetings of the Committee. If the Chair is absent from any meeting of the Committee, members shall elect from amongst themselves one of the other Committee members to chair the meeting.

4.3 The agenda and supporting papers will be sent out at least five clear days before the meeting.

5. REMIT

5.1 The Committee shall have accountability to the Board for ensuring that the financial position of the Board is soundly based, having regard to:

- compliance with statutory financial requirements and achievement of financial targets;
- such financial monitoring and reporting arrangements as may be specified from time-to-time by Scottish Government Health & Social Care Directorates and/or the Board;
- the impact of planned future policies and known or foreseeable future developments on the financial position;
- undertake an annual self-assessment of the Committee's work and effectiveness; and
- review regularly the sections of the NHS Fife Integrated Performance & Quality Report relevant to the Committee's responsibility.

Arrangements for Securing Value for Money

5.2 The Committee shall keep under review arrangements for securing economy, efficiency and effectiveness in the use of resources. These arrangements will include procedures for (a) planning, appraisal, control, accountability and evaluation of the use of resources, and for (b) reporting and reviewing performance and managing performance issues as they arise in a timely and effective manner. In particular, the Committee will review action (proposed or underway) to ensure that the Board achieves financial balance in line with statutory requirements.

Allocation and Use of Resources

5.3 The Committee has key responsibilities for:

- reviewing the development of the Board's Financial Strategy in support of the Annual Operational / Remobilisation Plan, and recommending approval to the Board;
- reviewing all resource allocation proposals outwith authority delegated by the Board and make recommendations to the Board thereon;
- monitoring the use of all resources available to the Board; and
- reviewing all matters relating to Best Value.

5.4 Specifically, the Committee is charged with recommending to the Board annual revenue and capital budgets and financial plans consistent with its statutory financial responsibilities. It shall also have responsibility for the oversight of the Board's Capital Programme (including individual Business Cases for Capital Investment) and the review of the Property Strategy (including the acquisition and disposal of property), and for making recommendations to the Board as appropriate on any issue within its terms of reference.

5.5 The Committee will receive minutes from the Pharmacy Practices Committee and the Primary Medical Services Committee. Issues arising from these Committees will be brought to the attention of the Chair of the Finance, Performance and Resources Committee for further consideration as required.

5.6 The Committee will produce an Annual Report incorporating a Statement of Assurance for submission to the Board, via the Audit and Risk Committee. The proposed Annual Report will be presented to the first Committee meeting in the new financial year or agreed with the Chairperson of the respective Committee by the end of May each year for presentation to the Audit and Risk Committee in June.

5.7 The Annual Report will include the Committee's assessment and conclusions on its effectiveness over the financial year in question.

5.8 The Committee shall draw up and approve, before the start of each financial year, an Annual Workplan for the Committee's planned work during the forthcoming year.

5.9 The Committee shall provide assurance to the Board on achievement and maintenance of Best Value standards, relevant to the Committee's area of governance as set out in Audit Scotland's baseline report "Developing Best Value Arrangements".

6. AUTHORITY

6.1 The Committee is authorised by the Board to investigate any activity within its Terms of Reference, and in so doing, is authorised to seek any information it requires from any employee.

6.2 In order to fulfil its remit, the Finance, Performance and Resources Committee may obtain whatever professional advice it requires, and require Directors or other officers of the Board to attend meetings.

6.3 The authority of the Committee is included in the Board's Scheme of Delegation, as set out in the Purpose and Remit of the Committee.

7. REPORTING ARRANGEMENTS

7.1 The Finance, Performance and Resources Committee reports directly to Fife NHS Board on its work. Minutes of the Committee are presented to the Board by the Committee Chair, who provides a report, on an exception basis, on any particular issues which the Committee wishes to draw to the Board's attention.

7.2 Each Committee of the Board will scrutinise relevant risks on the Corporate Risk Register on a bi-monthly basis.

7.3 Each Committee of the Board will scrutinise the Board Assurance Framework risk(s) aligned to it on a bi-monthly basis.

PUBLIC HEALTH & WELLBEING COMMITTEE
CONSTITUTION AND TERMS OF REFERENCE

Date of Board Approval: 30 November 2021

1. PURPOSE

1.1 To assure Fife NHS Board that NHS Fife is fully engaged in supporting wider population health and wellbeing for the local population, including overseeing the implementation of the population health and wellbeing actions defined in the Board's strategic plans and ensuring effective contribution to population health and wellbeing related activities.

1.2 To exercise scrutiny and challenge over the delivery performance of a range of services for which NHS Fife is accountable to Scottish Ministers.

1.3 To strengthen collaboration, build momentum, enable ownership and demonstrate leadership across all current partnerships and networks in Fife (particularly Fife Partnership Board), to address health inequalities and improve the wider determinants of health for our population.

1.4 To assure the Board that appropriate mechanisms and structures are in place for public health and wellbeing activities to be supported effectively throughout the whole of Fife NHS Board's responsibilities, including services delivered by partners, to reflect NHS Fife's ambition to be an anchor institution within its population area.

2. COMPOSITION

2.1 The membership of the Public Health & Wellbeing Committee will be:

- The Chair of the Board (who will act as Chair of the Committee)
- Three Non-Executive members of the Board
- Employee Director
- Chief Executive
- Director of Finance & Strategy
- Director of Nursing
- Director of Public Health
- Medical Director

2.2 Officers of the Board will be expected to attend meetings of the Committee when issues within their responsibility are being considered by the Committee. In addition, the Committee Chair will agree with the lead Executive officer to the Committee which other Senior Staff should attend meetings, routinely or otherwise. The following will normally be routinely invited to attend Committee meetings:

- Director of Health & Social Care
- Associate Director, Planning & Performance
- Board Secretary

2.3 The Director of Public Health shall serve as the lead Executive officer to the Committee.

3. QUORUM

3.1 No business shall be transacted at a meeting of the Committee unless at least three members are present, two of whom should be Non-Executive members of the Board. There may be occasions when due to the unavailability of the above Non-Executive members, the Chair will ask other Non-Executive members to act as members of the Committee so that quorum is achieved. This will be drawn to the attention of the Board.

4. MEETINGS

4.1 The Committee shall meet initially on a monthly basis.

4.2 The Chair of Fife NHS Board shall preside at meetings of the Committee. If the Chair is absent from any meeting of the Committee, members shall elect from amongst themselves one of the other Non-Executive Committee members to chair the meeting.

4.3 The agenda and supporting papers will be sent out at least five clear days before the meeting.

5. REMIT

5.1 The remit of the Public Health & Wellbeing Committee is:

- To agree key areas of focus within the public health priorities that will be taken forward every year, oversee the agreed population health activities, ensure equity in provision and access to services, and provide assurance thereon to Fife NHS Board.
- To ensure that a strategic plan is formulated that reflects public health and wellbeing needs and priorities for the population serviced by NHS Fife in line with the priorities of the national care and wellbeing programmes.
- To monitor strategy implementation through regular progress reports and review of intermediate measures and long-term outcomes.
- To receive assurance that the risks relating to primary care and community services are addressed in line with the directions set and that robust mitigating actions are in place to address any areas of concern or where performance is not in line with national standards or targets.
- To support the work of the Anchor Institute Programme Board and Population Health and Wellbeing Portfolio Board and receive updates on progress and outcomes.
- To support the ambitions set out in the Plan for Fife (Community Planning Partnership) through collaboration on agreed areas of influence.
- To undertake scrutiny of individual topics / projects / work-streams to promote the health of the population in Fife, including NHS Fife staff, with particular emphasis on prevention and addressing health inequalities.

- To ensure appropriate linkages to other key work of the Board, such as the development of new services, workstreams and delivery plans.
- To undertake an annual self-assessment of the Committee's work and effectiveness.

5.2 The Committee shall review regularly the sections of the NHS Fife Integrated Performance & Quality Report relevant to the Committee's areas of responsibility.

5.3 The Committee will produce an Annual Report incorporating a Statement of Assurance for submission to the Board, via the Audit and Risk Committee. The proposed Annual Report will be presented to the first Committee meeting in the new financial year or agreed with the Chairperson of the respective Committee by the end of May each year for presentation to the Audit and Risk Committee in June.

5.4 The Committee shall provide assurance to the Board on achievement and maintenance of Best Value standards, relevant to the Committee's area of governance as set out in Audit Scotland's baseline report "Developing Best Value Arrangements".

5.5 The Committee shall draw up and approve, before the start of each financial year, an Annual Workplan for the Committee's planned work during the forthcoming year.

6. AUTHORITY

6.1 The Committee is authorised by the Board to investigate any activity within its Terms of Reference, and in so doing, is authorised to seek any information it requires from any employee.

6.2 In order to fulfil its remit, the Public Health & Wellbeing Committee may obtain whatever professional advice it requires, and require Directors or other officers of the Board to attend meetings.

7. REPORTING ARRANGEMENTS

7.1 The Public Health & Wellbeing Committee reports directly to Fife NHS Board. Minutes of the Committee are presented to the Board by the Committee Chair, who provides a report, on an exception basis, on any particular issues which the Committee wishes to draw to the Board's attention.

7.2 Each Committee of the Board will scrutinise relevant risks on the Corporate Risk Register on a bi-monthly basis.

7.3 Each Committee of the Board will scrutinise the Board Assurance Framework risk(s) aligned to it on a bi-monthly basis.

REMUNERATION COMMITTEE
CONSTITUTION AND TERMS OF REFERENCE

Date of Board Approval: 25 May 2021

1. PURPOSE

1.1 To consider and agree performance objectives and performance appraisals for staff in the Executive cohort and to oversee performance arrangements for designated senior managers.

1.2 To direct the appointment process for the Chief Executive and Executive Members of the Board.

2. COMPOSITION

2.1 The membership of the Remuneration Committee will be:

- Fife NHS Board Chairperson
- Two Non-Executive Board members
- Chief Executive
- Employee Director

2.2 The Director of Workforce shall act as Lead Officer for the Committee.

2.3 The NHS Fife Chief Executive will leave the meeting when there is any discussion with regard to their own performance. The Director of Workforce will leave the meeting when there is any discussion with regard to their own performance.

3. QUORUM

3.1 Meetings will be quorate when at least three members are present, at least two of whom are Non-Executive members.

4 MEETINGS

4.1 The Committee shall meet as necessary, but not less than three times a year.

4.2 The Fife NHS Board Chairperson will chair the Committee. If the Chairperson is absent from the meeting, one of the other Non-Executive members will chair the meeting.

4.3 The agenda and supporting papers for each meeting will be sent out at least five clear days before the meeting.

4.4 The full minutes will be circulated to all Committee members. Minutes edited to remove all personal details will be circulated to the Board.

5 REMIT

5.1 The remit of the Remuneration Committee is to consider:

- job descriptions for the Executive cohort;
- other terms of employment which are not under Ministerial direction;
- to hear and determine appeals against the decisions of the Consultant Discretionary Awards Panel. The Remuneration Committee can make decisions regarding Discretionary Points in exceptional circumstances;
- agree performance objectives and appraisals directly for the Executive cohort only, and oversee arrangements for designated senior managers;
- redundancy, early retiral or termination arrangement in respect of all staff in situations where there is a financial impact upon the Board (this excludes early retiral on grounds of ill health) and approve these or refer to the Board as it sees fit.

5.2 The Committee will produce an Annual Report incorporating a Statement of Assurance for submission to the Board, via the Audit & Risk Committee. The proposed Annual Report will be presented to the first Committee meeting in the new financial year or agreed with the Chairperson of the Committee by the end of May each year for presentation to the Audit & Risk Committee in June.

5.3 The Committee shall draw up and approve, before the start of each financial year, an Annual Workplan for the Committee's planned work during the forthcoming year.

5.4 The Committee will undertake an annual self-assessment of its work and effectiveness.

5.5 The Committee shall provide assurance to the Board on achievement and maintenance of Best Value standards, relevant to the Committee's area of governance as set out in Audit Scotland's baseline report "Developing Best Value Arrangements".

6. AUTHORITY

6.1 The Committee is authorised by the Board to investigate any activity within its Terms of Reference, and in so doing, is authorised to seek any information it requires from any employee.

6.2 In order to fulfil its remit, the Remuneration Committee may obtain whatever professional advice it requires, and require Directors or other officers of the Board to attend meetings.

6.3 Delegated authority is detailed in the Board's Standing Orders and Standing Financial Instructions and is set out in the Purpose and Remit of the Committee.

7. REPORTING ARRANGEMENTS

7.1 The Remuneration Committee reports directly to the Fife NHS Board on its work. Minutes of the Committee, edited to remove all personal details, are presented to the Board by the Committee Chairperson, who provides a report, on an exception basis, on any particular issues which the Committee wishes to draw to the Board's attention.

STAFF GOVERNANCE COMMITTEE
CONSTITUTION AND TERMS OF REFERENCE

Date of Board Approval: 25 May 2021

1. PURPOSE

1.1 The purpose of the Staff Governance Committee is to support the development of a culture within the health system where the delivery of the highest standard possible of staff management is understood to be the responsibility of everyone working within the system, and is built upon partnership and collaboration, and within the direction provided by the Staff Governance Standard.

1.2 To assure the Board that the staff governance arrangements in the Integration Joint Board are working effectively.

1.3 To escalate any issues to the NHS Fife Board if serious concerns are identified regarding staff governance issues within the services devolved to the Integration Joint Board.

2. COMPOSITION

2.1 The membership of the Staff Governance Committee will be:

- Four Non-Executive members, one of whom will be the Chair of the Committee.
- Employee Director (as a Stakeholder member of the Board by virtue of holding the Chair of the Area Partnership Forum)
- Chief Executive
- Director of Nursing
- Staff Side Chairs of the Local Partnership Forums, or their nominated deputy

2.2 Each member shall give notification if they are unable to attend a meeting. For Non-Executive members, they shall notify the Chair, who may ask other Non-Executive members to act as members of the Committee to achieve a quorum. For Staff Side Chairs of the Local Partnership Forums, they will notify the Lead Officer, confirming their nominated deputy. This will be reported to the Chair.

2.3 Officers of the Board will be expected to attend meetings of the Committee when issues within their responsibility are being considered by the Committee. In addition, the Committee Chair will agree with the Lead Officer to the Committee which other Senior Staff should attend meetings, routinely or otherwise. The following will normally be routinely invited to attend Committee meetings:

- Director of Workforce
- Director of Acute Services
- Director of Health & Social Care
- Board Secretary
- Deputy Director of Workforce and Heads of Service, Workforce Directorate

2.4 The Director of Workforce will act as Lead Officer to the Committee.

3. QUORUM

3.1 No business shall be transacted at a meeting of the Committee unless:

- at least three members are present, at least two of whom should be Non-Executive members of the Board.
- at least one of the Staff Side Chairs of the Local Partnership Forums or their nominated deputy is present.

There may be occasions when due to unavailability of the above Non-Executive members the Chair will ask other Non-Executive members to act as members of the Committee so that quorum is achieved. Similarly, there may be occasions due to unavailability a Staff Side Chair of the Local Partnership Forums shall confirm the nominated deputy who will attend meetings in their absence. This will be reported to the Chair. This information will be drawn to the attention of the Board.

4. MEETINGS

4.1 The Staff Governance Committee shall meet as necessary to fulfil its purpose but not less than four times a year.

4.2 The Chair of Fife NHS Board shall appoint a Chair who shall preside at meetings of the Committee. If the Chair is absent from any meeting of the Committee, members shall elect from amongst themselves one of the other Committee members to chair the meeting.

4.3 The agenda and supporting papers will be sent out at least five clear days before the meeting.

5. REMIT

5.1 The remit of the Staff Governance Committee is to:

- Consider NHS Fife's performance in relation to its achievements of effective Staff Governance and its compliance with the Staff Governance Standard;

- Review action taken on recommendations made by the Committee, NHS Boards, or the Scottish Ministers on Staff Governance matters;

- Give assurance to the Board on the operation of Staff Governance systems within NHS Fife, identifying progress, issues and actions being taken, where appropriate;

- Support the operation of the Area Partnership Forum and the Local Partnership Forums in their Staff Governance monitoring role and the appropriate flow of information to facilitate this;

- Encourage the further development of mechanisms for engaging effectively with all members of staff within the NHS in Fife;

- Contribute to the development of the Annual Operational Plan, in particular but not exclusively, around issues affecting staff;

- Support the continued development of personal appraisal professional learning and performance;

- Review regularly the sections of the NHS Fife Integrated Performance & Quality Report relevant to the Committee's responsibility;

- Undertake an annual self-assessment of the Committee's work and effectiveness.

5.2 The Committee is also required to carry out a review of its function and activities and to provide an Annual Report incorporating a Statement of Assurance. This will be submitted to the Board via the Audit and Risk Committee. The proposed Annual Report will be presented to the first Committee meeting in the new financial year or agreed with the Chairperson of the respective Committee by the end of May each year for presentation to the Audit and Risk Committee in June.

5.3 The Committee shall draw up and approve, before the start of each financial year, an Annual Workplan for the Committee's planned work during the forthcoming year.

5.4 The Committee shall provide assurance to the Board on achievement and maintenance of Best Value standards, relevant to the Committee's area of governance as set out in Audit Scotland's baseline report "Developing Best Value Arrangements".

6. AUTHORITY

6.1 The Committee is authorised by the Board to investigate any activity within its Terms of Reference, and in so doing, is authorised to seek any information it requires from any employee.

6.2 In order to fulfil its remit, the Staff Governance Committee may obtain whatever professional advice it requires, and require Directors or other officers of the Board to attend meetings.

6.3 Delegated authority is detailed in the Board's Standing Orders, as set out in the Purpose and Remit of the Committee.

7. REPORTING ARRANGEMENTS

7.1 The Staff Governance Committee reports directly to Fife NHS Board on its work. Minutes of the Committee are presented to the Board by the Committee Chair, who provides a report, on an exception basis, on any particular issues which the Committee wishes to draw to the Board's attention.

7.2 Each Committee of the Board will scrutinise relevant risks on the Corporate Risk Register on a bi-monthly basis.

7.3 Each Committee of the Board will scrutinise the Board Assurance Framework risk(s) aligned to it on a bi-monthly basis.

STANDING FINANCIAL INSTRUCTIONS

INDEX

1. INTRODUCTION

1.1 Standing Financial Instructions (SFIs) are issued in accordance with the financial directions made under the provisions of the NHS (Financial Provisions) (Scotland) Regulations 1974, and all other enabling powers, for the regulation of the conduct of the Board, its members, officers and agents in relation to all financial matters. These SFIs form part of the Standing Orders and should be used along with the Standing Orders and Scheme of Delegation.

1.2 **Terminology**

Any expression to which a meaning is given in the Health Service Acts, Scottish Statutory Instrument number 302 (2001) which brought NHS Boards into being, or in the financial regulations made under the Acts shall have the same meaning in these Instructions; and:

(a) "NHS Fife" means all elements of the NHS under the auspices of Fife Health Board.
(b) "Board" and "Health Board" mean Fife NHS Board, the common name of Fife Health Board.
(c) "Budget" means a resource expressed in financial terms and set by the Board for the purposes of carrying out for a specified period any or all functions of the Health Board.
(d) "Chief Executive" means the Chief Officer of the Health Board.
(e) "Director of Finance" means the Chief Financial Officer of the Health Board.
(f) "Budget Holder" means any individual with delegated authority to manage finances (Income and/or expenditure) for a specific area of the Board.

1.3 All staff individually and collectively are responsible for the security of the property of the Board, for avoiding loss, for economy and efficiency in the use of the resources and for conforming with the requirements of the Code of Corporate Governance, including Standing Orders, Standing Financial Instructions and Financial Operating Procedures.

1.4 The Director of Finance, on behalf of the Chief Executive, shall be responsible for supervising the implementation of the Board's Standing Financial Instructions and Financial Operating Procedures and for co-ordinating any action necessary to further these as agreed by the Chief Executive. The Director of Finance shall review these at least every three years and be accountable to the Board for these duties.

1.5 Wherever the title, Chief Executive, Director of Finance, or other nominated officer is used in these Instructions, it shall be deemed to include such other staff who have been duly authorised to represent them.

1.6 All relevant employees and agents shall be provided with a copy of these SFIs and are required to complete a form stating that these Instructions have been read and understood and that the individual will comply with the Instructions. They must also sign for any amendments.

1.7 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Director of Finance must be sought before acting.

1.8 Failure to comply with Standing Financial Instructions is a disciplinary matter, which could result in dismissal.

1.9 The Standing Financial Instructions along with the Scheme of Delegation and Financial Operating Procedures provide details of delegated financial responsibility and authority.

2. KEY RESPONSIBILITIES FOR FINANCIAL GOVERNANCE

The Board and Audit and Risk Committee

2.1 The Board shall approve these SFIs and Scheme of Delegation

2.2 The Board shall ensure and be assured that the SFIs and Scheme of Delegation are complied with at all times.

2.3 The Board shall agree the terms of reference of the Audit and Risk Committee, which must conform with extant Scottish Government Instruction and other guidance on good practice.

2.4 The Board shall perform its functions within the total funds allocated by the Scottish Government.

The Chief Executive (Accountable officer)

2.5 The Chief Executive as Accountable Officer for the organisation is ultimately responsible for ensuring that the Board meets its obligations to perform its functions within the allocated financial resources. The Director of Finance is responsible for providing a sound financial framework that assists the Chief Executive when fulfilling these commitments.

2.6 The Board shall delegate executive responsibility for the performance of its functions to the Chief Executive. Board Members shall exercise financial supervision and control by requiring the submission and approval of budgets within approved allocations, by defining and approving essential features of the arrangements in respect of important procedures and financial systems, including the need to obtain value for money, and by defining specific responsibilities placed on individuals.

2.7 It shall be the duty of the Chief Executive to ensure that existing staff and all new employees and agents are notified of their responsibilities within these Instructions.

The Director of Finance

2.8 Without prejudice to any other functions of employees of the Board, the duties of the Director of Finance shall include the provision of financial advice to the Board and its employees, the design, implementation and supervision of systems of financial control and preparation and maintenance of such accounts, certificates, estimates, records and reports as the Board may require for the purpose of carrying out its statutory duties.

2.9 The Director of Finance shall keep records of the Board's transactions sufficient to disclose with reasonable accuracy at any time the financial position of the Board.

2.10 The Director of Finance shall require any individual who carries out a financial function to discharge his duties in a manner, and keep any records in a form, that shall be to the satisfaction of the Director of Finance.

2.11 The Director of Finance shall prepare, document and maintain detailed financial procedures and systems incorporating the principles of separation of duties and internal checks to supplement these Standing Financial Instructions.

2.12 The Director of Finance shall be responsible for setting the Board's accounting policies, consistent with the Scottish Government and Treasury guidance and generally accepted accounting practice.

2.13 The Director of Finance will either undertake the role of Fraud Liaison Officer or nominate another senior manager to the role, to work with Counter Fraud Services and co-ordinate the reporting of Fraud and Thefts.

2.14 The Director of Finance is entitled without necessarily giving prior notice to require and receive:-

- access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
- access at all reasonable times to any land, premises or employee of the health board;
- the production of any cash, stores or other property of the health board under an employee's control; and
- explanations concerning any matter under investigation.

All Directors and Employees

2.15 All directors and employees, individually and working together, are responsible for:

- Keeping the property of the Board secure, and to apply appropriate routine security practices as may be determined by the Board. This includes:-

  a. ensuring that the assets within their area of responsibility are included within the appropriate asset register (see Section 7);

  b. ensuring that asset records/registers are kept up-to-date;

  c. performing verification exercises to confirm the existence and condition of the assets, and the completeness of the appropriate asset register; and

  d. following any prescribed procedures to notify the organisation of any theft, loss or damage to assets.

- Avoiding loss;

- Securing Best Value in the use of resources; and

- Following these SFIs and any other policy or procedure that the Board may approve.

2.16 All budget holders shall ensure that:-

- Information is provided to the Director of Finance to enable budgets to be compiled;

- Budgets are only used for their stated purpose; and

- Budgets are never exceeded.

2.17 When a budget holder expects his expenditure will exceed his delegated budget, he must secure an increased budget, or seek explicit approval to overspend before doing so.

2.18 All NHS staff who commit NHS resources directly or indirectly must be impartial and honest in their conduct of business and all employees must remain beyond suspicion.

2.19 All employees shall observe the requirements of MEL (1994) 48, which sets out the Code of Conduct for all NHS staff. There are 3 crucial public service values which underpin the work of the health service:-

Conduct
There should be an absolute standard of honesty and integrity which should be the hallmark of all personal conduct in decisions affecting patients, staff and suppliers; in the use of information acquired in the course of NHS duties; in dealing with the assets of the NHS.

Accountability

Everything done by those who work in the NHS must be able to stand the test of parliamentary and public scrutiny, judgements on propriety and professional codes of conduct.

Openness
The Board should be open about its activities and plans so as to promote confidence between the component parts of NHS Fife, other health organisations and its staff, patients and the public.

2.20 All employees shall:-

- Ensure that the interest of patients remain paramount at all times;
- Be impartial and honest in the conduct of their official business;
- Use the public funds entrusted to them to the best advantage of the service, always ensuring value for money; and
- Demonstrate appropriate ethical standards of personal conduct.

2.21 Furthermore all employees shall not:-

- Abuse their official position for the personal gain or to the benefit of their family or friends;
- Undertake outside employment that could compromise their NHS duties; and
- Seek to advantage or further their private business or interest in the course of their official duties.

2.22 The Director of Finance shall publish supplementary guidance and procedures in the form of Financial Operating Procedures to ensure that the above principles are understood and applied in practice.

2.23 The Chief Executive shall establish procedures for voicing complaints or concerns about misadministration, breaches of the standards of conduct, suspicions of criminal behaviour (e.g. theft, fraud, bribery) and other concerns of an ethical nature.

2.24 All employees must protect themselves and the Board from any allegations of impropriety by seeking advice from their line manager, or from the appropriate contact point, whenever there is any doubt as to the interpretation of these standards.

3. AUDIT

Audit and Risk Committee

3.1 In accordance with Standing Orders the Board shall formally establish an Audit and Risk Committee, with clearly defined terms of reference.

3.2 Where the Audit and Risk Committee feels there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the committee wish to raise, the Chairperson of the Audit and Risk Committee should raise the matter at a full meeting of the Board. In considering whether to do so, the Committee must be mindful of the arrangements with NHS Counter Fraud Services (CFS) and the role of the Fraud Liaison Officer (FLO). Exceptionally, the matter may need to be referred to the Scottish Government Health & Social Care Directorates (SGHSCD).

3.3 It is the responsibility of the Audit and Risk Committee to ensure an effective internal audit service is provided and this will be largely influenced by the professional judgement of the Director of Finance.

Director of Finance

3.4 The Director of Finance is responsible for:

a. Ensuring there are arrangements to measure, evaluate and report on the effectiveness of internal control and efficient use of resources, including the establishment of a professional internal audit function headed by a Chief Internal Auditor;

b. Ensuring that Internal Audit is adequate and meets the mandatory NHS internal audit standards;

c. Taking appropriate steps, in line with SGHSCD guidance, to involve CFS and/or the Police in cases of actual or suspected fraud, misappropriation, and other irregularities;

d. Ensuring that the Chief Internal Auditor prepares the following risk based plans for approval by the Audit and Risk Committee:

- Strategic audit plan covering the coming four years,
- A detailed annual plan for the coming year.

e. Ensuring that an annual internal audit report is prepared by the Chief Internal Auditor, in accordance with the timetable laid down by the Audit and Risk Committee, for the consideration of the Audit and Risk Committee and the Board.

The report should include:

- A clear statement on the adequacy and effectiveness of internal control;
- Main internal control issues and audit findings during the year;

- Extent of audit cover achieved against the plan for the year.

f. Progress on the implementation of internal audit recommendations including submission to the Audit and Risk Committee.

3.5 The Director of Finance shall refer audit reports to the appropriate officers designated by the Chief Executive and failure to take any necessary remedial action within a reasonable period shall be reported to the Chief Executive.

Internal Audit

3.6 Internal Audit shall adopt the Public Sector Internal Audit Standards (PSIAS), which are mandatory and which define internal audit as "an independent, objective assurance and consulting activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes."

Minor deviations from the PSIAS should be reported to the Audit and Risk Committee. More significant deviations should be considered for inclusion in the Annual Governance Statement.

3.7 Internal Audit activity must evaluate and contribute to the improvement of governance, risk management and control processes using a systematic and disciplined approach. Internal Audit activity and scope is fully defined within the Audit plan, approved by the Audit & Risk Committee.

3.8 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance, as the FLO, must be notified immediately, and before any detailed investigation is undertaken.

3.9 The Chief Internal Auditor (or Counter Fraud Services staff, acting on the Director of Finance's behalf on any matters related to the investigation of fraud) is entitled without necessarily giving prior notice to require and receive:

(a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature (in which case he shall have a duty to safeguard that confidentiality), within the confines of the data protection act.

(b) Access at all reasonable times to any land, premises or employees of the Board;

(c) The production or identification by any employee of any cash, stores or other property of the Board under an employee's control; and

(d) Explanations concerning any matter under investigation.

3.10 The Chief Internal Auditor, or appointed representative, will normally attend Audit and Risk Committee meetings; and has a right of access to all Audit Committee members, the Chairperson and Chief Executive of the Board.

3.11 The Chief Internal Auditor shall be accountable to the Director of Finance. The reporting and follow-up systems for internal audit shall be agreed between the Director of Finance, the Audit and Risk Committee and Chief Internal Auditor. The agreement shall comply with the guidance on reporting contained in Government Internal Audit Standards.

External Audit

3.12 The External Auditor is concerned with providing an independent assurance of the Board's financial stewardship including value for money, probity, material accuracy, compliance with guidelines and accepted accounting practice for NHS accounts. Responsibility for securing the audit of the Board rests with Audit Scotland. The appointed External Auditor's statutory duties are contained in the Public Finance and Accountability (Scotland) Act 2000 which supersedes the Local Government (Scotland) Act 1973 (Part VII) as amended by the National Health Services and Community Care Act 1990.

3.13 The appointed auditor has a general duty to satisfy himself that:

(a) The Board's accounts have been properly prepared in accordance with the Direction of the Scottish Ministers to comply with the accounting principles and disclosure requirements of the edition of the Government Financial Reporting Manual (FReM) which is in force for the year for which the statement of accounts are prepared;

(b) Proper accounting practices have been observed in the preparation of the accounts;

(c) The Board has made proper arrangements for securing economy, efficiency and effectiveness in the use of its resources.

3.14 In addition to these responsibilities, Audit Scotland's Code of Audit Practice requires the appointed auditor to consider:

(a) Whether the statement of accounts presents fairly the financial position of the Board;

(b) The Board's main financial systems;

(c) The arrangements in place at the Board for the prevention and detection of fraud and corruption;

(d) Aspects of the performance of particular services and activities;

(e) The Board's management arrangements to secure economy, efficiency and effectiveness in the use of resources.

3.15 The Board's Audit and Risk Committee provides a forum through which Non-Executive Members can secure an independent view of any major activity within the appointed auditor's remit. The Audit and Risk Committee has a responsibility to ensure that the Board receives a cost-effective audit service and that co-operation with Board senior managers and Internal Audit is appropriate.

3.16 The External Auditor, or appointed representative, will normally attend Audit and Risk Committee meetings; and has a right of access to all Audit and Risk Committee members, the Chairperson and Chief Executive of the Board.

4. FINANCIAL MANAGEMENT

This section applies to both revenue and capital budgets.

Planning

4.1 The Scottish Government has set the following financial targets for all boards:-

- To operate within the revenue resource limit.
- To operate within the capital resource limit.
- To operate within the cash requirement.

4.2 The Chief Executive shall produce an Annual Operational Plan. The Chief Executive shall submit a Plan for approval by the Board that takes into account financial targets and forecast limits of available resources. The Annual Operational Plan shall contain:-

- a statement of the significant assumptions within the Plan; and
- details of major changes in workload, delivery of services or resources required to achieve the plan.

4.3 Before the financial year begins, the Director of Finance shall prepare and present a financial plan to the Board. The report shall:-

- show the total allocations received from the Scottish Government and their proposed uses, including any sums to be held in reserve;
- be consistent with the Annual Operational Plan;
- be consistent with the Board's financial targets;
- identify potential risks;

- identify funding and expenditure that is of a recurring nature; and

- identify funding and expenditure that is of a non-recurring nature.

4.4 The Health Board shall approve the financial plan for the forthcoming financial year.

4.5 The Director of Finance shall continuously review the financial plan, to ensure that it meets the Board's requirements and the delivery of financial targets.

4.6 The Director of Finance shall regularly update the Board on significant changes to the allocations and their uses.

4.7 The Director of Finance shall keep the Chief Executive and the Board informed of the financial consequences of changes in policy, pay awards and other events and trends affecting budgets and shall advise on the financial and economic aspects of future plans and projects.

4.8 The Director of Finance shall establish the systems for identifying and approving how the Board's capital allocation will be used, consisting of proposals for individual schemes, major equipment, IT developments, backlog maintenance, statutory compliance works and minor scheme provision. The approval of business cases shall be as described in the Scheme of Delegation.

4.9 The Director of Finance shall release capital funds allowing for project start dates and phasing.

Budgetary Control

4.10 The Board shall approve the opening budgets for each financial year on an annual basis.

4.11 The Chief Executive shall delegate the responsibility for budgetary control to designated budget holders. The Scheme of Delegation sets out the delegated authorities to take decisions and approve expenditure for certain posts.

4.12 Employees shall only act on their delegated authority when there is an approved budget in place to fund the decisions they make.

4.13 Delegation of budgetary responsibility shall be in writing and be accompanied by a clear definition of:-

- the amount of the budget;

- the purpose(s) of each budget heading;

- what is expected to be delivered with the budget in terms of organisational performance; and

- how the budget holder will report and account for his or her budgetary performance.

4.14 The Chief Executive may agree a virement procedure that would allow budget holders to transfer resources from one budget heading to another. The Board shall set the virement limits for the Chief Executive and the Chief Executive shall ensure these are not exceeded

4.15 If the budget holder does not require the full amount of the budget delegated to him for the stated purpose (s), and virement is not exercised, then the amount not required shall revert back to the Chief Executive.

4.16 The Director of Finance shall devise and maintain systems of budgetary control. These will include:-

- monthly financial reports to the Board in a form approved by the Board containing:-

  a. net expenditure of the Board for the financial year to date; and

  b. a forecast of the Board's expected net expenditure for the remainder of the year on a monthly basis from (at the latest) the month 6 position onwards.

  c. capital project spend and projected outturn against plan;

  d. explanations of any material variances from plan and/or emerging trends;

  e. details of any corrective action where necessary and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation;

- the issue of timely, accurate and comprehensible advice and financial reports to each holder of a budget, including those responsible for capital schemes, covering the areas for which they are responsible;

- investigation and reporting of variances from agreed budgets;

- monitoring of management action to correct variances and/or emerging adverse trends; and

- ensuring that adequate training is delivered on an on-going basis to budget holders.

Monitoring

4.17 The Director of Finance shall provide monthly reports in the form requested by the Cabinet Secretary showing the charge against the Board's resource limits on the last day of each month.

5. ANNUAL ACCOUNTS AND REPORTS

5.1 The Director of Finance, on behalf of the Board, shall prepare, certify and submit audited Annual Accounts to the SGHSCD in respect of each financial year in such a form as the SGHSCD may direct.

5.2 The Director of Finance will ensure that the Annual Accounts and financial returns are prepared in accordance with the guidance issued in the Government Financial Reporting Manual (FReM), detailing the accounts and returns to be prepared, the accounting standards to be adopted and the timetable for submission to the SGHSCD.

5.3 The Audit and Risk Committee will ensure that the Annual Accounts are reviewed and submitted to the Board for formal approval and the Chief Executive will ensure that they are recorded as having been so presented. The Annual Accounts will be subject to statutory audit by the external auditor appointed by Audit Scotland.

5.4 The Director of Finance shall prepare a Financial Statement for inclusion in the Board's Annual Report, in accordance with relevant guidelines, for submission to Board members and others who need to be aware of the Board's financial performance.

5.5 The Board shall publish an Annual Report, in accordance with the Scottish Government's guidelines on local accountability requirements.

6. BANKING AND CASH HANDLING

6.1 The Director of Finance shall manage the Board's banking arrangements and advise the Board on the provision of banking services and operation of accounts. This advice shall take into account guidance/Directions issued from time to time by the Scottish Government.

6.2 The Director of Finance shall ensure that the banking arrangements operate in accordance with the Scottish Government banking contract and Government Banking Service (GBS) and the Scottish Public Finance Manual.

6.3 The Board shall approve the banking arrangements. No employee may open a bank account for the Board's activities or in the Board's name, unless the Board has given explicit approval.

6.4 The Director of Finance shall:-

- Establish separate bank accounts for non-exchequer funds;
- Establish a separate bank account for all capital building projects where the budget is over £2m. This account will be used solely to process payments to Preferred Supply Chain Partners (PSCP);
- Ensure payments made from bank or GBS accounts do not exceed the amount credited to the account, except where arrangements have been made;

- Ensure money drawn from the Scottish Government against the Cash Requirement is required for approved expenditure only, and is drawn down only at the time of need;

- Promptly bank all monies received intact. Expenditure shall not be made from cash received that has not been banked, except under exceptional arrangements approved by the Director of Finance; and

- Report to the Board all arrangements made with the Board's bankers for accounts to be overdrawn.

6.5 The Director of Finance shall prepare detailed instructions on the operation of bank and GBS accounts, which must include:-

- The conditions under which each bank and GBS account is to be operated;

- Ensuring that the GBS account is used as the principal banker and that the amount of cleared funds held at any time within exchequer commercial bank accounts is limited to a maximum of £50,000 (of cleared funds). The bank account for capital building projects will only hold funds transferred from the GBS principal account to the value of the certified payment due at that time;

- The limit to be applied to any overdraft;

- Those authorised to sign cheques or other orders drawn on the Board's accounts; and

- The required controls for any system of electronic payment.

6.6 The Director of Finance shall:-

- Approve the stationery for officially acknowledging or recording monies received or receivable, and keep this secure;

- Provide adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

- Approve procedures for handling cash and negotiable securities on behalf of the Board.

6.7 Money in the custody of the Board shall not under any circumstances be used for the encashment of private cheques.

6.8 The holders of safe keys shall not accept unofficial funds for depositing in their safes other than in exceptional circumstances. Such deposits must be in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Board is not to be held liable for any loss, and written

indemnities must be obtained from the organisation or individuals absolving the Board from responsibility for any loss.

7. SECURITY OF ASSETS

7.1 Overall responsibility for the security of the Board's assets rests with the Board's Chief Executive. All members and employees have a responsibility for the security of property of the Board and it shall be an added responsibility of senior staff in all disciplines to apply appropriate routine security practices in relation to NHS property. Any significant breach of agreed security practice should be reported to the Chief Executive.

7.2 Wherever practicable, items of equipment shall be marked as property of Fife NHS Board.

7.3 The Chief Executive shall define the items of equipment to be controlled, and officers designated by the Chief Executive shall maintain an up-to-date register of those items. This shall include separate records for equipment on loan from suppliers, and lease agreements in respect of assets held under a finance lease and capitalised.

7.4 The Director of Finance shall approve the form of register and the method of updating which shall incorporate all requirements extant for capital assets.

7.5 Additions to the fixed asset register must be added to the records based on the documented cost of the asset at the time of acquisition.

7.6 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorised documentation.

7.7 The value of each asset where applicable shall be indexed to current values and depreciated using methods and rates as suggested in the Capital Accounting Manual and notified by the SGHSCD.

7.8 Revaluation of land and buildings will be provided by the Board's recommended Valuation Agent on a rolling annual programme designed to ensure that all such assets are revalued once every five years.

7.9 Annual indexation for land and buildings not included in the revaluation exercise in any given year will be provided by the Board's recommended Valuation Agent.

7.10 Any damage to the Board's premises, vehicles and equipment, or any loss of equipment or supplies shall be reported by staff in accordance with the procedure for reporting losses.

8. PAY

Remuneration Committee

8.1 The Board shall approve the terms of reference for the Remuneration Committee, in line with any extant guidance or requirements.

8.2 The Board shall remunerate the Chair and other Non-Executive directors in accordance with instructions issued by Scottish Government

Processes

8.3 The Chief Executive shall establish a system of delegated budgetary authority within which budget holders shall be responsible for the engagement of staff within the limits of their approved budget.

8.4 All time records, payroll timesheets and other pay records and notifications shall be in a form approved by the Director of Finance and shall be authorised and submitted in accordance with his/her instructions. This also includes the payment of expenses and additions to pay whether via e-Expenses, SSTS or other arrangements, including manual systems.

8.5 The Director of Finance shall be responsible for ensuring that rates of pay and relevant conditions are applied in accordance with current agreements. The Chief Executive, or the Board in appropriate circumstances, shall be responsible for the final determination of pay. There will be no variation to agreed terms and conditions without the prior approval of the Director of Human Resources and Director of Finance. The Director of Finance shall determine the dates on which the payment of salary and wages are to be made. These may vary due to special circumstances (e.g. Christmas and other Public Holidays). Payments to an individual shall not be made in advance of normal pay, except:

a. To cover a period of authorised leave, involving absence on the normal pay day; or

b. As authorised by the Chief Executive and Director of Finance to meet special circumstances, and limited to the net pay due at the time of payment.

8.6 Wherever possible, officers should not compile their own payroll input. Where it is unavoidable that the compiler of the payroll input is included on that input, then the entry in respect of the compiler must be supported by evidence that it has been checked and found to be appropriate by another officer holding a higher position.

8.7 Under no circumstance should officers authorise/approve their own payroll input or expenses.

8.8 All employees shall be paid by bank credit transfer unless otherwise agreed by the Director of Finance.

8.9 The Board shall delegate responsibility to the Director of Workforce for ensuring that all employees are issued with a contract of employment in a form approved by the Board and which complies with employment legislation and any extant NHS policies.

9. NON PAY

Tendering, Contracting and Purchasing Procedures

9.1 The Director of Finance shall prepare detailed procedural instructions on the obtaining of goods, services and works, incorporating thresholds set by the Board. The current Authorisation Limits are set out in Scheme of Delegation and the Financial Operating Procedures.

9.2 The Chief Executive shall designate a senior officer as the lead senior officer for procurement, and this person shall oversee the procurement of goods and services, to ensure there is an adequate approval of suppliers and their supplies based on cost and quality.

9.3 NSS National Procurement shall undertake procurement activity on a national basis on behalf of boards (including NHS Fife), and the Board shall implement these nationally negotiated contracts.

9.4 The Board shall operate within the processes established for the procurement of publicly funded construction work.

9.5 The Board shall comply with Public Contracts (Scotland) Regulations 2012 (and any subsequent relevant legislation) for any procurement it undertakes directly.

9.6 The Director of Finance shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

9.7 All other aspects of procurement activity must follow the requirements of the Standing Orders and SFIs. Any decision to depart from the requirements of this section must have the approval of NHS Fife Board.

9.8 The Director of Finance shall:-

- Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained in accordance with the Public Contracts (Scotland) Regulations, as issued annually through Scottish Statutory Instrument.

- Ensure the preparation of comprehensive procedures for all aspects of procurement activity.

9.9 The following basic principles shall be generally applied:-

- Procurement activity satisfies all legal requirements;

- Adequate contracts are in place with approved suppliers for the supply of approved products and services;

- Segregation of duties is applied throughout the process;

- Adequate approval mechanisms are in place before orders are raised;

- All deliveries are checked for completeness and accuracy, and confirmed before approval to pay is made; and

- All payments made are in accordance with previously agreed terms, and what the Board has actually received.

9.10 Limits of Authorisation of Orders

(a) Up to £100,000

- All Corporate Directors, Director of Acute Services and the Director of Health & Social Care can on their own authority commit expenditure up to £100,000 provided this is within the budgets for which they have responsibility.

- All other orders with a value up to £100,000 are subject to a scheme of delegation to Designated Ordering Officers with assigned limits. This scheme is detailed in the Financial Operating Procedures

(b) £100,000 to £1,000,000

All orders between £100,000 and £1,000,000 submitted by any authorised officer must be countersigned by the Board Chief Executive, Director of Acute Services, Director of Health & Social Care (or a designated deputy for them), or Director of Finance.

(c) Above £1,000,000 and less than £2,000,000

All orders above £1,000,000 and less than £2,000,000 must be authorised by the Board Chief Executive and the Director of Finance, subject to the expenditure having been approved by the Board as part of a capital or revenue plan.

(d) The placing of annual orders and the acceptance of all annual contracts over £2,000,000, whether capital or revenue, is reserved to the Board and must be authorised by the Board Chief Executive and Director of Finance.

9.11 For all orders raised between £2,500 and £10,000 there is a requirement for the ordering officer to obtain two written quotations. Orders over £10,000 and up to £25,000 should ensure 3 tendered quotes are received subject to the Board's tendering procedures.

In the following exceptional circumstances, except in cases where EU Directives must be adhered to, the Director of Finance and Chief Executive, as specified in the Scheme of Delegation, can approve the waiving of the above requirements. Where goods and services are supplied on this basis and the value exceeds £2,500, a "Waiver of Competitive Tender/Quotation" may be granted by completing a Single Source Justification form for approval by the

appropriate director and the Head of Procurement. Where the purchase of equipment is valued in excess of £5,000 and where the purchase of other goods and services on this basis exceeds £10,000, the completed Single Source Justification Form shall be endorsed by the Director of Finance and Chief Executive and submitted to the Audit and Risk Committee.

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

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

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

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

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

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

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

The use of supplies within the Office of Government (OGC) framework agreements may negate the need for three competitive tenders. The use of this route must always be recorded. In all instances, the regulations in respect of Official Journal of the European Union (OJEU) must be followed.

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

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

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

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

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

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

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

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

Commissioning of Patient Services

9.17 The Director of Finance, jointly with the Director of Acute Services or Director of Health & Social Care will ensure service agreements are in place with other healthcare providers for the delivery of patient services, ensuring the appropriate financial details are contained and clarity on reporting of performance, quality and safety issues.

9.18 The Director of Finance shall be responsible for maintaining a system for the payment of invoices in respect of patient services in accordance with agreed terms and national guidance and shall ensure that adequate financial systems are in place to monitor and control these.

Payment of Accounts and Expense Claims

9.19 The Director of Finance shall be responsible for the prompt payment of all accounts and expense claims. The Director of Finance shall publish the Board's performance in achieving the prompt payment targets in accordance with specified terms and national guidance.

9.20 The Director of Finance shall be responsible for designing and maintaining a system for the verification, recording and payment of all amounts payable by

the Board. The system shall provide for authorisation by agreed delegated officers, a timetable and system for the payment of accounts and instruction to staff regarding handling, checking and payment of accounts and claims.

9.21 The Director of Finance shall ensure that payments for goods and services are made only after goods and services are received. Prepayments will be permitted in exceptional circumstances and with the prior approval of the Director of Finance

Additional Matters for Capital Expenditure

Overall Arrangements for the Approval of the Capital Plan

9.22 The Board shall follow any extant national instructions on the approval of capital expenditure, such as the Scottish Capital Investment Manual. The authorisation process shall be described in the Scheme of Delegation.

9.23 The Chief Executive shall ensure that:-

- there is an adequate appraisal and approval process in place for determining capital expenditure priorities within the Property Strategy and the effect of each proposal upon business plans;
- all stages of capital schemes are managed, and are delivered on time and to cost;
- capital investment is not undertaken without confirmation that the necessary capital funding and approvals are in place; and
- all revenue consequences from the scheme, including capital charges, are recognised, and the source of funding is identified in financial plans.

Implementing the Capital Programme

9.24 For every major capital expenditure proposal the Chief Executive shall ensure:-

- that a business case as required by the Scottish Capital Investment Manual (SCIM) is produced setting out:-
    a. an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs; and
    b. appropriate project management and control arrangements; and
- that the Director of Finance has assessed the costs and revenue consequences detailed in the business case.

9.25 The approval of a business case and inclusion in the Board's capital plan shall not constitute approval of the individual elements of expenditure on any

scheme. The Chief Executive shall issue to the manager responsible for any scheme:-

- specific authority to commit expenditure; and
- following the required approval of the business case, authority to proceed to tender.

9.26 The Scheme of Delegation shall stipulate where delegated authority lies for:-

- approval to accept a successful tender; and
- where Frameworks Scotland applies, authority to agree risks and timelines associated with a project in order to arrive at a target price.

9.27 The Director of Finance shall issue procedures governing the financial management of capital investment projects (e.g. including variations to contract, application of Frameworks Scotland) and valuation for accounting purposes.

Public Private Partnerships and other Non-Exchequer Funding

9.28 When the Board proposes to use finance which is to be provided other than through its capital allocations, the following procedures shall apply:-

- The Director of Finance shall demonstrate that the use of public private partnerships represents value for money and genuinely transfers significant risk to the private sector.
- Where the sum involved exceeds the Board's delegated limits, the business case must be referred to the Scottish Government for approval or treated as per current guidelines.
- Board must specifically agree the proposal.
- The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

Disposals of Assets

9.29 The Director of Finance shall issue procedures for the disposal of assets including condemnations. All disposals shall be in accordance with MEL(1996)7: Sale of surplus and obsolete goods and equipment.

9.30 There is a requirement to achieve Best Value for money when disposing of assets belonging to the Health Board. A competitive process should normally be undertaken.

9.31 When it is decided to dispose of a Health Board asset, the head of department or authorised deputy will determine and advise the Director of Finance of the

estimated market value of the item, taking account of professional advice where appropriate.

9.32 All unserviceable articles shall be:-

- Condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance.

- Recorded by the Condemning Officer in a form approved by the Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance.

Capital Accounting

9.33 The Director of Finance shall be notified when capital assets are sold, scrapped, lost or otherwise disposed of, and what the disposal proceeds were. The value of the assets shall be removed from the accounting records. Each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

9.34 The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

9.35 The value of each asset shall be indexed and depreciated in accordance with methods specified by the Capital Accounting Manual.

9.36 The Director of Finance shall calculate capital charges, which will be charged against the Board's revenue resource limit.

10. PRIMARY CARE CONTRACTORS

10.1 In these SFIs and all other Board documentation, Primary Care contractor means:-

- an independent provider of healthcare who is registered to provide general dental, medical, ophthalmic or pharmaceutical services under the National Health Service in the United Kingdom (UK); or

- an employee of an National Health Service organisation in the UK who is registered to provide general dental, medical, ophthalmic or pharmaceutical services under the National Health Service in the UK.

10.2 The Primary Care Manager shall devise and implement systems to control the registers of those who are entitled to provide general dental, medical, ophthalmic or pharmaceutical services under the National Health Service in Fife. Systems shall include criteria for entry to and deletions from the registers.

10.3 The Director of Finance shall agree the Service Level Agreement (s) with NHS National Services Scotland for:-

- the development, documentation and maintenance of systems for the verification, recording and receipt of NHS income collected by or on behalf of primary care contractors; and

- the development, documentation and maintenance of systems for the verification, recording and payment of NHS expenditure incurred by or on behalf of primary care contractors.

10.4 The agreements at paragraph F10.3 shall comply with guidance issued from time to time by the Scottish Government. In particular they shall take account of any national systems for the processing of income and expenditure associated with primary care contractors.

10.5 The Director of Finance shall ensure that all transactions conducted for or on behalf of primary care contractors by the Board shall be subject to these SFIs.

11. INCOME AND SCOTTISH GOVERNMENT ALLOCATIONS

11.1 The Director of Finance shall be responsible for designing and maintaining systems for the proper recording and collection of all monies due.

11.2 The Director of Finance shall take appropriate recovery action on all outstanding debts and shall establish procedures for the write-off of debts after all reasonable steps have been taken to secure payment.

11.3 The Director of Finance is responsible for ensuring the prompt banking of all monies received.

11.4 In relation to business development/income generation schemes, the Director of Finance shall ensure that there are systems in place to identify and control all costs and revenues attributed to each scheme.

11.5 The Director of Finance shall approve all fees and charges other than those determined by the Scottish Government or by Statute.

11.6 Scottish Government letters that change funding allocations must be signed by two members of the Finance Directorate Senior Team to evidence their review of the aggregate allocation received.

12. FINANCIAL MANAGEMENT SYSTEM

12.1 The Director of Finance shall carry prime responsibility for the accuracy and security of the computerised financial data of the Board and shall devise and implement any necessary procedures to protect the Board and individuals from inappropriate use or misuse of any financial and other information held on computer files for which he is responsible, after taking account of all relevant legislation and guidance

12.2 The Director of Finance shall ensure that contracts for computer services for financial applications with another Board or any other agency shall clearly

define the responsibility of all the parties for the security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage.

12.3 The Director of Finance shall ensure that adequate data controls exist to provide for security of financial applications during data processing, including the use of any external agency arrangements.

12.4 The Director of Finance shall satisfy her/himself that such computer audit checks as s/he may consider necessary are being carried out.

12.5 The Director of Finance shall ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and are thoroughly tested prior to implementation.

12.6 Where another health organisation or any other agency provides a financial system service to the Board, the Director of Finance shall periodically seek assurances, through Audit where appropriate, that adequate controls are in operation and that disaster recovery arrangements are robust.

13. CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

13.1 Any employee or agent discovering or suspecting a loss of any kind shall forthwith inform his head of department, who shall immediately inform the Chief Executive and the Director of Finance. Where a criminal offence is suspected, the Director of Finance shall follow the Anti-Theft, Fraud, and Corruption Policy, as set out in the Financial Operating Procedures.

13.2 The Director of Finance shall notify the Audit and Risk Committee and Counter Fraud Services of all actual or suspected frauds. See 13.10 below.

13.3 In all instances where there is any suspicion of fraud then the guidance contained within NHS Circular, HDL (2005) 5: “Tackling Fraud in Scotland – Joint Action Programme. Financial Control : Procedures where criminal offences are suspected” must be followed. The Board’s Fraud Liaison Officer (FLO) must be notified immediately of all cases of fraud or suspected fraud.

13.4 The Director of Finance shall issue procedures on the recording of and accounting for Losses and special payments to meet the requirements of the Scottish Public Finance Manual. These procedures shall include the steps to be taken where the loss may have been caused by a criminal act.

13.5 The Scheme of Delegation shall describe the process for the approval of the write-off of losses and making of special payments

13.6 The Director of Finance shall maintain a Losses and Special Payments Register in which details of all Category 1 and Category 2 losses shall be recorded as they are known. Category 3 losses may be recorded in summary form. Write-off action shall be recorded against each entry in the Register.

13.7 No special payments exceeding the delegated limits shall be made without prior approval by the SGHSCD.

13.8 The Director of Finance shall be authorised to take any necessary steps to safeguard the Board's interest in bankruptcies and company liquidations.

13.9 The Director of Finance is required to produce a report on Condemnations, Losses and Special Payments, where the delegated limits have been exceeded and SGHSCD approval has been requested, to the Audit and Risk Committee.

13.10 The Bribery Act came into force in 2010; it aims to tackle bribery and corruption in both the private and public sectors. The Act is fully endorsed by Fife NHS Board. NHS Fife conducts its contracting and procurement practices with integrity, transparency and fairness and has a zero tolerance policy on bribery or any kind of fraud. There are robust controls in place to help deter, detect and deal with it. These controls are regularly reviewed in line with the Standing Financial Instructions and feedback is provided to the Audit & Risk Committee. Procurement actively engage with NHS Scotland Counter Fraud Services to ensure that our team is fully trained on spotting potential signs of fraud and knowing how to report suspected fraud. As an existing or potential contractor to NHS Fife, you are required to understand that it may be a criminal offence under the Bribery Act 2010, punishable by imprisonment, to promise, give or offer any gift, consideration, financial or other advantage whatsoever as an inducement or reward to any officer of a public body and that such action may result in the Board excluding the organisation from the selected list of Potential Bidders, and potentially from all future public procurements. It is therefore vital that staff, contractors and agents understand what is expected of them and their duties to disclose and deal with any instances they find.

14. RISK MANAGEMENT

14.1 The Chief Executive shall ensure that the Board has a programme of risk management, which will be approved and monitored by the Board and which complies with the Standards issued by NHS Health Improvement Scotland.

14.2 The programme of risk management shall include:

a. A process for identifying and quantifying risks and potential liabilities, including the establishment and maintenance of a Risk Register;

b. Engendering among all levels of staff a positive attitude towards the control of risk;

c. Management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover and decisions on the acceptable level of retained risk;

d. Contingency plans to offset the impact of adverse events;

4. Audit arrangements including internal audit, clinical audit and health and safety review;

5. Arrangements to review the risk management programme.

g.. A review by each Governance Committee of relevant risks pertaining to their business.

The existence, integration and evaluation of the above elements will provide a basis for the Audit and Risk Committee to make a statement on the overall effectiveness of Internal Control and Corporate Governance to the Board.

14.3 The programme of risk management will be underpinned by a Board Assurance Framework, approved, and reviewed annually by the NHS Board.

15. RETENTION OF DOCUMENTS

15.1 The Chief Executive shall be responsible for maintaining archives for all documents in accordance with the NHS Code of Practice on Records Management.

15.2 The documents held in archives shall be capable of retrieval by authorised persons.

15.3 Documents held under the Code shall only be destroyed at the express instigation of the Chief Executive, and records shall be maintained of documents so destroyed.

16. PATIENTS' PROPERTY AND FUNDS

16.1 The Board has a responsibility to provide safe custody, for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

16.2 The Chief Executive shall be responsible for ensuring that patients or their guardians, as appropriate, are informed before, or at their admission, by: -

- Notices and information booklets
- Hospitals' admission documentation and property records, and
- The oral advice of administrative and nursing staff responsible for admissions, that the Board will not accept responsibility or liability for patients' monies and personal property brought into Board premises unless it is handed in for safe custody and a copy of an official patient property record is obtained as a receipt.

16.3 The Director of Finance shall provide detailed written instructions on the collection, custody, investment, recording, safekeeping and disposal of patients' property (including instructions on the disposal of the property of deceased patients and patients transferred to other premises), for all staff whose duty it is to administer, in any way, the property of the patients.

16.4 Bank accounts for patients' monies shall be operated under arrangements agreed by the Director of Finance.

16.5 A patients' property record, in a form determined by the Director of Finance, shall be completed.

16.6 The Director of Finance is responsible for providing detailed instructions on the Board's responsibility as per the Adults with Incapacity (Scotland) Act 2000 and the updated Part 5 in CEL11(2008) Code of Practice. These instructions are contained within the Financial Operating Procedures.

16.7 The Director of Finance shall prepare an abstract of receipts and payments of patients private funds in the form laid down by Scottish Government.

17. STORES

17.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use), should be:-

- Kept to a minimum;
- Subject to annual stocktake; and
- Valued at the lower of cost and net realisable value.

17.2 Subject to the responsibility of the Director of Finance for the systems of control, the control of stores throughout the organisation shall be the responsibility of the relevant managers. The day-to-day management may be delegated to departmental officers and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance.

17.3 The responsibility for security arrangements, and the custody of keys for all stores locations, shall be clearly defined in writing by the manager responsible for the stores and agreed with the Director of Finance. Wherever practicable, stock items, which do not belong to the Board, shall be clearly identified.

17.4 All stores records shall be in such form and shall comply with such system of control and procedures as the Director of Finance shall approve.

17.5 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year. The physical check shall involve at least one officer other than the Storekeeper, and the Director of Finance and Internal & External Audit shall be notified and may attend, or be represented, at their discretion. The stocktaking records shall be numerically controlled and signed by the officers undertaking the check. Any surplus or deficiency revealed on stocktaking shall be reported immediately to the Director of Finance, and he may investigate as necessary. Known losses of stock items not on stores control shall be reported to the Director of Finance.

17.6 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

17.7 Instructions for stock take and the basis for valuation will be issued at least once a year by the Director of Finance.

18. AUTHORISATION LIMITS

18.1 The purpose of Standing Financial Instructions is to ensure adequate controls exist for the committing and payment of funds on behalf of NHS Fife. The main principles applied in determining authorisation limits are those of devolved accountability and responsibility. The rules for financial delegation to all levels of management within the Board's established policies and priorities are set out in the Scheme of Delegation and Financial Operating Procedures

18.2 Areas covered by the Scheme of Delegation include:

- Limitation and Authority to vire budgets between one budget heading and another.
- Limitation of level of Authority for the placing of orders or committing resources
- Limitation as to the level of authority to approve receipt of orders, expenses, travel claims, payment of invoices, write off of losses.

19. ENDOWMENT FUNDS

19.1 The Standing Financial Instructions deal with matters related to exchequer income and expenditure for NHS Fife. Whilst Endowment Funds fall outwith the scope of core exchequer funds, it is important that all relevant employees and agents are aware of the arrangements for the financial responsibility and authority for such funds.

19.2 Endowment Funds and are those held in trust for purposes relating to the National Health Service, either by the Board or Special Trustees appointed by the Scottish Ministers or by other persons.

19.3 Members of the Fife Health Board become Trustees of the Board's Endowment Funds. The responsibilities as Trustees are discharged separately from the responsibilities as members of the Board.

19.4 The Director of Finance shall prepare detailed procedural instructions covering the receiving, recording, investment and accounting for Endowment Funds.

19.5 Through the Board's Scheme of Delegation, authority will be given by the Trustees to allow for the day to day management of the funds within specified limits.

19.6 The Authorisation Limits are set out in the Scheme of Delegation and the Financial Operating Procedures.

19.7 The Director of Finance shall prepare annual accounts for the funds held in trust, to be audited independently and presented annually to the trustees.

FIFE NHS BOARD SCHEME OF DELEGATION

1. Introduction

Board's Responsibility

The Standing Orders for the proceedings and Business of the Fife NHS Board include a section on Matters Reserved for the Board (Section 6). This section of the Standing Orders summarises all matters where decision making is reserved to the Board.

The subsequent section (Section 7) within the Standing Orders, identifies that other "matters" may be delegated to Committees or individuals to act on behalf of the Board.

The following appendix sets out:

- Committees' delegated responsibility on behalf of the Board
- Matters delegated to individuals

2. Committees' Delegated Responsibility on behalf of the Board

2.1 Audit & Risk Committee	
Responsible Director for this Section	Director of Finance

Role and Remit	• Supporting the Accountable Officer and Fife NHS Board formulate their assurance needs with regard to risk management, governance and internal control;
	
	• Drawing attention to weaknesses in systems of risk management, governance and internal control;
	
	Internal Control and Corporate Governance
	
	• To evaluate the framework of internal control and corporate governance comprising the following components, as recommended by the Turnbull Report:
	
	  • control environment;
	  • risk management;
	  • information and communication;
	  • control procedures;
	  • monitoring and corrective action.
	
	• To review the system of internal financial control, which includes:
	
	  • the safeguarding of assets against unauthorised use and disposition;
	
	  • the maintenance of proper accounting records and the reliability of financial information used within the organisation or for publication.
	
	• To ensure that the activities of Fife NHS Board are within the law and regulations governing the NHS.
	
	• To review the disclosures included in the Governance Statement on behalf of the Board.
	
	• To present an annual statement of assurance on the above to the Board, to support the NHS Fife Chief Executive's Governance Statement.

	Internal Audit
	
	• To review and approve the Internal Audit Strategic and Annual Plans.
	
	• To monitor audit progress and review audit reports.
	
	• To monitor the management action taken in response to the audit recommendations through an appropriate follow-up mechanism.
	
	• To consider the Chief Internal Auditor's annual report and assurance statement.
	
	• To review the operational effectiveness of Internal Audit by considering the audit standards, resources, staffing, technical competency and performance measures.
	
	External Audit
	
	• To note the appointment of the Statutory Auditor and to approve the appointment and remuneration of the External Auditors for Patients' Funds and Endowment Funds.
	
	• To review the Audit Strategy and Plan, including the Best Value and Performance Audits programme.
	
	• To consider all statutory audit material, in particular:-
	
	  • Audit Reports;
	  • Annual Reports;
	  • Management Letters
	
	  relating to the certification of Fife NHS Boards Annual Accounts, Annual Patients' Funds Accounts.
	
	Risk Management
	
	The Committee shall seek assurance that**:**
	
	• There is a comprehensive risk management system in place to identify, assess, manage and monitor risks at all levels of the organisation.
	
	• There is appropriate ownership of risk in the organisation, and that there is an effective culture of risk management
	
	• The Board has clearly defined its risk appetite (i.e. the level of risk that the Board is prepared to accept, tolerate, or be exposed to at any time), and that the executive's approach to risk management is consistent with that appetite.

	• The Committee will also receive and review a report summarising any significant changes to the Board's Board Assurance Framework, and what plans are in place to manage them. The Committee may also elect to occasionally request information on significant risks held on any risk registers held in the organisation. • Assess whether the Board Assurance Framework is an appropriate reflection of the key risks to the Board, so as to advise the Board. • Receive an annual report on risk management, confirming whether or not there have been adequate and effective risk management arrangements throughout the year, and highlighting any material areas of risk. **Standing Orders and Standing Financial Instructions** • To review the model Standing Orders for Boards as issued by NHS Scotland, and associated appendices of Fife NHS Board, and advise the Board of any amendments required. • To examine the circumstances associated with any occasion when Standing Orders of Fife NHS Board have been waived or suspended. **Annual Accounts** • To review and recommend approval of draft Fife NHS Board Annual Accounts to the Board. • To review the draft Annual Report and Financial Review of Fife NHS Board as found within the Directors Report incorporated within the Annual Accounts. • To review annually (and approve any changes in) the accounting policies of Fife NHS Board. • To review schedules of losses and compensation payments where the amounts exceed the delegated authority of the Board prior to being referred to the Scottish Government for approval. **Other Matters** • The Committee shall review the arrangements for employees raising concerns, in confidence, about possible wrongdoing in financial reporting or other matters. The Committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow-up action.

	• The Committee shall review regular reports on Fraud and potential Frauds. • The Committee shall provide assurance to the Board on achievement and maintenance of Best Value standards, relevant to the Committee's area of governance as set out in Audit Scotland's baseline report "Developing Best Value Arrangements". • The Committee shall seek assurance that the Board has systems of control to ensure that it discharges its responsibilities under the Freedom of Information (Scotland) Act 2002. • The Committee shall review the Board's arrangements to prevent bribery and corruption within its activities. This includes the systems to support Board members' compliance with the NHS Fife Board Code of Conduct (Ethical Standards in Public Life Act 2000), the systems to promote the required standards of business conduct for all employees and the Boards procedure to prevent Bribery (Bribery Act 2000).

2.2 Clinical Governance Committee	
Responsible Director for this Section	Medical Director
Sub-Committees	• Health & Safety
Role and Remit	• To monitor progress on the health status targets set by the Board. • The Committee will produce an Annual Statement of Assurance for submission to the Board, via the Audit & Risk Committee. The proposed Annual Statement will be presented to the first Committee meeting in the new financial year or agreed with the Chairperson of the respective Committee by the end of May each year for presentation to the Audit and Risk Committee in June. • To capture and record all issues and risks on an operational risk register to be monitored through the Committee, and where appropriate these should be escalated to the Board for consideration in addition to the corporate risk register until mitigated to a tolerable level. • To receive updates on and oversee the progress on the recommendations from relevant external reports of reviews of all healthcare organisations including clinical governance reports and recommendations from relevant regulatory bodies which may include Healthcare Improvement Scotland (HIS) reviews and visits. • To provide assurance to Fife NHS Board about the quality of services within NHS Fife. • The Committee shall review regularly the sections of the NHS Fife Integrated Performance & Quality Report relevant to the Committee's responsibility. • To undertake an annual self-assessment of the Committee's work and effectiveness. • The Committee shall provide assurance to the Board on achievement and maintenance of Best Value standards, relevant to the Committee's area of governance as set out in Audit Scotland's baseline report "Developing Best Value Arrangements".

2.3 Finance, Performance and Resources Committee	
Responsible Director for this Section	Director of Finance
Sub-Committees	• Pharmacy Practices • Primary Medical Services
Role and Remit	• The Committee shall have accountability to the Board for ensuring that the financial position of the Board is soundly based, having regard to: • compliance with statutory financial requirements and achievement of financial targets; • such financial monitoring and reporting arrangements as may be specified from time-to-time by SGHSCD and/or the Board; • levels of balances and reserves; • the impact of planned future policies and known or foreseeable future developments on the financial position; • undertake an annual self-assessment of the Committee's work and effectiveness; and • review regularly the sections of the NHS Fife Integrated Performance & Quality Report relevant to the Committee's responsibility. **Arrangements for Securing Value for Money** • The Committee shall keep under review arrangements for securing economy, efficiency and effectiveness in the use of resources. These arrangements will include procedures for (a) planning, appraisal, and control, accountability and evaluation of the use of resources, and for (b) reporting and reviewing performance and managing performance issues as they arise in a timely and effective manner. In particular, the Committee will review action (proposed or underway) to ensure that the Board achieves financial balance in line with statutory requirements. **Allocation and Use of Resources** The Committee has key responsibilities for: • reviewing the development of the Board's Financial Strategy in support of the Annual Operational Plan, and recommending approval to the Board; • reviewing all resource allocation proposals outwith authority delegated by the Board and make recommendations to the Board thereon; and

	• monitoring the use of all resources available to the Board. • Specifically, the Committee is charged with recommending to the Board annual revenue and capital budgets and financial plans consistent with its statutory financial responsibilities. It shall also have responsibility for the oversight of the Board's Capital Programme (including individual Business Cases for Capital Investment) and the review of the Property Strategy (including the acquisition and disposal of property), and for making recommendations to the Board as appropriate on any issue within its terms of reference; • The Committee will produce an Annual Statement of Assurance for submission to the Board, via the Audit and Risk Committee. The proposed Annual Statement will be presented to the first Committee meeting in the new financial year or agreed with the Chairperson of the respective Committee by the end of May each year for presentation to the Audit and Risk Committee in June; and • The Committee shall provide assurance to the Board on achievement and maintenance of Best Value standards, relevant to the Committee's area of governance as set out in Audit Scotland's baseline report "Developing Best Value Arrangements".

2.4 Public Health & Wellbeing Committee	
Responsible Director for this Section	Director of Public Health
Role and Remit	The remit of the Public Health & Wellbeing Committee is: • To agree key areas of focus within the public health priorities that will be taken forward every year, oversee the agreed population health activities, ensure equity in provision and access to services, and provide assurance thereon to Fife NHS Board. • To ensure that a strategic plan is formulated that reflects public health and wellbeing needs and priorities for the population serviced by NHS Fife in line with the priorities of the national care and wellbeing programmes. • To monitor strategy implementation through regular progress reports and review of intermediate measures and long-term outcomes. • To receive assurance that the risks relating to primary care and community services are addressed in line with the directions set and that robust mitigating actions are in place to address any areas of concern or where performance is not in line with national standards or targets. • To support the work of the Anchor Institute Programme Board and Population Health and Wellbeing Portfolio Board and receive updates on progress and outcomes. • To support the ambitions set out in the Plan for Fife (Community Planning Partnership) through collaboration on agreed areas of influence. • To undertake scrutiny of individual topics / projects / work-streams to promote the health of the population in Fife, including NHS Fife staff, with particular emphasis on prevention and addressing health inequalities. • To ensure appropriate linkages to other key work of the Board, such as the development of new services, workstreams and delivery plans.

	• To undertake an annual self-assessment of the Committee's work and effectiveness. • The Committee will produce an Annual Report incorporating a Statement of Assurance for submission to the Board, via the Audit & Risk Committee. The proposed Annual Report will be presented to the first Committee meeting in the new financial year or agreed with the Chairperson of the Committee by the end of May each year for presentation to the Audit & Risk Committee in June. • The Committee shall provide assurance to the Board on achievement and maintenance of Best Value standards, relevant to the Committee's area of governance as set out in Audit Scotland's baseline report "Developing Best Value Arrangements".

2.5 Remuneration Committee	
Responsible Director for this Section	Director of Workforce

Role and Remit	• The remit of the Remuneration Committee is to consider:
	  • job descriptions for the Executive cohort;
	  • other terms of employment which are not under Ministerial direction;
	  • to hear and determine appeals against the decisions of the Consultant Discretionary Awards Panel. The Remuneration Committee can make decisions regarding Discretionary Points in exceptional circumstances;
	  • agree performance objectives and appraisals directly for the Executive cohort only, and oversee arrangements for designated senior managers;
	  • redundancy, early retiral or termination arrangement in respect of all staff in situations where there is a financial impact upon the Board (this excludes early retiral on grounds of ill health) and approve these or refer to the Board as it sees fit; and
	  • undertake an annual self-assessment of the Committee's work and effectiveness.
	• The Committee will produce an Annual Report incorporating a Statement of Assurance for submission to the Board, via the Audit & Risk Committee. The proposed Annual Report will be presented to the first Committee meeting in the new financial year or agreed with the Chairperson of the Committee by the end of May each year for presentation to the Audit & Risk Committee in June.
	• The Committee shall provide assurance to the Board on achievement and maintenance of Best Value standards, relevant to the Committee's area of governance as set out in Audit Scotland's baseline report "Developing Best Value Arrangements".

2.6 Staff Governance Committee	
Responsible Director for this Section	Director of Workforce
Role and Remit	• The remit of the Staff Governance Committee is to: • consider NHS Fife's performance in relation to its achievements of effective Staff Governance and its compliance with the Staff Governance Standard; • review action taken on recommendations made by the Committee, NHS Boards, or the Scottish Ministers on Staff Governance matters; • give assurance to the Board on the operation of Staff Governance systems within NHS Fife, identifying progress, issues and actions being taken, where appropriate; • support the operation of the Area Partnership Forum and the Local Partnership Forums in their Staff Governance monitoring role and the appropriate flow of information to facilitate this; • encourage the further development of mechanisms for engaging effectively with all members of staff within the NHS in Fife; • contribute to the development of the Annual Operational Plan, in particular but not exclusively, around issues affecting staff; • support the continued development of personal appraisal professional learning and performance; • review regularly the sections of the NHS Fife Integrated Performance & Quality Report relevant to the Committee's responsibility; and • undertake an annual self-assessment of the Committee's work and effectiveness. • The Committee is also required to carry out a review of its function and activities and to provide an Annual Statement of Assurance. This will be submitted to the Board via the Audit and Risk Committee. The proposed Annual Statement will be presented to the first Committee meeting in the new financial year or agreed with the Chairperson of the

	respective Committee by the end of May each year for presentation to the Audit and Risk Committee in June. • The Committee shall provide assurance to the Board on achievement and maintenance of Best Value standards, relevant to the Committee's area of governance as set out in Audit Scotland's baseline report "Developing Best Value Arrangements".

3. Matters Delegated to Individuals

3.1 Matters Delegated to the Chief Executive	
	General Provisions In the context of the Board's principal role to protect and improve the health of Fife residents, the Chief Executive as Accountable Officer shall have delegated authority and responsibility to secure the economical, efficient and effective operation and management of Fife NHS Board and to safeguard its assets: • in accordance with the statutory requirements and responsibilities laid upon the Chief Executive as Accountable Officer for Fife NHS Board; • in accordance with direction from the Scottish Government Health and Social Care Directorates; • in accordance with the current policies of and decisions made by the Board; • within the limits of the resources available, subject to the approval of the Board; • and in accordance with the Code of Corporate Governance as detailed in Standing Orders and Standing Financial Instructions. The Chief Executive is authorised to take such measures as may be required in emergency situations, subject to advising, where possible, the Chairperson and the Vice-Chairperson of the Board, and the relevant Standing Committee Chairperson. Such measures, that might normally be outwith the scope of the authority delegated by the Board or its Standing Committees to the Chief Executive, shall be reported to the Board or appropriate Standing Committee as soon as possible thereafter. The Chief Executive is authorised to give a direction in special circumstances that any officer shall not exercise a delegated function subject to reporting on the terms of the direction to the next meeting of the appropriate Committee. **Finance** Resources shall be used only for the purpose for which they are allocated, unless otherwise approved by the Chief Executive, after taking account of the advice of the Director of Finance. The Chief Executive acting together with the Director of Finance has delegated authority to approve the transfer of funds between budget heads, including transfers from reserves and balances, up to a maximum of £2,000,000 in any one instance.

	The Chief Executive shall report to the Finance, Performance and Resources Committee those instances where this authority is exercised and/or the change in use of the funds relates to matters of public interest. The Chief Executive may, acting together with the Director of Finance, and having taken all reasonable action to pursue recovery, approve the writing-off of losses, subject to the financial limits and categorisation of losses laid down from time to time by the Scottish Government Health and Social Care Directorates. **Legal Matters** The Chief Executive is authorised to institute, defend or appear in any legal proceedings or any inquiry, including proceedings before any statutory tribunal, board or authority, and following consideration of the advice of the Central Legal Office of the National Services Scotland (NSS), to appoint or consult with Counsel where it is considered expedient to do so, for the promotion or protection of the Board's interests. In circumstances where a claim against the Board is settled by a decision of a Court, and the decision is not subject to appeal, the Chief Executive shall implement the decision of the relevant Court on behalf of the Board. In circumstances where the advice of the Central Legal Office is to reach an out-of-court settlement, the Chief Executive may, acting together with the Director of Finance, settle claims against the Board, subject to a report thereafter being submitted to the Finance, Performance and Resources Committee. The Chief Executive, acting together with the Director of Finance, may make ex gratia payments subject to the limits laid down from time to time by the Scottish Government Health & Social Care Directorates. The arrangements for signing of documents in respect of matters covered by the Property Transactions Manual shall be in accordance with the direction of Scottish Ministers. The Chief Executive and the Director of Finance are currently authorised to sign such documentation on behalf of the Board and Scottish Ministers. The Chief Executive shall have responsibility for the safe keeping of the Board's Seal, and together with the Chairperson or other nominated Non-Executive Member of the Board, shall have responsibility for the application of the Seal on behalf of the Board.

	Procurement of Supplies and Services The Chief Executive shall have responsibility for nominating officers or agents to act on behalf of the Board, for specifying, and issuing documentation associated with invitations to tender, and for receiving and opening of tenders. Where post tender negotiations are required, the Chief Executive shall nominate in writing, officers and/or agents to act on behalf of the Board. The Chief Executive, acting together with the Director of Finance, has authority to approve on behalf of the Board the acceptance of tenders, submitted in accordance with the Board's Standing Orders, up to an annual value of £2,000,000, within the limits of previously approved Revenue and Capital Budgets, where the most economically advantageous tender is to be accepted. The Chief Executive through the Director of Finance shall produce a listing, including specimen signatures, of those officers or agents to whom they have given delegated authority to sign official orders on behalf of the Board. **Human Resources** The Chief Executive may, after consultation and agreement with the Director of Workforce, and the relevant Director, amend staffing establishments in respect of the number and grading of posts. In so doing, the Director of Finance must have been consulted, and have confirmed that the cost of the amended establishment can be contained within the relevant limit approved by the Board for the current and subsequent financial years. Any amendment must also be in accordance with the policies and arrangements relating to workforce planning, approved by the Board or Staff Governance Committee. The Chief Executive has delegated authority from Fife NHS Board to approve the establishment of salaried dentist posts within NHS Fife, within the systematic approach as laid down by the Scottish Government Health & Social Care Directorates Circular No PCA(D)(2005)3. The Chief Executive may attend and may authorise any member of staff to attend within and outwith the United Kingdom conferences, courses or meetings of relevant professional bodies and associations, provided that: • attendance is relevant to the duties or professional development of such member of staff; and

	• appropriate allowance has been made within approved budgets; or • external reimbursement of costs is to be made to the Board. • Under the terms of the public sector reform act the Chief Executive is required to keep a register of all such approvals. The Chief Executive may, in accordance with the Board's agreed Employee Conduct Policy, take disciplinary action, in respect of members of staff, including dismissal where appropriate. The Chief Executive shall have overall responsibility for ensuring that the Board complies with Health and Safety legislation, and for ensuring the effective implementation of the Board's policies in this regard. The Chief Executive may, following consultation and agreement with the Director of Workforce and the Director of Finance approve payment of honoraria to any employee. The Chief Executive may, in consultation with the Director of Workforce and Director of Finance, approve applications to leave the employment of the Board on grounds of early retirement by any employee provided the terms and conditions relating to the early retirement are in accordance with the relevant Board policy. All such applications and outcomes will be reported to the Remuneration Committee. **Patients' Property** The Chief Executive shall have overall responsibility for ensuring that the Board complies with legislation in respect of patients' property. The term 'property' shall mean all assets other than land and building. (e.g. furniture, pictures, jewellery, bank accounts, shares, cash.)

3.2 Matters Delegated to the Director of Finance	
	Authority is delegated to the Director of Finance to take the necessary measures as undernoted, in order to assist the Board and the Chief Executive in fulfilling their corporate responsibilities: **Accountable Officer** The Director of Finance has a general duty to assist the Chief Executive in fulfilling their responsibilities as the Accountable Officer of the Board. **Financial Statements** The Director of Finance is empowered to take all steps necessary to assist the Board to: • Act within the law and ensure the regularity of transactions by putting in place systems of internal control to ensure that financial transactions are in accordance with the appropriate authority; • Maintain proper accounting records; and • Prepare and submit for External Audit timeous financial statements which give a true and fair view of the financial position of the Board and its income and expenditure for the period in question. **Corporate Governance and Management** The Director of Finance is authorised to put in place proper arrangements to ensure that the financial position of the Board is soundly based by ensuring that the Board, its Committees, and supporting management groupings receive appropriate, accurate and timely information and advice with regard to: • The development of financial plans, budgets and projections; • Compliance with statutory financial requirements and achievement of financial targets; • The impact of planned future policies and known or foreseeable developments on the Board's financial position. The Director of Finance is empowered to take steps to ensure that proper arrangements are in place for: • Developing, promoting and monitoring compliance with Standing Orders and Standing Financial Instructions, and appropriate guidance on standards of business conduct; • Developing and implementing systems of internal control, including systems of financial, operational and compliance controls and risk management;

	• Developing and implementing strategies for the prevention and detection of fraud and irregularity; • Internal Audit. **Performance Management** The Director of Finance is authorised to assist the Chief Executive to ensure that suitable arrangements are in place to secure economy, efficiency, and effectiveness in the use of resources and that they are working effectively. These arrangements include procedures: • for planning, appraisal, authorisation and control, accountability and evaluation of the use of resources; • to ensure that performance targets and required outcomes are met and achieved. **Banking** The Director of Finance is authorised to oversee the Board's arrangements in respect of accounts held in the name of the Board with the Paymaster General Office and the commercial bankers duly appointed by the Board. The Director of Finance will be responsible for ensuring that the Paymaster General's Office and the commercial bankers are advised in writing of amendments to the panel of nominated authorised signatories. **Tax** The Director of Finance shall have delegated authority as lead officer for Tax matters, in relation to the management of taxes as they affect NHS Fife's financial affairs. This includes but is not limited to final determination in cases of off payroll working, application of the Construction Industry Scheme regulations, VAT etc. **Patients' Property** The Director of Finance shall have delegated authority to ensure that detailed operating procedures in relation to the management of the property of patients (including the opening of bank accounts where appropriate) are compiled for use by staff involved in the management of patients' property and financial affairs, in line with the terms of the Adults with Incapacity (Scotland) Act 2000.

3.3 Matters Delegated to Other Senior Officers of the Board	
	Director of Acute Services and Director of Health and Social Care
	General Provisions The Director of Acute Services/Director of Health and Social Care shall have delegated authority and responsibility from the Board Chief Executive to secure the economical, efficient and effective operation and management of their services: • in accordance with the current policies and decisions made by the Board; • within the limits of the resources made available to the Division/IJB; • in accordance with the Code of Corporate Governance as detailed in the Board's Standing Orders and Standing Financial Instructions. The Director of Acute Services and Director of Health and Social Care have a general duty to assist the Chief Executive in fulfilling their responsibilities as the Accountable Officer of the Board. The Director of Acute Services and Director of Health and Social Care are authorised to take such measures as may be required in emergency situations, subject to advising, where possible, the Chairperson or the Vice-Chairperson of the Board, the Chief Executive and where appropriate the relevant Standing Committee Chairperson. Such measures, that might normally be outwith the scope of the authority delegated by the Board or its Standing Committees to the Chief Executive, shall be reported to the Board or appropriate Standing Committee as soon as possible thereafter. The Director of Acute Services and Director of Health and Social Care are authorised to give a direction in special circumstances that any officer within their area shall not exercise a delegated function subject to reporting on the terms of the direction to the next meeting of the Board. **Finance** Resources shall be used only for the purpose for which they are allocated, unless otherwise approved by the Director of Acute Services and Director of Health and Social Care, after taking account of the advice of the Deputy Director of Finance. The Director of Acute Services and Director of Health and Social Care acting together with the Deputy Director of Finance have delegated

	authority to approve the transfer of funds between budget heads, up to a maximum of £500,000 in any one instance. Those instances where this authority is exercised and/or the change in use of the funds relates to matters of public interest shall be notified to the Finance, Performance and Resources Committee. **Legal Matters** The Director of Acute Services and Director of Health and Social Care are authorised to institute, defend or appear in any legal proceedings or any inquiry, (including proceedings before any statutory tribunal, board or authority) in respect of their service areas, and following consideration of the advice of the Central Legal Office of the National Services Scotland and in consultation with the Chief Executive, to appoint or consult with Counsel where it is considered expedient to do so, for the promotion or protection of the Board's interests. **Procurement of Supplies and Services** The Director of Acute Services and Director of Health and Social Care shall have responsibility for nominating officers or agents to act on behalf of the Board, for specifying, and issuing documentation associated with invitations to tender, and for receiving and opening of tenders. The Director of Acute Services and Director of Health and Social Care shall work with the Deputy Director of Finance and the Director of Finance to produce a listing, including specimen signatures, of those officers or agents to whom he has given delegated authority to sign official orders on behalf of the Board within their areas of responsibility. **Human Resources** The Director of Acute Services and Director of Health and Social Care may, after consultation and agreement with Human Resources, amend staffing establishments in respect of the number and grading of posts. In so doing, the Deputy Director of Finance, must have been consulted, and have confirmed that the cost of the amended establishment can be contained within the relevant limit approved for the current and subsequent financial years. Any amendment must also be in accordance with the policies and arrangements relating to workforce planning, approved by the Board or the Staff Governance Committee. The Director of Acute Services and Director of Health and Social Care may, in accordance with the Board's agreed Employee Conduct Policy, take disciplinary action in respect of members of staff, including dismissal where appropriate.

	Patients' Property The Director of Acute Services and Director of Health and Social Care shall have overall responsibility for ensuring compliance with legislation in respect of patient's property and that effective and efficient management arrangements are in place.
	3.4 Champion Roles The following roles are filled by Non-Executive Board members. • Counter Fraud Services Champion • Digital Champion • Equality & Diversity Champion • Safety & Cleanliness Champion • Whistle Blowing Champion (appointed nationally)

FRAMEWORK OF GOVERNANCE: SOUTH EAST AND TAYSIDE (SEAT) REGIONAL PLANNING GROUP

1. STATUTORY DUTY

1.1 The National Health Service Reform (Scotland) Act 2004 placed a statutory duty on NHS Boards to co-operate for the benefit of the people of Scotland.

1.2 The Scottish Executive Health Department (SEHD) letter of 13 December 2004 (HDL (2004) 46) entitled "Regional Planning", set out a framework for NHS Boards engagement in the regional planning of health services, in support of the legislation, covering both service and workforce planning.

1.3 There are three Regional Planning Groups within NHS Scotland, which provide structures and mechanisms for taking forward the statutory duty. NHS Fife participates in the South East and Tayside (SEAT) Regional Planning Group, which comprises the following NHS Board areas:-

- NHS Borders;
- NHS Fife;
- NHS Forth Valley;
- NHS Lothian; and
- NHS Tayside.

For the purposes of planning some specific services, NHS Dumfries and Galloway and NHS Highland also participate in SEAT.

1.4 The Framework of Governance: SEAT Regional Planning Group (Appendix A) describes how decisions in SEAT are made and how the Regional Planning Group carries out its functions and is accountable for its performance. The Framework covers the following four areas:-

- Scheme of Delegation;
- Terms of Reference;
- Statement of the Expected Standards of Corporate Governance and Internal Control; and
- Repository of control documents and operating procedures.

1.5 The Framework of Governance does not take precedence over the Board's internal Code of Corporate Governance.

Appendix 5

APPENDIX A

SOUTH EAST AND TAYSIDE (SEAT) REGIONAL PLANNING GROUP

FRAMEWORK OF GOVERNANCE

Introduction

SEAT Regional Planning Group requires to have a framework of governance to describe how decisions will be made when it convenes, and how it will carry out its functions and be accountable for its performance.

This Framework has four key sections:

1. A **Scheme of Delegation**, describing the relationship between SEAT and the member boards, and how boards will delegate authority to SEAT and the individual members, namely the Chief Executives.

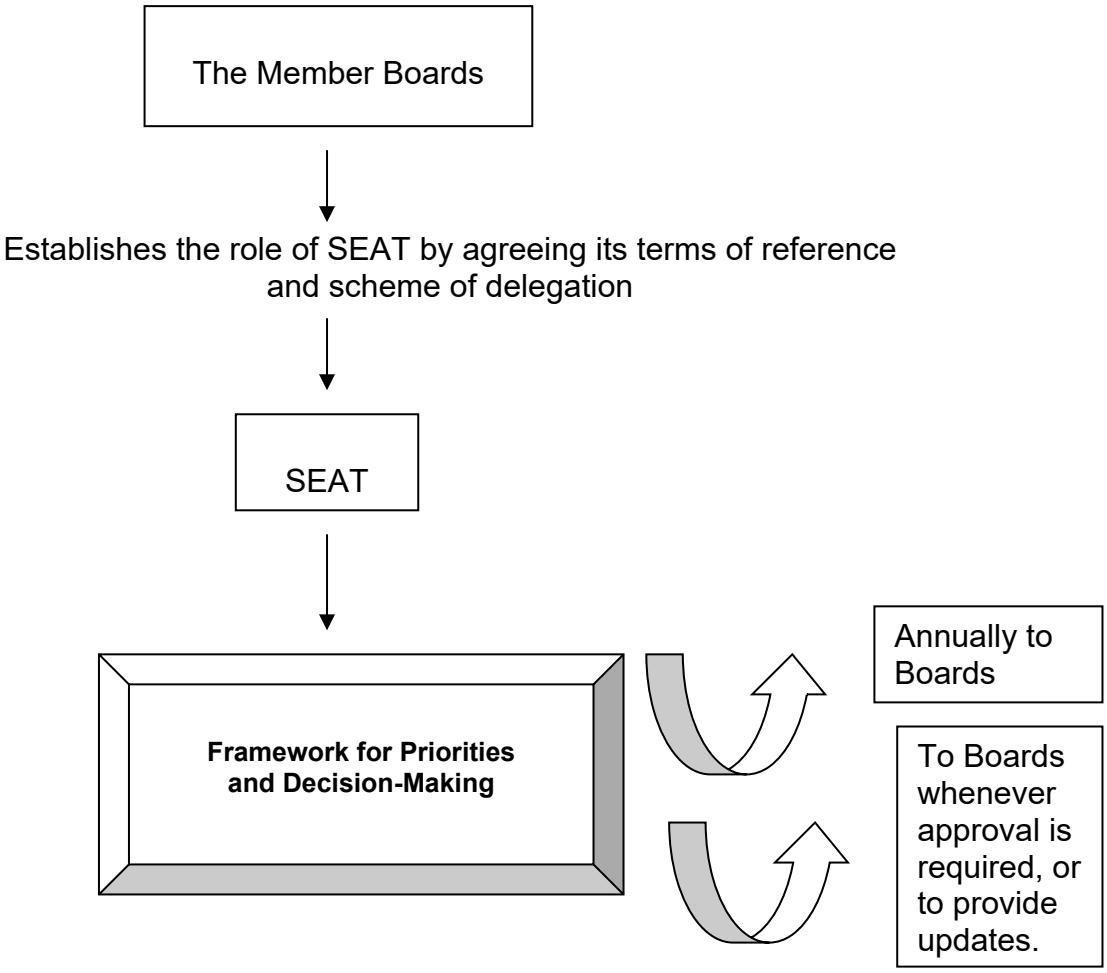
2. A **Terms of Reference**, describing the remit of the group, how it will make decisions, and how the different control elements of regional planning comes together to form the system of governance for SEAT.

3. A **Statement of the Expected Standards of Corporate Governance and Internal Control** that the member boards expect of each other when implementing the work of SEAT.

4. A **repository of control documents and operating procedures** that will be used to implement, monitor and account for the activities of SEAT. These together will form the system of control for SEAT operations. These will be live control documents and will not normally be presented as part of the framework of governance, but should be available upon request.

1. THE SCHEME OF DELEGATION

1.1 – The Overall Process



1.2 – Schedule of Delegated Authority from Member Boards to SEAT

DELEGATE	Description of Agreed Authority/ Responsibilities
SEAT (through the designated Chair of SEAT)	• To take forward the member boards' objectives and responsibilities with regard to regional planning in accordance with HDL (2004) 46; • To operate within its terms of reference; • To develop a work plan for member boards' approval, and implement the Framework for Priorities and Investments (as approved by the member boards).
Chief Executives of Member Boards	• To represent his or her Board at SEAT and act on its behalf; • To operate within the terms of reference of SEAT and to ensure that the board's statutory responsibilities for regional planning are met; • To ensure that this Framework of Governance has been presented and agreed by his or her Board; • To present SEAT documents to his or her Board for approval, as required by this Framework of Governance; • If designated as the lead member of a project within the Framework of Priorities and Decision Making, to lead the delivery of that project with the autonomy normally granted to a Chief Executive if acting entirely within his or her own host board; • To be accountable for the performance of projects assigned to him or her within the Framework of Priorities and Decision Making; • Generally to act in such a way as to deliver the goals of regional planning.
SEAT Project Officers (these are individuals who are identified by SEAT to lead work commissioned by them)	• To operate within the scope of his or her job description and any further delegated authority that may be given by the lead member for the project.

2. TERMS OF REFERENCE OF THE SEAT REGIONAL PLANNING GROUP

2.1 REMIT

2.1.1 The remit of the Group is to assist in the delivery of the following NHS Scotland objectives:

- To plan, fund and implement services across NHS Board boundaries;
- To harness and support the potential of Managed Clinical Networks;
- To develop integrated workforce planning for cross-board services;
- To facilitate the commissioning and monitoring of services which extend beyond NHS Board boundaries, services between members and out with the region on an inter-regional or national basis;
- To harmonise the NHS Board service plans at the regional level;
- To plan emergency response across NHS Board boundaries; and
- To support the delivery of NHS Boards' duty to co-operate for the benefit of the people of Scotland.

2.1.2 The above remit is to be delivered by the Group. However, the member boards remain accountable and responsible for the continued delivery of their statutory duties and general corporate governance requirements.

2.2 OUTCOMES FROM THE SEAT REGIONAL PLANNING GROUP ("THE GROUP")

2.2.1 The Group maintains and works to a Framework for Priorities and Decision-Making. The members must present this to their Boards for approval on an annual basis. This is the SEAT equivalent of the "Annual Regional Planning Agenda" referred to in HDL (2004) 46.

2.2.2 The Framework will include service, workforce, financial and other appropriate planning issues.

2.2.3 It is the responsibility of the member organisations to ensure congruence between their local plans and the Framework.

2.2.4 The Framework will contain all projects that have progressed beyond initial review stage, and require approval from member boards to progress to implementation. This document will also provide an analysis of the progress of projects that have previously been approved by the Boards for implementation, and is therefore key to effective performance management of the Group's agenda.

2.2.5 The Group will prepare an Annual Report of its activities, which will be sent to all members and partner organisations, and will be used as the focus for any public accountability processes. The Annual Report, prepared in accordance with this Framework of Governance, is submitted direct to Member Boards and, therefore, does not need to comply with the Audit Committee schedule and process for the production of Annual Reports.

2.2.6 The Group will support the retained accountability duties of member organisations, by making available any information to those organisations, which will support public reporting and the development of Local Delivery Plans.

2.2.7 The principal form of reporting by the Regional Group to the Board will be through the regular presentation of its minutes to the Board by the Board Chief Executive.

2.3 MEMBERSHIP OF THE SEAT REGIONAL PLANNING GROUP

2.3.1 The executive members of the SEAT Regional Planning Group are the Chief Executives of NHS Borders, NHS Fife, NHS Forth Valley, NHS Lothian and NHS Tayside.

2.3.2 Each member remains personally and legally accountable for their decisions both to their local Board and the Chief Executive of the NHS in Scotland. (This accountability incorporates the duty of regional planning as set out in SE guidance). All of the member Boards must formally recognise and approve the Scheme of Delegation in Section 1 of this Framework of Governance.

2.3.3 Once a decision is reached, each Board is bound by collective responsibility. The minutes of the meeting will reflect the decision of the Group.

2.3.4 The position of Chair of SEAT will rotate every three years as agreed by the executive members.

2.3.5 The Group will invite any other organisation or officers to attend meetings as it sees fit. Those who will be routinely invited to SEAT meetings will be:

- Directors of Planning for the member boards;
- Regional Planning Director;
- Regional Workforce Planning Director;
- Director (National Services Division);
- Representatives of:
  - the Chief Executive (NHS Scotland);
  - the Scottish Ambulance Service;
  - NHS Education Scotland;
  - Dumfries and Galloway NHS Board;
- The Postgraduate Dean for SE Scotland;
- Director of Pay Modernisation (SGHSCD);
- SEAT Workforce Champion; and
- the Lead Representative from each functional group, recognised by SEAT.

2.4 IMPLEMENTING THE WORK PLAN AND THE FRAMEWORK OF PRIORITIES AND DECISION MAKING

2.4.1 SEAT cannot progress any item on the Work Plan or implement any project on the Framework of Priorities and Decision Making without the prior approval of member boards. This would normally be via approval of the Annual Workplan.

2.4.2 Once all member board approvals are in place, SEAT is free to decide how to progress its workload. Each project will have a lead member assigned to it.

2.4.3 Once a member has been given lead responsibility for an item in the Work Plan or Framework of Priorities and Decision Making, he or she has complete authority from SEAT to progress the matter, as if the matter was an issue contained within his or her Board. The lead member will account to the SEAT Regional Planning Group by updating the Framework of Priorities and Decision Making.

2.4.4 All members are required to conduct SEAT business under the same standards of internal control and corporate governance as is generally expected of Chief Executives in NHS Scotland (Section 3). The lead member for a particular SEAT project will be primarily responsible for standards of internal control for activities within the scope of the project, on the understanding that all members have established adequate systems of internal control in their organisations.

2.4.5 For all items in the Framework of Priorities and Decision Making, a Project Agreement will be developed. This will describe the precise scope and objectives of the project, including timescales and accountability arrangements, as well as the associated resources required to deliver the project. This Project Agreement will define the parameters within which the member with lead responsibility for the project can operate.

2.4.6 In the event of the SEAT Regional Planning Group being in disagreement with the aspects of the delivery of the implementation of a project agreement, or if the Group wishes to amend or discontinue an agreed project, then a resolution to overrule the lead member responsible for the project (as stated in the project agreement) or alter the project terms of reference must be approved by the Group. An event of this nature should be reported back to the member boards.

2.5 SCOPE OF ACTIVITY TO BE ADDRESSED BY THE SEAT REGIONAL PLANNING GROUP

2.5.1 The national regional planning framework grants SEAT the authority to act on behalf of its members in the delivery of the following tasks:

- Develop and progress a co-ordinated approach to service delivery for and on behalf of constituent NHS Boards;
- Facilitate commissioning and monitoring of services which extend beyond NHS Board boundaries, services between members and out with the region on an inter-regional or national basis;
- Develop strategic workforce solutions which support service delivery models;

- Commit and monitor resources, within the agreed financial framework, for the purposes for which it was approved;
- Determine commissioning policy for those services within its workplan;
- Agree a prioritisation framework for the regional planning group, reflective of those within individual NHS Boards;
- Commission reviews or other research in order to inform decisions;
- Agree. Monitor and update action plans;
- Develop delivery plans (often in collaboration with other Regional Planning Groups) for highly specialised services;
- Performance manage regional Managed Clinical Networks.
- Establish sub-groups as appropriate.

2.6 EXCEPTIONAL MATTERS

2.6.1 There may exceptionally be decisions that require significant expenditure commitments (or controversial service changes), which would be beyond the scope of delegated authority conventionally awarded to Board Chief Executives. In these exceptional circumstances, the member NHS Boards can delegate the authority to act on their behalf to executive sub-committees of each Board as opposed to their Chief Executive. It would be for the member NHS Boards to determine the membership of this executive subcommittee. The five executive sub-committees would then meet together (as opposed to the five Chief Executives acting on their own delegated authority) to form the Regional Planning Group.

2.6.2 The undertaking of work not previously foreseen in the agreed Work Plan or Framework of Priorities and Decision Making can be classed as an exceptional matter. This may be because the issue relates to a matter that requires an emergency response.

2.6.3 In these exceptional circumstances, the Chair of each executive sub-committee will act on behalf of his or her Board.

2.6.4 The Chair of SEAT has the authority to make decisions in emergency situations on behalf of this group, following consultation with the other members. If the issue falls within the agreed Work Plan or Framework of Priorities and Decision Making, then it can be formally endorsed at the next meeting of the Group. If the issue is not within these documents, then it should be formally endorsed at the next meetings of the member boards.

2.6.5 It is intended that the members of the Regional Planning Groups will work together in order to reach consensus. In the event of a material dispute arising, a meeting will be convened between the Chief Executives and Chairs of the member boards in order to resolve the issue, recognising the back-up arrangements set out in Section 4 of Annex 3 of HDL (2004) 46.

3. THE EXPECTED STANDARDS OF CORPORATE GOVERNANCE AND INTERNAL CONTROL

Introduction

Paragraph 2.4.4 of the SEAT Regional Planning Group's Framework of Governance makes reference to the "standards of internal control and corporate governance as is generally expected of chief executives in NHS Scotland".

The standards of corporate governance and internal control which apply to NHS Boards will apply to the work of SEAT. In the event of a query arising about this, e.g. if wording differs between Boards' governance documents, the Chair for the time being of SEAT shall decide the issue.

Scope of Corporate Governance

Six key subjects make up Corporate Governance for the member boards:-

- **Clinical Governance** – How we deliver our clinical services;
- **Patient Focus and Public Accountability** – How we inform individual patients and involve them and other stakeholders in the manner by which we deliver our clinical services;
- **Staff Governance** – How we engage our employees and their representatives;
- **Financial Governance** – How we manage our financial resources;
- **Research Governance** – How we conduct research and development;
- **Educational Governance** – How we teach and train healthcare professionals.

The principles of corporate governance are covered at slightly greater length in Annex A.

4. REPOSITORY OF CONTROL DOCUMENTS

SEAT has developed standardised templates to implement the above terms of reference. The templates are maintained centrally and made widely available for use. These are then elements of the overall Framework of Governance.

Items included:

- Template for the Work Plan;

- Template for the Framework of Priorities and Decision Making.

These are designed in a way that allows new projects and existing commitments to be presented efficiently, providing high level information to the member boards. They can be used to seek approval of new items, and present updates on progress. The detail will be in the individual Project Agreements.

- Template for the Project Agreement

Appendix 5

This is the key control document to be presented to SEAT for approval. This should contain everything you need to know about the project, e.g. SMART objectives, funding requirements, service implications, lead Chief Executive, project staff, monitoring arrangements, etc.

ANNEX A

THE EXPECTED STANDARDS OF CORPORATE GOVERNANCE AND INTERNAL CONTROL

The Principles of Corporate Governance

In the following, the "organisation" is taken to be both the member boards individually and when they come together as the Regional Planning Group. All of the organisation's activities, policies and procedures should be consistent with these principles. In the absence of a specific procedure, employees should comply with the requirements of these principles.

General

1. The organisation will discharge its responsibilities in accordance with the relevant legislative requirements of European Parliament, and the United Kingdom and Scottish Parliaments. The organisation will also comply with any directions or guidance issued by the Scottish Ministers.

2. No person will receive less favourable treatment regardless or individual differences or be disadvantaged by conditions or requirements which cannot be shown to be justifiable.

Clinical Governance

3. The organisation will plan for, and monitor the provision of a range of services consistent with the overall strategy of NHS Scotland, as established by Scottish Ministers.

4. The organisation will provide care in accordance with relevant and nationally recognised standards and with all due care and attention.

5. The organisation will work in partnership with others in the development of healthcare and the general well-being of the public.

6. The organisation will provide undergraduate and postgraduate education to the standards required by the relevant funding authorities.

Patient Focus and Public Accountability

7. The organisation will conduct its activities in an open and accountable manner. Its activities and organisational performance will be auditable.

8. The organisation will give patients the knowledge to make it possible for them to become active partners, with professionals, in making informed decisions and choices about their own treatment and care.

9. The organisation will establish mechanisms to inform, engage and consult patients and members of the public to inform its decision making appropriately.

Staff Governance

10. The organisation recognises the important of working in partnership with its staff.

11. The organisation will ensure that its employees are well informed, appropriately trained, involved in decisions that affect them, treated fairly and consistently and provided with a safe working environment.

Financial Governance

12. The organisation will perform its activities within the available financial resources at its disposal.

13. The organisation will conduct its activities in a manner that is cost-effective and demonstrably secures value for money.

Research Governance

14. The organisation will conduct research and development activity in accordance with the Research Governance Framework.

Educational Governance

15. This is taken forward through the applications of principles 1, 2, 6, 9 and 10.

CODE of CONDUCT

for

MEMBERS

of

The NHS Fife Public Board

CODE OF CONDUCT for MEMBERS of the NHS Fife Public Board

CONTENTS

Section 5: Declaration of Interests

General

Interests which Require Declaration

Your Financial Interests

Your Non-Financial Interests

The Financial Interests of Other Persons

The Non-Financial Interests of Other Persons

Making a Declaration

Frequent Declaration of Interests

Dispensations

Section 6: Lobbying and Access to Members of Public Bodies

Introduction

Rules and Guidance

Annexes

Annex 6.1: Sanctions Available to the Standards Commission for Breach of Code

Annex 6.2: Definitions

SECTION 1: INTRODUCTION TO THE CODE OF CONDUCT

1.1 The Scottish public has a high expectation of those who serve on the boards of public bodies and the way in which they should conduct themselves in undertaking their duties. You must meet those expectations by ensuring that your conduct is above reproach.

1.2 The Ethical Standards in Public Life etc. (Scotland) Act 2000, "the Act", provides for Codes of Conduct for local authority councillors and members of relevant public bodies; imposes on councils and relevant public bodies a duty to help their members to comply with the relevant code; and establishes a Standards Commission for Scotland, "The Standards Commission" to oversee the new framework and deal with alleged breaches of the codes.

1.3 The Act requires the Scottish Ministers to lay before Parliament a Code of Conduct for Councillors and a Model Code for Members of Devolved Public Bodies. The Model Code for members was first introduced in 2002 and has now been revised in December 2013 following consultation and the approval of the Scottish Parliament. These revisions will make it consistent with the relevant parts of the Code of Conduct for Councillors, which was revised in 2010 following the approval of the Scottish Parliament.

1.4 As a member of The NHS Fife PUBLIC BOARD, "the Board", it is your responsibility to make sure that you are familiar with, and that your actions comply with, the provisions of this Code of Conduct which has now been made by the Board.

Appointments to the Boards of Public Bodies

1.5 Public bodies in Scotland are required to deliver effective services to meet the needs of an increasingly diverse population. In addition, the Scottish Government's equality outcome on public appointments is to ensure that Ministerial appointments are more diverse than at present**.** In order to meet both of these aims, a board should ideally be drawn from varied backgrounds with a wide spectrum of characteristics, knowledge and experience. It is crucial to the success of public bodies that they attract the best people for the job and therefore it is essential that a board's appointments process should encourage as many suitable people to apply for positions and be free from unnecessary barriers. You should therefore be aware of the varied roles and functions of the public body on which you serve and of wider diversity and equality issues. You should also take steps to familiarise yourself with the appointment process that your board will have agreed with the Scottish Government's Public Appointment Centre of Expertise.

1.6 You should also familiarise yourself with how the public body's policy operates in relation to succession planning, which should ensure public bodies have a strategy to make sure they have the staff in place with the skills, knowledge and experience necessary to fulfil their role economically, efficiently and effectively.

Guidance on the Code of Conduct

1.7 You must observe the rules of conduct contained in this Code. It is your personal responsibility to comply with these and review regularly, and at least annually, your personal circumstances with this in mind, particularly when your circumstances change. You must not at any time advocate or encourage any action contrary to the Code of Conduct.

1.8 The Code has been developed in line with the key principles listed in Section 2 and provides additional information on how the principles should be interpreted and applied in practice. The Standards Commission may also issue guidance. No Code can provide for all circumstances and if you are uncertain about how the rules apply, you should seek advice from the public body. You may also choose to consult your own legal advisers and, on detailed financial and commercial matters, seek advice from other relevant professionals.

1.9 You should familiarise yourself with the Scottish Government publication "On Board – a guide for board members of public bodies in Scotland". This publication will provide you with information to help you in your role as a member of a public body in Scotland and can be viewed on the Scottish Government website.

Enforcement

1.10 Part 2 of the Ethical Standards in Public Life etc. (Scotland) Act 2000 sets out the provisions for dealing with alleged breaches of this Code of Conduct and where appropriate the sanctions that will be applied if the Standards Commission finds that there has been a breach of the Code. Those sanctions are outlined in **Annex 6.1**.

SECTION 2: KEY PRINCIPLES OF THE CODE OF CONDUCT

2.1 The general principles upon which this Code is based should be used for guidance and interpretation only. These general principles are:

Duty
You have a duty to uphold the law and act in accordance with the law and the public trust placed in you. You have a duty to act in the interests of the public body of which you are a member and in accordance with the core functions and duties of that body.

Selflessness
You have a duty to take decisions solely in terms of public interest. You must not act in order to gain financial or other material benefit for yourself, family or friends.

Integrity
You must not place yourself under any financial, or other, obligation to any individual or organisation that might reasonably be thought to influence you in the performance of your duties.

Objectivity

You must make decisions solely on merit and in a way that is consistent with the functions of the public body when carrying out public business including making appointments, awarding contracts or recommending individuals for rewards and benefits.

Accountability and Stewardship
You are accountable for your decisions and actions to the public. You have a duty to consider issues on their merits, taking account of the views of others and must ensure that the public body uses its resources prudently and in accordance with the law.

Openness
You have a duty to be as open as possible about your decisions and actions, giving reasons for your decisions and restricting information only when the wider public interest clearly demands.

Honesty
You have a duty to act honestly. You must declare any private interests relating to your public duties and take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership
You have a duty to promote and support these principles by leadership and example, and to maintain and strengthen the public's trust and confidence in the integrity of the public body and its members in conducting public business.

Respect
You must respect fellow members of your public body and employees of the body and the role they play, treating them with courtesy at all times. Similarly you must respect members of the public when performing duties as a member of your public body.

2.2 You should apply the principles of this Code to your dealings with fellow members of the public body, its employees and other stakeholders. Similarly you should also observe the principles of this Code in dealings with the public when performing duties as a member of the public body.

SECTION 3: GENERAL CONDUCT

3.1 The rules of good conduct in this section must be observed in all situations where you act as a member of the public body.

Conduct at Meetings

3.2 You must respect the chair, your colleagues and employees of the public body in meetings. You must comply with rulings from the chair in the conduct of the business of these meetings.

Relationship with Board Members and Employees of the Public Body (including those employed by contractors providing services)

3.3 You will treat your fellow board members and any staff employed by the body with courtesy and respect. It is expected that fellow board members and employees will show you the same consideration in return. It is good practice for employers to provide examples of what is unacceptable behaviour in their organisation. Public bodies should promote a safe, healthy and fair working environment for all. As a board member you should be familiar with the policies of the public body in relation to bullying and harassment in the workplace and also lead by exemplar behaviour.

Remuneration, Allowances and Expenses

3.4 You must comply with any rules of the public body regarding remuneration, allowances and expenses.

Gifts and Hospitality

3.5 You must not accept any offer by way of gift or hospitality which could give rise to real or substantive personal gain or a reasonable suspicion of influence on your part to show favour, or disadvantage, to any individual or organisation. You should also consider whether there may be any reasonable perception that any gift received by your spouse or cohabitee or by any company in which you have a controlling interest, or by a partnership of which you are a partner, can or would influence your judgement. The term “gift” includes benefits such as relief from indebtedness, loan concessions or provision of services at a cost below that generally charged to members of the public.

3.6 You must never ask for gifts or hospitality.

3.7 You are personally responsible for all decisions connected with the offer or acceptance of gifts or hospitality offered to you and for avoiding the risk of damage to public confidence in your public body. As a general guide, it is usually appropriate to refuse offers except:

(a) isolated gifts of a trivial character, the value of which must not exceed £50;
(b) normal hospitality associated with your duties and which would reasonably be regarded as appropriate; or
(c) gifts received on behalf of the public body.

3.8 You must not accept any offer of a gift or hospitality from any individual or organisation which stands to gain or benefit from a decision your body may be involved in determining, or who is seeking to do business with your organisation, and which a person might reasonably consider could have a bearing on your judgement. If you are making a visit in your capacity as a member of your public body then, as a general rule, you should ensure that your body pays for the cost of the visit.

3.9 You must not accept repeated hospitality or repeated gifts from the same source.

3.10 Members of devolved public bodies should familiarise themselves with the terms of the Bribery Act 2010 which provides for offences of bribing another person and offences relating to being bribed.

Confidentiality Requirements

3.11 There may be times when you will be required to treat discussions, documents or other information relating to the work of the body in a confidential manner. You will often receive information of a private nature which is not yet public, or which perhaps would not be intended to be public. You must always respect the confidential nature of such information and comply with the requirement to keep such information private.

3.12 It is unacceptable to disclose any information to which you have privileged access, for example derived from a confidential document, either orally or in writing. In the case of other documents and information, you are requested to exercise your judgement as to what should or should not be made available to outside bodies or individuals. In any event, such information should never be used for the purposes of personal or financial gain or for political purposes or used in such a way as to bring the public body into disrepute.

Use of Public Body Facilities

3.13 Members of public bodies must not misuse facilities, equipment, stationery, telephony, computer, information technology equipment and services, or use them for party political or campaigning activities. Use of such equipment and services etc. must be in accordance with the public body's policy and rules on their usage. Care must also be exercised when using social media networks not to compromise your position as a member of the public body.

Appointment to Partner Organisations

3.14 You may be appointed, or nominated by your public body, as a member of another body or organisation. If so, you are bound by the rules of conduct of these organisations and should observe the rules of this Code in carrying out the duties of that body.

3.15 As a member of the Board, you are appointed, ex officio, as a Trustee of the Endowment Fund. You do not need to declare an interest in the Endowment Fund when participating in Board meetings or vice versa in the Board of Trustees but you must act in only the discrete interests of each.

3.16 Members who become directors of companies as nominees of their public body will assume personal responsibilities under the Companies Acts. It is possible that conflicts of interest can arise for such members between the company and the public body. It is your responsibility to take advice on your responsibilities to the public body and to the company. This will include questions of declarations of interest.

SECTION 4: REGISTRATION OF INTERESTS

4.1 The following paragraphs set out the kinds of interests, financial and otherwise which you have to register. These are called "Registerable Interests". You must, at all times, ensure that these interests are registered, when you are appointed and whenever your circumstances change in such a way as to require change or an addition to your entry in the body's Register. It is your duty to ensure any changes in circumstances are reported within one month of them changing.

4.2 The Regulations[1] as amended describe the detail and timescale for registering interests. It is your personal responsibility to comply with these regulations and you should review regularly and at least once a year your personal circumstances. **Annex 6.2** contains key definitions and explanatory notes to help you decide what is required when registering your interests under any particular category. The interests which require to be registered are those set out in the following paragraphs and relate to you. It is not necessary to register the interests of your spouse or cohabitee.

Category One: Remuneration

4.3 You have a Registerable Interest where you receive remuneration by virtue of being:

- employed;
- self-employed;
- the holder of an office;
- a director of an undertaking;
- a partner in a firm; or
- undertaking a trade, profession or vocation or any other work.

4.4 In relation to 4.3 above, the amount of remuneration does not require to be registered and remuneration received as a member does not have to be registered.

4.5 If a position is not remunerated it does not need to be registered under this category. However, unremunerated directorships may need to be registered under category two, "Related Undertakings".

4.6 If you receive any allowances in relation to membership of any organisation, the fact that you receive such an allowance must be registered.

4.7 When registering employment, you must give the name of the employer, the nature of its business, and the nature of the post held in the organisation.

4.8 When registering self-employment, you must provide the name and give details of the nature of the business. When registering an interest in a partnership, you must give the name of the partnership and the nature of its business.

4.9 Where you undertake a trade, profession or vocation, or any other work, the detail to be given is the nature of the work and its regularity. For example, if you

[1] SSI - The Ethical Standards in Public Life etc. (Scotland) Act 2000 (Register of Interests) Regulations 2003 Number 135, as amended.

write for a newspaper, you must give the name of the publication, and the frequency of articles for which you are paid.

4.10 When registering a directorship, it is necessary to provide the registered name of the undertaking in which the directorship is held and the nature of its business.

4.11 Registration of a pension is not required as this falls outside the scope of the category.

Category Two: Related Undertakings

4.12 You must register any directorships held which are themselves not remunerated but where the company (or other undertaking) in question is a subsidiary of, or a parent of, a company (or other undertaking) in which you hold a remunerated directorship.

4.13 You must register the name of the subsidiary or parent company or other undertaking and the nature of its business, and its relationship to the company or other undertaking in which you are a director and from which you receive remuneration.

4.14 The situations to which the above paragraphs apply are as follows:

- you are a director of a board of an undertaking and receive remuneration declared under category one – and
- you are a director of a parent or subsidiary undertaking but do not receive remuneration in that capacity.

Category Three: Contracts

4.15 You have a registerable interest where you (or a firm in which you are a partner, or an undertaking in which you are a director or in which you have shares of a value as described in paragraph 4.19 below) have made a contract with the public body of which you are a member:

(i) under which goods or services are to be provided, or works are to be executed; and
(ii) which has not been fully discharged.

4.16 You must register a description of the contract, including its duration, but excluding the consideration.

Category Four: Houses, Land and Buildings

4.17 You have a registerable interest where you own or have any other right or interest in houses, land and buildings, which may be significant to, of relevance to, or bear upon, the work and operation of the body to which you are appointed.

4.18 The test to be applied when considering appropriateness of registration is to ask whether a member of the public acting reasonably might consider any

interests in houses, land and buildings could potentially affect your responsibilities to the organisation to which you are appointed and to the public, or could influence your actions, speeches or decision making.

Category Five: Interest in Shares and Securities

4.19 You have a registerable interest where you have an interest in shares comprised in the share capital of a company or other body which may be significant to, of relevance to, or bear upon, the work and operation of (a) the body to which you are appointed and (b) the **nominal value** of the shares is:

(i) greater than 1% of the issued share capital of the company or other body; or
(ii) greater than £25,000.

Where you are required to register the interest, you should provide the registered name of the company in which you hold shares; the amount or value of the shares does not have to be registered.

Category Six: Gifts and Hospitality

4.20 You must register the details of any gifts or hospitality received within your current term of office. This record will be available for public inspection. It is not however necessary to record any gifts or hospitality as described in paragraph 3.7 (a) to (c) of this Model Code.

Category Seven: Non–Financial Interests

4.21 You may also have a registerable interest if you have non-financial interests which may be significant to, of relevance to, or bear upon, the work and operation of the body to which you are appointed. It is important that relevant interests such as membership or holding office in other public bodies, clubs, societies and organisations such as trades unions and voluntary organisations, are registered and described.

4.22 In the context of non-financial interests, the test to be applied when considering appropriateness of registration is to ask whether a member of the public might reasonably think that any non-financial interest could potentially affect your responsibilities to the organisation to which you are appointed and to the public, or could influence your actions, speeches or decision-making.

SECTION 5: DECLARATION OF INTERESTS

General

5.1 The key principles of the Code, especially those in relation to integrity, honesty and openness, are given further practical effect by the requirement for you to declare certain interests in proceedings of the public body. Together with the rules on registration of interests, this ensures transparency of your interests which might influence, or be thought to influence, your actions.

5.2 Public bodies inevitably have dealings with a wide variety of organisations and individuals and this Code indicates the circumstances in which a business or personal interest must be declared. Public confidence in the public body and its members depends on it being clearly understood that decisions are taken in the public interest and not for any other reason.

5.3 In considering whether to make a declaration in any proceedings, you must consider not only whether you will be influenced but whether anybody else would think that you might be influenced by the interest. You must, however, always comply with the **objective test** ("the objective test") which is whether a member of the public, with knowledge of the relevant facts, would reasonably regard the interest as so significant that it is likely to prejudice your discussion or decision making in your role as a member of a public body.

5.4 If you feel that, in the context of the matter being considered, your involvement is neither capable of being viewed as more significant than that of an ordinary member of the public, nor likely to be perceived by the public as wrong, you may continue to attend the meeting and participate in both discussion and voting. The relevant interest must however be declared. It is your responsibility to judge whether an interest is sufficiently relevant to particular proceedings to require a declaration and you are advised to err on the side of caution. If a board member is unsure as to whether a conflict of interest exits, they should seek advice from the board chair.

5.5 As a member of a public body you might serve on other bodies. In relation to service on the boards and management committees of limited liability companies, public bodies, societies and other organisations, you must decide, in the particular circumstances surrounding any matter, whether to declare an interest. Only if you believe that, in the particular circumstances, the nature of the interest is so remote or without significance, should it not be declared. You must always remember the public interest points towards transparency and, in particular, a possible divergence of interest between your public body and another body. Keep particularly in mind the advice in paragraph 3.15 of this Model Code about your legal responsibilities to any limited company of which you are a director.

Interests which Require Declaration

5.6 Interests which require to be declared if known to you may be financial or non-financial. They may or may not cover interests which are registerable under the terms of this Code. Most of the interests to be declared will be your personal interests but, on occasion, you will have to consider whether the interests of other persons require you to make a declaration. The paragraphs which follow deal with (a) your financial interests (b) your non-financial interests and (c) the interests, financial and non-financial, of other persons.

5.7 You will also have other private and personal interests and may serve, or be associated with, bodies, societies and organisations as a result of your private and personal interests and not because of your role as a member of a public body. In the context of any particular matter you will need to decide whether to declare an interest. You should declare an interest unless you believe that, in

the particular circumstances, the interest is too remote or without significance. In reaching a view on whether the objective test applies to the interest, you should consider whether your interest (whether taking the form of association or the holding of office) would be seen by a member of the public acting reasonably in a different light because it is the interest of a person who is a member of a public body as opposed to the interest of an ordinary member of the public.

Your Financial Interests

5.8 You must declare, if it is known to you, any financial interest (including any financial interest which is registerable under any of the categories prescribed in Section 4 of this Code). If, under category one (or category seven in respect of non-financial interests) of section 4 of this Code, you have registered an interest

(a) as an employee of the Board; or
(b) as a Councillor or a Member of another Devolved Public Body where the Council or other Devolved Public Body, as the case may be, has nominated or appointed you as a Member of the Board;

you do not, for that reason alone, have to declare that interest.

There is no need to declare an interest which is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

You must withdraw from the meeting room until discussion of the relevant item where you have a declarable interest is concluded. There is no need to withdraw in the case of an interest which is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

Your Non-Financial Interests

5.9 You must declare, if it is known to you, any non-financial interest if:

(i) that interest has been registered under category seven (Non- Financial Interests) of Section 4 of the Code; or
(ii) that interest would fall within the terms of the objective test.

There is no need to declare an interest which is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

You must withdraw from the meeting room until discussion of the relevant item where you have a declarable interest is concluded. There is no need to withdraw in the case of an interest which is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

The Financial Interests of Other Persons

5.10 The Code requires only your financial interests to be registered. You also, however, have to consider whether you should declare any financial interest of certain other persons.

You must declare if it is known to you any financial interest of:-

(i) a spouse, a civil partner or a co-habitee;
(ii) a close relative, close friend or close associate;
(iii) an employer or a partner in a firm;
(iv) a body (or subsidiary or parent of a body) of which you are a remunerated member or director;
(iv) a person from whom you have received a registerable gift or registerable hospitality;
(v) a person from whom you have received registerable expenses.

There is no need to declare an interest if it is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

You must withdraw from the meeting room until discussion of and voting on the relevant item where you have a declarable interest is concluded. There is no need to withdraw in the case of an interest which is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

5.11 This Code does not attempt the task of defining “relative” or “friend” or “associate”. Not only is such a task fraught with difficulty but is also unlikely that such definitions would reflect the intention of this part of the Code. The key principle is the need for transparency in regard to any interest which might (regardless of the precise description of relationship) be objectively regarded by a member of the public, acting reasonably, as potentially affecting your responsibilities as a member of the public body and, as such, would be covered by the objective test.

The Non-Financial Interests of Other Persons

5.12 You must declare if it is known to you any non-financial interest of:-

(i) a spouse, a civil partner or a co-habitee;
(ii) a close relative, close friend or close associate;
(iii) an employer or a partner in a firm;
(iv) a body (or subsidiary or parent of a body) of which you are a remunerated member or director;
(v) a person from whom you have received a registerable gift or registerable hospitality;
(vi) a person from whom you have received registerable election expenses.

There is no need to declare the interest if it is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

There is only a need to withdraw from the meeting if the interest is clear and substantial.

Making a Declaration

5.13 You must consider at the earliest stage possible whether you have an interest to declare in relation to any matter which is to be considered. You should consider whether agendas for meetings raise any issue of declaration of interest. Your declaration of interest must be made as soon as practicable at a meeting where that interest arises. If you do identify the need for a declaration of interest only when a particular matter is being discussed you must declare the interest as soon as you realise it is necessary.

5.14 The oral statement of declaration of interest should identify the item or items of business to which it relates. The statement should begin with the words "I declare an interest". The statement must be sufficiently informative to enable those at the meeting to understand the nature of your interest but need not give a detailed description of the interest.

Frequent Declarations of Interest

5.15 Public confidence in a public body is damaged by perception that decisions taken by that body are substantially influenced by factors other than the public interest. If you would have to declare interests frequently at meetings in respect of your role as a board member you should not accept a role or appointment with that attendant consequence. If members are frequently declaring interests at meetings then they should consider whether they can carry out their role effectively and discuss with their chair. Similarly, if any appointment or nomination to another body would give rise to objective concern because of your existing personal involvement or affiliations, you should not accept the appointment or nomination.

Dispensations

5.16 In some very limited circumstances dispensations can be granted by the Standards Commission in relation to the existence of financial and non-financial interests which would otherwise prohibit you from taking part and voting on matters coming before your public body and its committees.

5.17 Applications for dispensations will be considered by the Standards Commission and should be made as soon as possible in order to allow proper consideration of the application in advance of meetings where dispensation is sought. You should not take part in the consideration of the matter in question until the application has been granted.

SECTION 6: LOBBYING AND ACCESS TO MEMBERS OF PUBLIC BODIES

Introduction

6.1 In order for the public body to fulfil its commitment to being open and accessible, it needs to encourage participation by organisations and individuals in the decision-making process. Clearly however, the desire to involve the public and other interest groups in the decision-making process must take account of the need to ensure transparency and probity in the way in which the public body conducts its business.

6.2 You will need to be able to consider evidence and arguments advanced by a wide range of organisations and individuals in order to perform your duties effectively. Some of these organisations and individuals will make their views known directly to individual members. The rules in this Code set out how you should conduct yourself in your contacts with those who would seek to influence you. They are designed to encourage proper interaction between members of public bodies, those they represent and interest groups.

Rules and Guidance

6.3 You must not, in relation to contact with any person or organisation that lobbies do anything which contravenes this Code or any other relevant rule of the public body or any statutory provision.

6.4 You must not, in relation to contact with any person or organisation who lobbies, act in any way which could bring discredit upon the public body.

6.5 The public must be assured that no person or organisation will gain better access to or treatment by, you as a result of employing a company or individual to lobby on a fee basis on their behalf. You must not, therefore, offer or accord any preferential access or treatment to those lobbying on a fee basis on behalf of clients compared with that which you accord any other person or organisation who lobbies or approaches you. Nor should those lobbying on a fee basis on behalf of clients be given to understand that preferential access or treatment, compared to that accorded to any other person or organisation, might be forthcoming from another member of the public body.

6.6 Before taking any action as a result of being lobbied, you should seek to satisfy yourself about the identity of the person or organisation that is lobbying and the motive for lobbying. You may choose to act in response to a person or organisation lobbying on a fee basis on behalf of clients but it is important that you know the basis on which you are being lobbied in order to ensure that any action taken in connection with the lobbyist complies with the standards set out in this Code.

6.7 You should not accept any paid work:-

(a) which would involve you lobbying on behalf of any person or organisation or any clients of a person or organisation.
(b) to provide services as a strategist, adviser or consultant, for example, advising on how to influence the public body and its members. This does not prohibit you from being remunerated for activity which may arise because of, or relate to, membership of the public body, such as journalism

or broadcasting, or involvement in representative or presentational work, such as participation in delegations, conferences or other events.

6.8 If you have concerns about the approach or methods used by any person or organisation in their contacts with you, you must seek the guidance of the public body.

ANNEX 6.1

SANCTIONS AVAILABLE TO THE STANDARDS COMMISSION FOR BREACH OF THE CODE

(a) Censure – the Commission may reprimand the member but otherwise take no action against them;

(b) Suspension – of the member for a maximum period of one year from attending one or more, but not all, of the following:

i) all meetings of the public body;
ii) all meetings of one or more committees or sub-committees of the public body;
(iii) all meetings of any other public body on which that member is a representative or nominee of the public body of which they are a member.

(c) Suspension – for a period not exceeding one year, of the member's entitlement to attend all of the meetings referred to in (b) above;

(d) Disqualification – removing the member from membership of that public body for a period of no more than five years.

Where a member has been suspended, the Standards Commission may direct that any remuneration or allowance received from membership of that public body be reduced, or not paid.

Where the Standards Commission disqualifies a member of a public body, it may go on to impose the following further sanctions:

(a) Where the member of a public body is also a councillor, the Standards Commission may disqualify that member (for a period of no more than five years) from being nominated for election as, or from being elected, a councillor. Disqualification of a councillor has the effect of disqualifying that member from their public body and terminating membership of any committee, sub-committee, joint committee, joint board or any other body on which that member sits as a representative of their local authority.
(b) Direct that the member be removed from membership, and disqualified in respect of membership, of any other devolved public body (provided the members' code applicable to that body is then in force) and may disqualify that person from office as the Water Industry Commissioner.

In some cases the Standards Commission do not have the legislative powers to deal with sanctions, for example if the respondent is an executive member of the board or appointed by the Queen. Sections 23 and 24 of the Ethical Standards in Public Life etc. (Scotland) Act 2000 refer.

Full details of the sanctions are set out in Section 19 of the Act.

ANNEX 6.2

DEFINITIONS

"Chair" includes Board Convener or any person discharging similar functions under alternative decision making structures.

"Code" code of conduct for members of devolved public bodies

"Cohabitee" includes a person, whether of the opposite sex or not, who is living with you in a relationship similar to that of husband and wife.

"Group of companies" has the same meaning as "group" in section 262(1) of the Companies Act 1985. A "group", within s262 (1) of the Companies Act 1985, means a parent undertaking and its subsidiary undertakings.

"Parent Undertaking" is an undertaking in relation to another undertaking, a subsidiary undertaking, if a) it holds a majority of the rights in the undertaking; or b) it is a member of the undertaking and has the right to appoint or remove a majority of its board of directors; or c) it has the right to exercise a dominant influence over the undertaking (i) by virtue of provisions contained in the undertaking's memorandum or articles or (ii) by virtue of a control contract; or d) it is a councillor of the undertaking and controls alone, pursuant to an agreement with other shareholders or councillors, a majority of the rights in the undertaking**.**

"A person" means a single individual or legal person and includes a group of companies.

"Any person" includes individuals, incorporated and unincorporated bodies, trade unions, charities and voluntary organisations.

"**Public body"** means a devolved public body listed in Schedule 3 of the Ethical Standards in Public Life etc. (Scotland) Act 2000, as amended.

"Related Undertaking" is a parent or subsidiary company of a principal undertaking of which you are also a director. You will receive remuneration for the principal undertaking though you will not receive remuneration as director of the related undertaking.

"Remuneration" includes any salary, wage, share of profits, fee, expenses, other monetary benefit or benefit in kind. This would include, for example, the provision of a company car or travelling expenses by an employer.

“Spouse” does not include a former spouse or a spouse who is living separately and apart from you.

“Undertaking” means:
a) a body corporate or partnership; or
b) an unincorporated association carrying on a trade or business, with or without a view to a profit.

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**9 December 2021**
Title:	**Update on Board Action Plan for the Implementation of the NHS Scotland 'Blueprint for Good Governance'**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Gillian MacIntosh, Board Secretary**

1 Purpose

This is presented to the Audit & Risk Committee for:

- Assurance

This report relates to a:

- Government policy/directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

By a Director's letter issued in February 2019, all NHS Boards and Special Health Boards are required by the Scottish Government to adopt NHS Scotland's 'A Blueprint for Good Governance'. This report reviewed best practice in corporate governance and set out a model 'blueprint' for a refreshed system of corporate governance to be applied consistently across all NHS Boards.

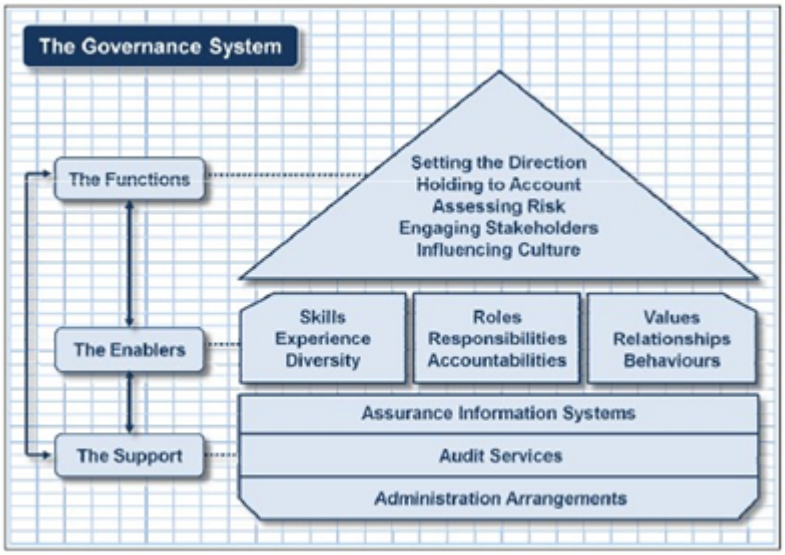
Practical implementation of the Blueprint and its supporting suite of documents has been overseen through the NHS Scotland Chairs' sub-group, the Corporate Governance Steering Group, on which the NHS Fife Chair, Tricia Marwick, serves as a member.

The NHS Scotland Board Secretaries' Group has also been leading on a number of supporting workstreams, including the creation of various 'Once for Scotland' templates to inform key governance documents, such as model Standing Orders for NHS Boards, Board and Board Committee paper templates, Terms of Reference for key governance committees, and Induction programmes and material to be used for new members. Since

the Blueprint's launch, some of this material has been issued formally by a number of Director's Letters and have thus been adopted by NHS Fife.

2.2 Background

The NHS Scotland Blueprint defines governance as the system by which organisations are directed and controlled, describing therein a three-tiered model that outlines the Functions of a governance system, the Enablers and the Support required to effectively deliver those functions. Five key elements are included for Boards to demonstrate, namely: (i) Setting the Direction; (ii) Holding to Account; (iii) Assessing Risk; (iv) Engaging Stakeholders; and (v) Influencing Culture. This model is illustrated as follows:



In order to implement the above model, all NHS Boards in Scotland were invited in February 2019 to undertake a baseline assessment of their current governance practice against the Blueprint's requirements, via Board members' completion of an online national survey. The detailed results for this assessment were reported previously to the Board in May 2019. A Development Session was then held in April 2019 with the Board to discuss the results of the 2019 self-assessment survey, broken down at the level of individual questions, reviewing how well the Board is presently delivering on the functions outlined in the Blueprint. The session considered the context for the final ratings and consideration of where improvements can be made, to enhance governance across NHS Fife. Consideration was also given at the session to the results of the self-assessment exercise undertaken (as a separate exercise) for all Board standing committees, which is part of the routine year-end reflection of each Committee's effectiveness.

Facilitated by national colleagues, a follow-up questionnaire for Board members on the Blueprint's implementation was to be undertaken annually, with the next iteration of the survey expected to be released for members' completion in early 2020. This, however, was delayed, principally due to the Covid-19 pandemic, and was not carried out in either 2020 or 2021. It is, however, anticipated that the next national-led survey will be undertaken in early 2022, against a refreshed copy of the Blueprint itself. That being the

case, it is thought helpful to formally close off the previous action plan, by reporting its conclusion to the Committee and thence the Board.

2.3 Assessment

In reviewing previous results both from the original benchmarking exercise against the Blueprint and the annual Committee effectiveness questionnaires, the Board identified a number of areas of strength in existing governance practice, such as the current committee structure and system of assurance it provides; the setting of strategy / policy and its implementation; the robust level of scrutiny and constructive challenge; positive Board dynamics and member relationships; and the continual development of the governance framework of the Board over the past few years, which was thought to leave NHS Fife in a positive position in comparison to other Boards across Scotland. A number of areas for review were however identified in the Board's detailed discussions, and an action plan outlining that proposed activity was agreed by the Board in May 2019. Further updates on the delivery of this this action plan were reviewed by the Board in November 2019 and September 2020. As previously agreed, regular updates on the Blueprint workstreams have also been given to the Audit & Risk Committee, which has a key role in approving key governance documentation such as Standing Orders and in ensuring that systems of corporate governance are fit for purpose and operating according to relevant regulations.

Given that the next national survey is expected to be released in early 2022, it is thought useful to provide the Board with a further update on the previously agreed Action Plan, which seeks to formally close off the previous iteration in preparation for a new plan being developed from a refreshed survey. The attached document has been expanded to provide further information on the improvement activities that are being taken forward in delivery of these original actions. Full details are provided in the enclosed appendix to this paper.

The Board's recent Active Governance session also generated a number of actions (reported separately to the Board in November) that are due to be implemented by end of March 2022. These are largely related to improving the use of data and clarity of reporting to the Board; further rolling out assurance principles across the Board (which will also be captured in the ongoing review of risk and the BAF structure); and continuing to use local self-assessment exercises to reflect on what we need to improve and where additional training can be offered to members.

2.3.1 Quality / Patient Care

Delivering improved governance across the organisation is supportive of enhanced patient care and quality standards.

2.3.2 Workforce

The implementation of any of the recommendations from this paper can be met from existing resource.

2.3.3 Financial

There are no financial implications from this work.

2.3.4 Risk Assessment/Management

Recording completion of the enclosed action plan helps mitigate any risks of non-compliance with the Blueprint's core requirements. Compliance also evidences that NHS Fife has robust corporate governance practices in place that help deliver and support organisational objectives and is continually seeking to improve in this area.

2.3.5 Equality and Diversity, including health inequalities

There are no specific Equality and Diversity issues arising from undertaking this work.

2.3.6 Other impact

The consideration of an updated Action Plan by the Audit & Risk Committee and the Board also related to a recommendation from within the Internal Audit report B10/20, on our compliance with the Governance Blueprint. Overall, the audit opinion in the report was one of Comprehensive Assurance and a finding that the robust framework of key controls ensures objectives are likely to be achieved.

2.3.7 Communication, involvement, engagement and consultation

N/A

2.3.8 Route to the Meeting

This paper has been initially reviewed by the Chair, Chief Executive and Director of Finance & Strategy, prior to submission to the Audit & Risk Committee. It has also been reviewed by EDG at its meeting on 2 December.

It will be reported formally to the Board in January 2022.

2.4 Recommendation

The Audit & Risk Committee is invited to:

- **Note, for assurance,** the information provided in this paper, which closes off the previous Board action plan against the initial assessment against the Blueprint for Good Governance.

3 List of appendices

The following appendices are included with this report:

- Appendix No 1 - NHS Fife Action Plan – Update on the Implementation of Blueprint for Good Governance

Report Contact
Gillian MacIntosh

Head of Corporate Governance & Board Secretary
gillian.macintosh@nhs.scot

NHS FIFE ACTION PLAN – UPDATE ON THE IMPLEMENTATION OF BLUEPRINT FOR GOOD GOVERNANCE

Area for Improvement	No.	Action	Improvement Activity / Evidence	Who / When
Scrutiny & Assurance	**1**	Review format and content of Integrated Performance & Quality Report (IPQR), to enhance the clarity of information contained therein and remove potential areas of duplication or stasis.	The IPQR has developed over time to become a critical assurance tool for the Board and its committees. A review of its present format is timely, to ensure that the information contained therein is relevant, clear to members and reflects the most up-to-date performance information available.	Performance Team **COMPLETE**
	The Integrated Performance Report (IPR) produced monthly provides the Board with key performance indicators for Fife and, within this report, where an indicator is not meeting the standard, drill-down analysis is produced, including benchmarking information if available. The Board has valued this level of detail, which enables them to give adequate scrutiny to performance and provide appropriate assurance. A review in summer 2019 of the Integrated Performance Report has resulted in a more detailed and standardised report being produced, which now incorporates the Quality Report. The Integrated Performance & Quality Report (IPQR) now include benchmarking information over time for the key indicators, where available, and this provides the Board with more transparent benchmarking. Feedback from Non-Executive Board members has been very positive about the changes made. Update (September 2020) Follow-up enquiries with Committee chairs have confirmed that they are content with the revisions made, but further work in current year will look at increasing the performance data that falls under the section on Staff Governance (as has been raised at their own meetings). Update (December 2021) Further review of IPQR will be undertaken, to review both the metrics being tracked and the display of data within the document, following the Board's recent Active Governance session. This will be captured in business-as-usual work, reflecting the commitment to keep the IPQR under regular review to address the Board and Board committees' needs.			
	2	Develop Board members' skills and understanding of data presentation and interpretation by scheduling a specific training session on this topic.	Board papers frequently contain a large amount of data, in a variety of different layouts and graphical formats. A more consistent format of presentation used in reporting would enhance the scrutiny of often complex information and strengthen members' interpretative data skills.	Board Secretary **COMPLETE**
	A Board Development Session was held in August 2019, using the new format of the IPQR (as above) as the basis of a broader discussion on improving the presentation of complex data to Board members. The NHS Improvement England resource, Making Data Count, has also been made available to Board members, for further training and development. It is expected that the national Board Development work will also produce a training resource in this area on the new Turas platform for Non-Executives. Update (September 2020) A national programme has begun on the development of an assurance information system, as described at paragraphs 5.2 to 5.4 in the NHS Scotland Blueprint for Good Governance, which has been titled 'Active Governance'. Such an approach is aimed at ensuring NHS Boards have the necessary information to assist them in obtaining assurance on the delivery of the organisation's strategic, operational and financial plans, and that it is possible to measure the organisation's performance by benchmarking results against those of similar organisations. A specific development programme is being designed for Board members, to ensure that they can engage with the information, make informed assessments for assurance purposes and anticipate and identify substantive issues. Roll-out of the national programme and related training is expected to begin in December 2020. Update (December 2021) Board members took part in the national Active Governance development session on 2 November 2021 and members have been encouraged to also complete the online learning resources in this area. Taking forward the outcomes of this session are reflected in a separate action plan, as detailed in the SBAR to this paper.			
	3	Enhance the Board's visibility on the NHS Fife website, ensuring that the publication of Board papers is timely and easily accessible by an external audience.	A business case for creating a new website for NHS Fife is presently being progressed. The creation of a 'Board portal' is an early priority for the new website, bringing together information on Board members, dates of meetings, agenda papers and governance-related information.	Head of Communications **COMPLETE**
	An external web development agency is in the process of being appointed to work on the redesign, testing and development of the new NHS Fife website. As part of this development a dedicated area on the website will be allocated to the Board, bringing together information on individual Board members, dates of meetings, agenda papers and other governance-related information. It is expected that the agency will be appointed by end of November 2019, with design, development and testing from December 2019 to February 2020, and an initial launch in March 2020. Update (September 2020) The new NHS Fife website launched at the start of September 2020, after delays due to Covid-19. An enhanced Board portal is continually being developed, with increased information available on the background of Board members, committee roles / remits and governance structures. The publication of Board and Board Committee papers will follow protocol agreed by the Board in April 2020 (as aligned to the implementation of the new Standing Orders). Update (December 2021) Expanded Board portal is now live, containing further information on Committees and dedicated landing pages for the Board Members' Induction Pack and Code of Corporate Governance, to aid ease of locating these resources.			

NHS FIFE ACTION PLAN – UPDATE ON THE IMPLEMENTATION OF BLUEPRINT FOR GOOD GOVERNANCE

Area for Improvement	No.	Action	Improvement Activity / Evidence	Who / When
Board Administration & Support	**4**	Further enhance Board Committee self-assessment questionnaires, taking account of feedback from members on the relevance of some current questions and reviewing the current timing of the exercise.	The annual Board Committee self-assessment exercise provides valuable feedback from members and attendees about the effectiveness of the core governance structure. The move to an online questionnaire process in 2018/19 has significantly increased participation and captured helpful comments from respondents. A further review of the present question set is proposed, in addition to the earlier scheduling of the exercise to avoid clashes with other annual surveys (avoiding overload of members and lower participation).	Board Secretary **COMPLETE**
	In conjunction with Committee Chairs, the current list of questions for the annual self-assessment exercise has been comprehensively reviewed and amendments made to improve clarity of wording and relevance. A new questionnaire, based on the standard format, has also been developed for the Remuneration Committee, to reflect its new position as a standing committee of the Board. The online exercise will be scheduled earlier than in previous years, in December, to avoid a clash with other year-end surveys. Update (September 2020) The Committee surveys for 2019/20 were undertaken earlier than in the past and the outcome findings have been reported to all committees by March 2020. The Remuneration Committee undertook this exercise for the first time and have considered the feedback as per the system in place for other governance committees. In light of the impact of Covid-19 pandemic on routine business from March 2020, the completion of this programme of work earlier in the calendar year than scheduled previously was greatly beneficial, ensuring that this key aspect of the annual assurance process was not interrupted or delayed. Update (December 2021) Review of the Board Committee self-assessment question set and scheduling of the exercise takes place on an annual basis, as part of business-as-usual activities. In the 2020/21 exercise, specific questions around the Board's governance arrangements during the height of the Covid-19 pandemic were added, to gather helpful information in that area.			
	5	Reduce the number of late papers circulated to Board Committees, which can negatively impact the level of scrutiny of members on the content and proposals therein.	The ongoing development of detailed workplans for the Board and its Committees, scheduling agenda topics over a yearly cycle, is expected to enhance agenda management. The creation of a similar system for the Executive Directors Group will aid the forward planning of Board and Board Committee agendas, thus providing authors with adequate notice to meet strict deadlines for submission.	Directors & Board Secretary **COMPLETE**
	Board Committee workplans have all now been scrutinised and revised to follow a similar format. Template agendas for the full annual cycle of meetings are now in place for the four main scrutiny committees. An update is being drafted for EDG in November, proposing that Board committee agendas are brought forward earlier in the cycle to EDG for consideration, to inform earlier preparation of Committee papers. Additionally, using the Board's new electronic Outlook calendar, it will be suggested that key deadline dates are delivered electronically to Directors' diaries, as automatic reminders for Committee preparation. Update (September 2020) A process is now in place for EDG to consider draft committee agendas immediately after the preceding meeting, to help aid earlier preparation of papers. A central Board meeting calendar has also been successfully introduced. Further work is required on developing a workplan for EDG itself, to align papers with the reporting requirements of the Board and its committees. In general, however, this work has been disrupted by the impact of Covid-19 on routine business and the resultant need to prioritise Covid-related business, meaning that many of the routine workplans of key groups have been set aside or significantly amended. Update (December 2021) EDG approved its own workplan in Spring 2021 and this has evolved across the year, to ensure it remains reflective of the overall organisation's schedule of business, particularly in light of the continuing Covid pressures and the ongoing Gold Command structure that involves all of the Directors and usual EDG attendees. The schedule of EDG meetings, and the focus of meetings within the monthly cycle, continues to develop. The process of EDG considering draft Committee agendas and identifying papers to review in advance of distribution has worked well, though there remain some challenges in aligning the overall amount of business with EDG's busy agenda. This continues to be worked through. The introduction of the Board Committee Support Officer role from June 2021 has had a greatly beneficial impact in advance planning for Board Committee business, ensuring agendas and papers are produced to strict deadlines.			
	6	Implement locally the suite of nationally developed governance templates for the Board, such as Standing Orders, agenda paper templates, induction programme etc.	NHS Fife is involved in the ongoing workstreams led by the Board Secretaries group to develop a 'Once for Scotland' suite of key governance documents (for example, the NHS Fife Induction Pack has been selected as a model template for other national boards to follow). Other documents currently in draft are largely similar to our existing versions presently in use, so it is anticipated that we will be able to be implemented these locally in a short timeframe.	Board Secretary **COMPLETE– further work in this area remains tied to timings of national workstreams**
	The bulk of this work remains in draft, with final approval of key documents still to be granted via the Chairs' group. The NHS Fife Induction Pack / programme has however now been adopted nationally and is fully in use locally with newly appointed members. Update (September 2020) As part of this work, in addition to the roll-out of the induction programme, new model Standing Orders and the adoption of Board agenda paper templates / guidance has been issued and adopted by the Fife NHS Board. National work is ongoing on the creation of template remits for mandatory Board committees, to which the Board Secretary continues to have input. This national work was paused due to the Covid pandemic but has now recommenced. The delivery of these various initiatives however remains tied to the timing of national workstreams, over which we as an individual Board have limited input. Update (December 2021) The Board has adopted all nationally developed governance documents and templates issued thus far. The Board Secretary continues to work actively to develop further nationally-led initiatives, on a business-as-usual approach.			

NHS FIFE ACTION PLAN – UPDATE ON THE IMPLEMENTATION OF BLUEPRINT FOR GOOD GOVERNANCE

Area for Improvement	No.	Action	Improvement Activity / Evidence	Who / When
Partnership Working	**7**	Review current progress on integration of health and social care and develop revised Integration Scheme with Fife Council.	A detailed self-assessment exercise on integration progress has been undertaken by all partners in April 2019 and agreement reached to review the current version of the Fife Integration Scheme. This is expected to further develop the governance arrangements in place in the IJB and consequentially improve the NHS Board's own systems of governance and assurance for the matters delegated to the Health & Social Care Partnership.	Chair & Chief Exec **COMPLETE – scheme awaiting final SG approval**
	Final version of self-evaluation response to MSG Integration of Health & Social Care report was submitted by IJB to Scottish Government in May 2019, which detailed areas for further work locally. Review of present Integration Scheme is anticipated to take place in 2020. Appointment of new Director of Health & Social Care expected to provide further impetus to this programme of work. Update (September 2020) The review of the current Fife Integration Scheme was at an advanced stage when paused in mid-March 2020 due to prioritising Covid-19 mobilisation. This work is being led by the Director of Health & Social Care. Meetings of the review group were resumed in August 2020 and a deadline date of approval of a revised Integration Scheme via the governance structures of the respective partners has been set for the end of the calendar year. Update (December 2021) Fife NHS Board has approved a revised Integration Scheme for Fife at its meeting in September 2021, after initial consideration by the Clinical Governance Committee and the Finance, Performance & Resources Committee. This draft has now gone onward to Scottish Government for approval. After escalation to the respective Chief Executives in May 2021, a revised risk share agreement has been approved, which is reflected in the final, revised Scheme adopted by each respective partner.		
	8	Revise the governance arrangements in place to provide oversight of the Joint Strategic Transformation Programme.	A joint programme of strategic and operational transformation is essential to the sustainability of the services delivered by NHS Fife. We are implementing a refreshed approach to the oversight of this area under the leadership of the Chief Executive and Director of Finance & Performance, as well as an enhanced framework of performance and accountability between operational services and the Board's Committees.	Chief Exec and Ass. Director of Planning & Performance **COMPLETE**
	A new system of Performance & Accountability Review Framework has been initially established in 2019, to provide a structured, transparent and systematic approach to ensure delivery of standards and targets, with an effective reporting and assurance mechanism from each service to the Board. The process is expected to evolve further, to provide enhanced assurance on performance. A refreshed Integrated Transformation Board, to be additionally supported by the six-month appointment of a Director of Programme Management Office (PMO), has been established, to provide leadership and strategic direction to the joint transformation programmes underway in NHS Fife and the H&SCP. Update (September 2020) Work is underway to review and redesign the transformation programme, taking into account the transformation and changes taken place during and following the COVID-19 period and the new leadership of NHS Fife under a new CEO and directors. A workshop was held on 3 September 2020 with the directors to agree the priorities going forward and the proposed structure of governance and reporting. Update (December 2021) The newly established Public Health & Wellbeing Committee, supported by the Population Health & Wellbeing Portfolio Board, provides clear governance to the development and implementation of the new Population Health & Wellbeing Strategy, as well as existing system-wide programmes. Executive responsibility for this work now falls under the Director of Finance & Strategy's management portfolio. All work is aligned to NHS Fife's Strategic Priorities and supported by the enhanced corporate Programme Management Office, as part of business-as-usual activities.		
Public Engagement	**9**	Clarify the status of the Patient Focus Public Involvement Committee (PFPI) and agree the composition of a refreshed body that promotes enhanced public engagement in the delivery and planning of health services.	Noting the planned release of engagement-related guidance to Health Boards from the Scottish Government, NHS Fife will further develop our approach for identifying, involving and engaging our key stakeholders, including those who are difficult to reach or might be otherwise disenfranchised through traditional format participation activities.	Director of Nursing **COMPLETE – further work also underway**
	A revised model for participation and engagement has been developed, involving a three-strand approach of (i) a professional Advisory Group, to act as a single point of contact for participation and engagement activity, chaired by a member of the public; (ii) a structure Public Member Forum, to provide peer input and advice; and (iii) a community engagement assembly, fully utilising social media reach to attract a wide demographic. Following Board approval, development of terms of reference for the groups will follow, aligned with the recruitment of participants. Update (September 2020) The above model was ratified by the Clinical Governance Committee in November 2019 and by the Clinical & Care Governance Committee in January 2020. The aforementioned citizens assembly, due to take place in June 2020, was cancelled in light of the pandemic. In response to this, Patient Relations has reached out to the virtual directory to seek feedback on the public's experiences throughout lockdown. Whilst development and roll-out of Terms of Reference, appointment of a Chair, wider staff education and revision of the Participation & Engagement Strategy have been delayed due to the pandemic, work has now resumed, with forecasted completion dates of March 2021. However, the model has been in practise since ratification and is being embedded as services remobilise. The Participation & Engagement Advisory Group has been able to utilise the findings of the Scottish Government's scoping exercise to engage with service leads to further test the model, and as a result the levels of engagement correspond to the remobilisation plans described.		

NHS FIFE ACTION PLAN – UPDATE ON THE IMPLEMENTATION OF BLUEPRINT FOR GOOD GOVERNANCE

<table>
<tr><th>Area for Improvement</th><th>No.</th><th>Action</th><th>Improvement Activity / Evidence</th><th>Who / When</th></tr>
<tr><td></td><td colspan="4">Update (December 2021)
The new Participation & Engagement Advisory Group (PEAG) was established in 2020 and is made up of professional staff who acts as a single point of contact for services seeking public participation across Acute Services, H&SCP Services, Corporate Services and Localities. National guidance on “Planning with People, Community engagement and participation guidance for NHS Boards, Integration Joint Boards and Local Authorities that are planning and commissioning care services in Scotland” was published in March 2021. NHS Fife has been selected as a pilot Board to test the “Quality Framework for Community Engagement and Participation”, which forms part of the “Planning with People” guidance. This pilot involves self-evaluation, discussions with Healthcare Improvement Scotland (HIS) and the development of improvement plans. This framework and the accompanying evaluation cycle will provide assurance to NHS Fife and the IJB that its processes fully address the new guidance. The IJB is developing its strategy for community engagement and participation, also taking this guidance into account. NHS Fife’s participation and engagement model will dovetail with the strategy.</td></tr>
<tr><td></td><td>10</td><td>Review the effectiveness of the programme of engagement sessions held on a bi-monthly basis with external organisations working with NHS Fife and ensure that invited parties represent the breadth and diversity of our key stakeholders.</td><td>In 2018/19, a successful programme of engagement sessions has been established, allowing Board members and the Executive Team a chance to regularly meet with a wide range of external charity / voluntary organisations that work in partnership with NHS Fife to deliver improved outcomes for the population we serve. As this programme continues, a review will be undertaken to ensure that invited organisations are fully representative of the many groups we work in partnership with.</td><td>Chair & Board Secretary

CLOSED – No longer applicable</td></tr>
<tr><td></td><td colspan="4">The list of upcoming voluntary and external organisation invites has been reviewed and refreshed, with input sought from the Charity Manager of Fife Health Board Endowment Fund to ensure that the proposed invited groups cover the breadth of organisations that work in partnership with NHS Fife. It is anticipated the sessions will continue over 2019-20.

Update (September 2020)
No further sessions have been held since the last report to the Board, due initially to clashes with other events that were aligned to Board Development Sessions and then the impact of Covid-19 on the Board’s ability to meet in public. It is expected that the ability to hold further sessions in the near future will be severely limited, due to ongoing social distancing measures and the continuance of restrictions on the Board meeting in public. Once public meetings resume, consideration will be given to resuming this programme of work or exploring other avenues to improve Board engagement with key stakeholders.

Update (December 2021)
Given the continuance of Covid and the ongoing limitations on face-to-face meetings for the foreseeable future, it is not thought feasible to resume face-to-face engagement sessions in the manner delivered previously. Undertaking these by MS Teams would also not be suitable for the type of informal discussion and engagement that Board members found so useful in the previous sessions. Once face-to-face meetings are able to be safely held, consideration will be given to what type of events could be held for Board members to engage directly with patients, voluntary organisations and community groups.</td></tr>
</table>

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**09 December 2021**
Title:	**Internal Audit Progress Report**
Responsible Executive/Non-Executive:	**M McGurk, Director of Finance & Strategy**
Report Author:	**B Hudson – Regional Audit Manager**

1 Purpose

This is presented to the Audit and Risk Committee for:

- Assurance
- Discussion

This report relates to a:

- Local policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This paper provides the Audit and Risk Committee with comprehensive assurance on the progress of the 2021/22 Internal Audit Plan.

2.2 Background

The Internal Audit year runs from May to April. Audit work completed allowed the Chief Internal Auditor to provide the necessary assurances prior to the signing of the accounts.

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

2.3 Assessment

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

Appendix A shows:

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

Advice and input

In addition to formal audit reviews which result in a report to the Audit and Risk Committee, Internal Audit have continued to provide advice and assistance to officers and Board members on the following areas since the last Audit and Risk Committee meeting, including:

- Assurance reporting regarding Whistleblowing (quarterly and annual)
- Commenting on Terms of Reference for the Quality Management Assurance Group.

Improvement Activities

Further work since the September 2021 Audit and Risk Committee meeting includes:

- Development of the FTF website which is ongoing.

2.3.1 Quality/ Patient Care

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

2.3.2 Workforce

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

2.3.3 Financial

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

2.3.4 Risk Assessment/Management

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

2.3.5 Equality and Diversity, including health inequalities

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

2.3.6 Other impacts

N/A

2.3.7 Communication, involvement, engagement and consultation

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

2.3.8 Route to the Meeting

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

2.4 Recommendation

The Audit and Risk Committee is asked to:

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

3 List of appendices

The following appendices are included with this report:

- Appendix A – Internal Audit Progress Report

Internal Audit Progress Report

Introduction

This report presents the progress of internal audit activity up to 26 November 2021.

Internal Audit Activity

NHS Fife Completed Audit Work

The following audit products, with the audit opinion shown, have been issued since the previous Audit and Risk Committee meeting, where a progress report was considered, on 17 June 2021. Each review completed has been categorised within one of the five strands of corporate governance. A summary of each report is included for information within the 'Summary of Audit findings' section.

Audit 2020/21	Opinion on Assurance	Recommendations	Draft issued	Finalised
Corporate Governance				
B13/21 – Risk Management Strategy	N/A	Five 'Significant'	08 June 2021	23 September 2021
Clinical Governance				
B19/21 – Clinical Governance Strategy and Assurance	Moderate Assurance	One 'Significant' One 'Merits Attention'	26 August 2021	14 September 2021
B21/21 – Medical Equipment and Devices	Reasonable Assurance	Four 'Merits Attention'	14 September 2021	8 November 2021
Staff Governance				
B22/21 – Manual Handling Training	N/A	Three 'Significant' Four 'Merits Attention'	12 May 2021	29 June 2021
Information Governance				
B23/21 – ITIL Processes	Limited Assurance	Six 'Significant'	28 May 2021	7 July 2021

B28/21 – Digital and Information Governance Arrangements	Moderate Assurance	One 'Significant' Two 'Merits Attention'	24 May 2021	7 July 2021

Audit 2021/22	Opinion on Assurance	Recommendations	Draft issued	Finalised
Corporate Governance				
B06/22 – Internal Audit Annual Report	N/A	One 'Significant'	30 August 2021	09 September 2021
B08/22 Internal Control Evaluation	N/A	Five 'Significant' 7 'Merits Attention'	29 November 2021	TBC
B09/22 – Audit Follow Up	N/A	N/A	N/A	Report provided to each Audit and Risk Committee
Financial Governance				
B19/22 Post Transaction Monitoring	Category A	Two 'Merits Attention'	30 August 2021	31 August 2021

NHS Fife Work in Progress and Planned:

Audit 2021/22		Status	Target Audit and Risk Committee
B10/22	Attendance at Committees and Groups	Fieldwork	May 2022
B11/22	Assurance Mapping	Fieldwork	May 2022
B12/22	Risk Management Strategy, Standards and Operations	Planning	May 2022
B13/22	Strategic Planning	Fieldwork	March 2022
B16/22	Prescription Stationery Security	Fieldwork	March 2022
B17/22	Workforce Planning	Fieldwork	May 2022
B18/22	Procurement	Fieldwork	March 2022
B20/22	Financial Process Compliance	Fieldwork	March 2022
B21/22	Records Management	Planning	May 2022
B23/22	Resilience	Planning	March 2022

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, where a progress report was considered, on 17 June 2021.

1. B13/21 – Risk Management Strategy

This review was an evaluation of the extent to which previous audit recommendations have been implemented and reflected within the revised Risk Management Framework. A second phase is scheduled for the latter part of 2021/22 and will assess the Risk Management Maturity of the organisation and risk management processes.

Update on Progress

The main elements of a robust Risk Management Framework are in place albeit risk management arrangements between the Integrated Joint Board and NHS Fife, which cover a significant number of the Board's operational risks, still require clarification, although the IJB has been in existence for many years.

It has been acknowledged that in line with good practice, risk appetite and risk tolerance should be revalidated and that the risk tolerances, communications, training and awareness are the next steps of the process and implementation of the updated Risk Management Framework. Risk appetite and tolerance are essential if Risk Management is to add value and drive decision making and prioritisation.

The profile of Risk Management is to be raised through its integration with the Strategic Planning Resource and Allocation (SPRA) process, which will develop and support a three year organisational plan and the development of a Health and Wellbeing Strategy for NHS Fife.

Key steps to improve Risk Management in NHS Fife have been identified and need to be developed into a detailed project plan with key tasks, milestones and responsibility for each element, to ensure that the work is appropriately scoped and resourced and can be delivered in a stepped, timely manner.

Key Performance Indicators (KPIs) are reported to the Audit and Risk Committee to demonstrate how Risk Management is functioning in NHS Fife. On reviewing these KPIs we found that significant improvement is required with setting dates for reviewing risks and keeping to these. We also found that the KPIs themselves require further development to link relevant KPIs to NHS Fife's risk appetite and to better define KPIs and targets so that movement towards targets clearly demonstrates improvement.

The current NHS Fife Risk appetite is not well understood and it is not possible to conclude that it has had any impact on the organisations priorities, decisions or even its discussions on assurance.

There is a lack of accountability for BAFs in respect of achievement of, or at least movement towards, the Board's risk appetite and consideration should be given to including this within relevant Directors' individual objectives.

Implementation of Previous Audit Recommendations

Previous audit recommendations were considered to have been implemented other than the following:

- The number and nature of the BAFs should be reassessed as part of the new process to ensure that there is clear alignment with the Board's

overall and supporting strategies and to allow appropriate scrutiny and accountability [*supersedes B06/21 Internal Audit Annual Report, Action Point Reference 4*]

- A project plan should be developed and produced which details the key aspects of work which need to be undertaken to complete the Risk management Framework [*supersedes B13/20 Risk Management Staging Report, Action Point Reference 1*]
- Now that there is clarity around responsibility for operations, an IJB Risk Management Strategy should be produced and formally agreed with the parties as soon as possible and incorporated into the NHS Fife Framework. More detailed aspects of the risk management arrangements between NHS Fife and Fife IJB should be included in GP/R7 - Risk Register and Risk Assessment policy [*supersedes many previous recommendations including B06/19 Annual Internal Audit Report, Recommendation 5*]

The above recommendations are included in this report which entirely supersedes previous Internal Audit Report recommendations on risk management.

2. B19/21 - Clinical Governance Strategy and Assurance

We considered the planning and engagement stages of developing a revised Clinical Governance Strategy and the extent to which these address issues we identified with the previous Clinical and Care Governance Strategy.

The revised strategy is to be known as the Clinical Governance Framework and its development is to include review and revision of the different committees and groups that support Clinical Governance in NHS Fife. Engagement with key stakeholders has commenced and we are advised that the revised Clinical Governance Framework will address the issues raised in our previous report B15/17 & B18/18 – Clinical Governance Strategy and Assurance. We refreshed the issues raised and restated them so that they can be monitored through the audit follow-up process when the Clinical Governance Framework is finalised. The issues are summarised as follows:

- Ensuring that the strategy and framework are fully consistent and provide a clear vision of clinical governance responsibility across NHS Fife including services delegated to the IJB
- Refining assurance reporting routes for clinical governance, using the committee governance and integration principles, including assurance regarding clinical governance in services delegated to the IJB
- Reflecting that ownership of operational clinical risks associated with services delegated to the IJB rests with Fife NHS Board in the revised Clinical Governance Framework and embedding this in relevant documentation including the risk management strategies of the IJB and the Health Board
- Developing the assurance provided by the Clinical Governance Oversight Group to add routine and annual assurance reporting to the CGC in addition to providing its minutes to the CGC as is the case currently
- Adding responsibilities for providing assurance to Fife NHS Board regarding Information Governance to the Terms of Reference for the CGC
- For Information Governance assurance regarding services delegated to the IJB - clarifying roles and responsibilities, in particular the role of the IG&SSG, and reflecting this in the Clinical Governance Framework

- Reviewing annual assurance provision from sub-groups of the CGC, again using committee governance principles as a guide, to ensure that annual assurance reports are received, within the required timescale, from all sub-groups that the CGC relies upon to agree its own annual assurance report and statement
- Developing a Clinical Governance Framework Implementation Delivery Plan and reporting on its implementation to the CGC.

A timetable for the development of the Clinical Governance Framework has been prepared and communicated to EDG and the Clinical Governance Committee with a target timescale of January 2022 for presenting the framework and associated delivery plan to the Clinical Governance Committee for approval. Elements of the revised strategy are being implemented as it is developed including:

- Adverse Event Process and Policy Review
- Establishment of an Organisational Learning Group
- Collating all previous Internal Audit Findings in preparation for assurance to be provided to CGC that the revised Framework addresses these

As this review took the place of a scheduled Patient Safety Programme review we undertook a brief overview of how the 10 essentials are complied with in NHS Fife and the Health and Social Care Partnership. Our findings from this review are that the 10 essentials continue to be embedded in normal practice in the Acute Services Division and the applicable essentials are becoming embedded in the Health and Social Care Partnership.

This report entirely supersedes internal audit report B15/17 & B18/18 – Clinical Governance Strategy and Assurance and also supersedes action plan point 4 from B08/20 – Internal Control Evaluation.

3. B21/21 - Medical Equipment and Devices

The Medical Equipment Management Policy includes the following objective:

'*Manage medical equipment ensuring it is available when and where required, it is suitable for the intended purpose, maintained in a safe and reliable condition, and that users are appropriately trained in its safe use. This must include anyone who may be involved in any aspect of equipment management and use throughout its full life cycle from procurement to final disposal.*'

Our findings are summarised as follows:

- GP/E4 - Medical Equipment Management Policy (MEMP) is considered to set out the process in place to manage medical equipment as per the requirements of CEL 35 (2010) – A Policy for Property and Asset Management in NHS Scotland
- The MEMP includes ensuring equipment is available when and where required, is suitable for the intended purpose, is maintained in a safe and reliable condition, and that users are appropriately trained in its safe use.
- The E14.1 Equipment Procurement Operational Policy, details the role of the Capital Equipment Management Group (CEMG) in overseeing the arrangements in place for the procurement of equipment.
- Both the MEMP and the E14.1 Equipment Procurement Operational Policy were due to be reviewed by 31 August 2021, but this has not yet

been finalised.

- The updated Terms of Reference (ToR) for the CEMG were approved at the June 2021 CEMG meeting and our review found that they meet the requirements of the guidance outlined in CEL 35 (2010). Our review confirmed that CEMG has continued to meet throughout the pandemic in line with its ToR. We did note that attendance needs to be monitored and improved so that the required specialist input to equipment procurement is present at all meetings. Also performance against the Key Performance Indicators (KPIs) included in Annex 2 of CEL 35 (2010) is not reported to CEMG.
- There is a lack of clarity regarding training and maintenance arrangements recorded on Equipment Request Forms (ERFs). This does not enable the CEMG to fully evidence the requirement, as detailed in CEL 35 (2010), of overseeing these arrangements by confirming that arrangements have been put in place for both training and maintenance with regard to equipment purchases.
- Additional equipment needs resulting as a consequence of the Covid-19 pandemic, funded by the Scottish Government, were overseen by a Local Mobilisation Plan Group (LMPG) established for this purpose, rather than by CEMG.
- Our checking of a sample of ERFs found that these included the information and authorisation required by the E14.1 - Equipment Procurement Operational Policy. We did note that the level of detail entered for certain sections was minimal and did not provide CEMG with overt assurance regarding, for example, whether consultation had taken place and if not the reasons for this.

4. B22/21 - Manual Handling Training

This review, at the request of management, considered how manual handling training is provided in NHS Fife and in particular how this training is planned and monitored to confirm that it meets NHS Fife's requirements as per its Manual Handling Policy. We also considered how the pandemic has impacted upon manual handling training delivery and the steps that have been taken to mitigate this.

Overall we found that further actions are required to ensure the manual handling training provided, fully achieves its part in mitigating the Workforce Sustainability BAF risk 1415.

Planning and Monitoring

A training needs analysis is not undertaken by the manual handling training service to identify NHS Fife's manual handling training requirements and to establish areas where staff are at increased risk of musculoskeletal injury. A database is used to record details of staff attending manual handling training courses and to update their individual training records, however, no ongoing management information is produced to demonstrate the number and type of training courses held or the number of staff trained. As no planning information is maintained, no overview is available to measure the actual number of courses held and the number of staff trained.

Impact of Pandemic

Due to the current Covid-19 pandemic, it has not been possible to undertake face to face manual handling training as normal. The manual handling team have introduced a series of instruction videos, notably for new starts, to show the correct way to perform manual handling tasks which would normally be taught during face to face training. The Learnpro modules for both patient and non patient handling have been updated to cover areas normally dealt with

at face to face training and are now live on the Learnpro system. An exercise was also undertaken to train staff who had been redeployed due to the pandemic and bespoke training has been provided to areas where this was requested.

Although it is understandable that the Covid-19 pandemic has been of such a significant consequence over the provision of manual handling training (and this is likely to affect other areas of training as well), it does emphasise the need for annual planning and monitoring arrangements over the provision of manual handling training to be implemented, so that NHS Fife can meet the future needs of the service in line with manual handling training standards.

5. B23/21 – ITIL Processes

The full report was considered by the Audit and Risk Committee – Agenda Item 9.1 - 16 September 2021

6. B28/21 - Digital and Information Governance Arrangements

Having previously raised concerns regarding the provision of assurance regarding Digital and Information Governance, this review considered the extent to which recently revised governance arrangements, for Digital and Information and Information Governance & Security, address the previous issues and specifically whether the assurances provided to the Clinical Governance Committee are sufficient to allow its members to conclude regarding whether adequate and effective governance arrangements for Digital and Information are in place for yearend reporting (2020/21). We also considered whether the revised arrangements allow the Senior Information Risk Owner and Data Protection Officer to discharge their roles effectively.

New Governance and Assurance Arrangements

Internal Audit has provided feedback on the revised arrangements as they were being developed during 2020/21. These include the establishment of an Information Governance and Security (IG&S) Steering Group and an IG&S Operational Group, with agreed Terms of Reference and Annual Workplans, replacing the Information Governance Group. The eHealth Board has become the Digital and Information Board.

Although the IG&S Operational Group has only recently started to meet, and much of the time at the meetings of the IG&S Steering Group held to date has necessarily been taken up with agreeing the new governance arrangements, assurance reporting has begun and is anticipated to evolve in 2021/22. This report therefore entirely supersedes the recommendations made in previous internal audit Digital and IG reports and these previous recommendations have been removed from the audit follow-up system. To ensure that the momentum towards better assurance and governance in this area is maintained the following actions are required and are included in a recommendation in this report:

- Finalise the action plans listed in the assurance report presented to IG&SG on 23 March 2021 and report on progress in implementing these. The action plans referred to and their reported status is:
    i. Data Protection Act 2018 & GDPR Action Plan – '*To be prepared for consideration by the IG&S Operational Group*'
    ii. Freedom of Information (Scotland) Act 2002 Action Plan – '*will be presented to IG&S Operational and Steering Groups for review and comment'*
    iii. Public Records (Scotland) Act 2011 Action Plan – '*The response from the Keeper will inform the action plan for this domain'*

iv. NHS Scotland Information Security Policy Framework 2018 Action Plan – '*will be reviewed and detail for review following the completion of the audit update that was complete in March 2021'*

v. Information Governance and Security Incident Reports – '*will be prepared for consideration at the IG&S Operational and Steering groups'*

- Improve assurances provided to the IG&S Steering Group and the Clinical Governance Committee so that the context is clear and aids understanding of whether performance is positive, negative or somewhere in between
- Finalise the IG assurance dashboard and utilise this for more detailed assurance reporting to the IG&S Steering Group and the Clinical Governance Committee
- Provide assurance on IG&S arrangements to each meeting of the IG&S Steering Group and the Clinical Governance Committee including assurance on the action plans referred to above, the management of IG&S Risks and Incidents and on IG&S Training.

We will monitor the continued implementation of the new arrangements in 2021/22.

Follow-up

The following actions related to Digital and Information Governance:

- The Delivery Plan associated with the Digital and Information Strategy should be reported to the Clinical Governance Committee at least twice per annum.
- The new business case template for Digital and Information projects should be presented to the next Digital and Information Board for endorsement and to the next Finance, Performance and Resources Committee for approval. The SBAR supporting the new template should explain the reasons for changes made.

7. B06/22 – Internal Audit Annual Report

The full report was considered by the Audit and Risk Committee – Agenda Item 6.1 - 16 September 2021

8. B08/22 Internal Control Evaluation

Full report included on the agenda for the 9 December 2021 Audit and Risk Committee.

9. B09/22 Audit Follow Up (AFU)

Full report included on the agenda for the 9 December 2021 Audit and Risk Committee.

10.B19/22 – Post Transaction Monitoring

The full report was considered by the Audit and Risk Committee – Agenda Item 6.2 - 16 September 2021

Key Performance Indicators
2020/21

Performance against service specification as at 26 November 2021:

	Planning	Target	9 December 2021
1	Audit assignment plans for planned audits issued to the responsible Director at least 2 weeks before commencement of audit	75%	75%
2	Draft reports issued by target date	75%	67%
3	Responses received from client within timescale defined in reporting protocol	75%	100%
4	Final reports presented to target Audit Committee	75%	100%

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**9 December 2021**
Title:	**Internal Audit – Follow Up Report on Audit Recommendations: position as at 30 November 2021**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Report Author:	**Barry Hudson, Regional Audit Manager**

1 Purpose

This is presented to the Audit & Risk Committee for:

- Assurance
- Discussion

This report relates to the:

- Audit Follow up Protocol

This aligns to the following NHSScotland quality ambition:

- Effective

2 Report summary

2.1 Situation

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

2.2 Background

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

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

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

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 as at 30 November 2021, with comparable figures from the last Audit Follow-Up (AFU) report in June 2021.

	November 2021	**June 2021**
Remaining Recommendations	**47**	**49**
Extended with revised dates (agreed by Responding Officer) *(Appendix C)*	34	33
Outstanding – Date passed *(Appendix D)*	0	6
Not yet due	13	10

Progress summary

The following reports, which featured in the table at appendix B in our June 2021 report, no longer feature in this table as the recommendations that were remaining to be addressed have either been completed and validated or superseded by recommendations in more recent reports:

Report	**Remaining Actions Status**
B23&24/19 Savings & Financial Planning	Completed and Validated
B13/20 Risk Management Staging	Superseded by: B13/21 Risk Management Strategy
B19/20 Adverse Events Management	Superseded by: B20/21 Adverse Events Management
B32/20 Waiting Times Methodology	Completed and Validated
B25/21 Post Transaction Monitoring	Superseded by: B19/22 Post Transaction Monitoring

Recommendations made in the Internal Audit Annual Report and Internal Control Evaluation Report are followed up in the subsequent report and are therefore not included in the tables below.

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

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

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

2.3.1 Quality/ Patient Care

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

2.3.2 Workforce

There are no workforce implications arising from this report.

2.3.2 Financial

There are no direct financial implications arising from this report.

2.3.3 Risk Assessment/Management

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

2.3.4 Equality and Diversity, including health inequalities

Not applicable

2.3.5 Other impacts

Not applicable

2.3.6 Communication, involvement, engagement and consultation

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

2.3.7 Route to the Meeting

Not applicable

2.4 Recommendation

The Audit and Risk Committee is asked to:-

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

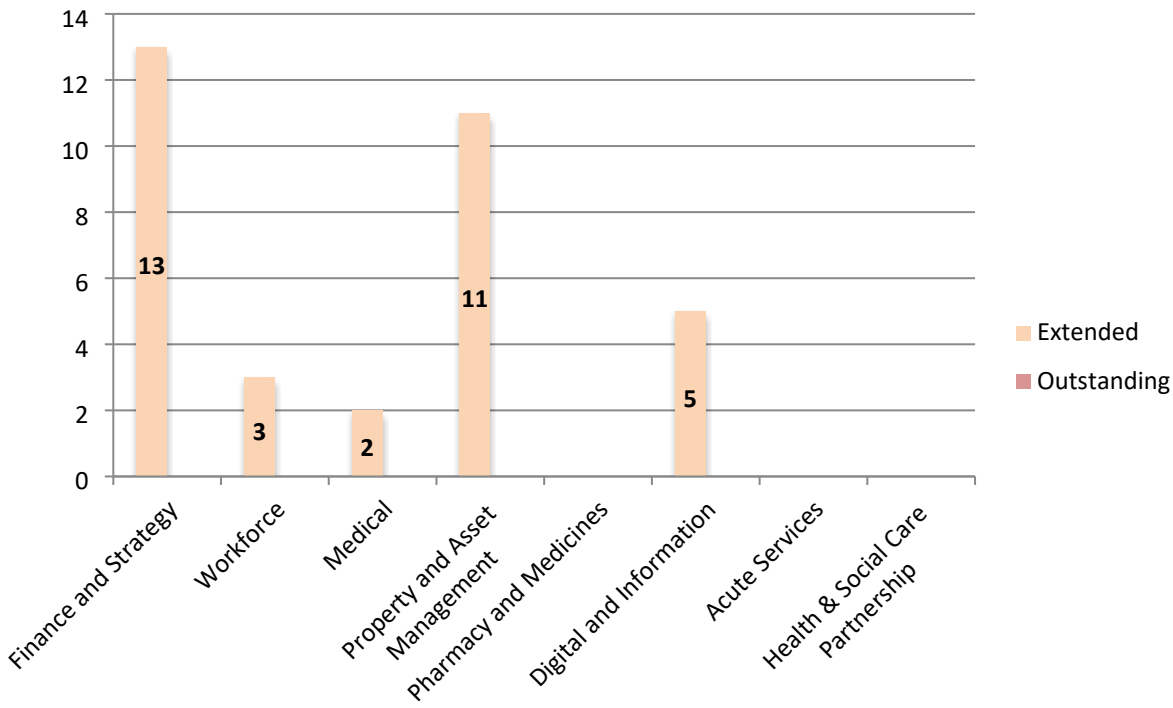
3. List of appendices

The following appendices are included with this report:

Report Contact

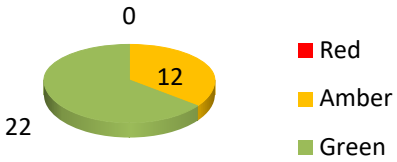
Barry Hudson, Regional Audit Manager, Email: barry.hudson@nhs.scot

Outstanding and Extended by Directorate

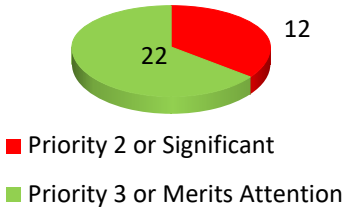


Extended Recommendations RAG Status and Priority

RAG Status



Priority



	Date of Issue	Total Recs.	Complete	Superseded	Remaining		Extended	Outstanding	Not Yet Due		Not Validated
Appendix							*C*	*D*			*E*
2018/19											
B11/19 Mandatory Training	Aug-19	3	2	0	1		1	0	0		-
B22/19 Losses & Comps	Apr-19	8	3	0	5		5	0	0		-
B25/19 Financial Management	Mar-20	2	0	1	1		1	0	0		-
2018/19 Totals		**13**	**5**	**1**	**7**		**7**	**0**	**0**		**-**
2019/20											
B14/20 Staff & Patient Environment	Dec-19	3	2	0	1		1	0	0		-
B17/20 Organisational Performance Management	Oct-20	6	1	0	5		5	0	0		-
B21/20 Medicines Management	Dec-19	23	23	0	0		0	0	0		1
B23A/20 Workforce Planning	Jan -20	4	3	0	1		1	0	0		-
B27/20 Financial Process Compliance	Jan-20	2	1	0	1		1	0	0		-
2019/20 Totals		**38**	**30**	**0**	**8**		**8**	**0**	**0**		**1**
2020/21											
B13/21 Risk Management Strategy	Sep 21	5	0	0	5		0	0	5		-
B14/21 Sharps Management	Dec-21	14	9	0	5		5	0	0		-
B19/21 Clinical Governance Strategy and Assurance	Sep-21	2	0	0	2		0	0	2		-
B20/21 Adverse Events Management	Mar-21	1	0	0	1		1	0	0		-
B21/21 Medical Equipment and Devices	Nov-21	4	0	0	4		0	0	4		-
B22/21 Manual Handling Training	Jun-21	7	0	0	7		7	0	0		-
B23/21 ITIL Processes	Jul-21	6	2	0	4		4	0	0		-
B26/21 Financial Process Compliance	May-21	1	0	0	1		1	0	0		-
B28/21 Digital & Information Governance Arrangements	Jul-21	3	1	0	2		1	0	1		-
2020/21 Totals		**43**	**12**	**0**	**31**		**19**	**0**	**12**		**-**
2021/22											
B19/22 Post Transaction Monitoring	Aug-21	2	1	0	1		0	0	1		-
2021/22 Totals		**2**	**1**	**0**	**1**		**0**	**0**	**1**		**-**
Overall Totals **(Actions from reports where recommendations remain unaddressed)**		**96**	**48**	**1**	**47**		**34**	**0**	**13**		**1**

	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
2018/19							
B11/19 Mandatory Training	1	3	A central record of course updates and reviews should be maintained and provided to the SGC at least annually.	Head of Workforce Development **Director of Workforce**	31-Mar-20 30 Apr 21 31 Jan 22		To allow time for a central record of course updates and reviews to be presented to EDG. This will be appended to the paper to be presented to EDG in January 2022.
B22/19 Losses & Comps	1a, 3 & 6	3 & 3 & 3	Managers responsible for recording incidents should be reminded of the requirement to follow FOP16a for all cases where property is lost, damaged or written off.	Head of Financial Services & Procurement **Director of Finance and Strategy**	31-Jul-19 30 Apr 21 31 Dec 21		FOP 16 is being updated along with all of the FOPs. A reminder of the need to comply with this specific FOP will be issued once the FOPs have been approved at the Audit and Risk Committee (9 December 2021).
	2b & 5	3 & 3	The losses and compensation form included in FOP16a should be amended to include: • provision for a cross reference to the related Datix incident	Ledger Control and Treasury Manager **Director of Finance and Strategy**	31-Jul-19 30 Apr 21 31 Dec 21		FOPs being updated for presentation to ARC 9 Dec 21
			• a section regarding the prevention of recurrence of losses.	Head of Financial Services & Procurement **Director of Finance and Strategy**	31-Jul-19 30 Apr 21 31 Dec 21		FOPs being updated for presentation to ARC 9 Dec 21
B25/19 Financial Management	1	S	Section 5 of the FOP Appendix A should be updated to include appropriate designations and authorisation levels and the reporting method for virements which are not fully delegated.	Deputy Director of Finance **Director of Finance and Strategy**	31-Jul-20 30-Apr-21 31 Dec 21		FOPs being updated for presentation to ARC 9 Dec 21
18/19 Sub Total	**7**						

	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
2019/20							
B14/20 Staff & Patient Environment	1a	M A	When available the 'Non-Compliance' report from the eESS system should be used to identify areas/departments/wards with low levels of attendance at Fire Safety Training so that these areas/departments/wards can be supported to improve attendance.	Learning & Development Officer **Director of Workforce**	31-Mar-20 31-May-21 31 Mar 22		eESS Reporting still not including non-compliance reporting functionality.
B17/20 Organisational Performance Management	1	M A	A revised schedule for the Performance and Accountability Review Framework (P&ARFF) meetings and the submission of a timetable for key documents should be agreed at the Executive Directors Group	Director of Finance & Strategy **Chief Executive**	01 Apr 21 30 Apr 22		NHS Fife is still under emergency planning measures and this will be ongoing until March 2022. The P&ARFF meetings have been paused during this time, we will however utilise the remaining months of 2021/22 to review the current process and embed that (with any agreed revisions) into the overall strategic planning and performance management arrangements for the Board. We expect to resume this process by 31 March 2022 at the latest and will route reporting on this through the recently reconfigured EDG meeting profile arrangements
	3	M A	The KSF/TURAS/appraisal performance completion rate should be included within the Workforce section of the report used for the P&ARFF.	Director of Finance & Strategy **Chief Executive**	30 Apr 21 30 Apr 22		NHS Fife is in emergency planning measures until March 2022 and the P&ARF have been paused during this time. Discussions are ongoing with the Workforce directorate about the KPIs includes in the IPQR for Workforce. The revised KPIs would be included from April 2022 forward.
	4	M A	Directorates and Departments should be reminded to include the links to strategic objectives and corporate objectives within the reports used for submission to the P&ARFF.	Director of Finance & Strategy **Chief Executive**	01 Apr 21 30 Apr 22		NHS Fife is in emergency planning measures until March 2022 and the P&ARF have been paused during this time. Links to corporate objectives are already in place to key programmes

	5	M A	Officers should be reminded to include the responsible officer and completion dates on action trackers. The action tracker should be amended to monitor attendance at the P&ARFF meetings.	Director of Finance & Strategy **Chief Executive**	01 Apr 21 30 Apr 22		NHS Fife is in emergency planning measures until March 2022 and the P&ARF have been paused during this time.
	6	M A	The P&ARFF should be further enhanced by including risk management	Director of Finance & Strategy **Chief Executive**	26 Feb 21 30 Apr 22		NHS Fife is in emergency planning measures until March 2022 and the P&ARF have been paused during this time. All aspects of strategic and performance work will include identification of risks and mitigations
B23a/20 Workforce Planning - Attendance Management	4	M A	A review should be undertaken to identify any gaps or duplication with the Attendance Management groups and ensure that there is a clear framework of all the groups, their purpose (strategic or operational) and how they interrelate to ensure that themes, reporting and escalation are defined and reported.	Director of Workforce **Chief Executive**	31-Mar-20 31-May-21 31-Mar-22		COVID-19 Pandemic and associated work pressures - While the content of the audit report has been shared with the NHS Fife Promoting Attendance Group and the associated local Promoting Attendance Groups and initial discussions have taken place with the Director of Workforce and Head of Human Resources on this recommendation, due to business as usual being interrupted by the COVID-19 Pandemic, we have been unable to have the fulsome discussion required on the framework for of all the groups, their purpose (strategic or operational) and how they interrelate, to ensure that themes, reporting and escalation are defined and reported. Update – November 2021. A draft Staff Health & Wellbeing Framework detailing the framework for all of the groups and their interrelationships has been drafted and will progress through the relevant approval routes for implementation in April 2022.
B27/20 Financial Process Compliance	2	M A	Financial Operating Procedures to be updated.	Head of Financial Services & Procurement **Director of Finance and Strategy**	31-Jul-20 30 Apr 21 31 Dec 21		FOPs being updated for presentation to ARC 9 Dec 21.
19/20 Sub Total	**8**						

	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
2020/21							
B14/21 Sharps Management	2f	M A	Update the Adverse Events Policy to: • clearly outline processes for review and analysis of Health and Safety Incidents related to staff • refer to lessons learned needing to be applied across the organisations to all departments and wards that they are applicable to.	Head of Quality and Clinical Governance **Medical Director**	26 Mar 21 30 Apr 22		An extension is requested to do the time taken for the Lead for Adverse Events to commence in post. Preparatory work has commenced however due to the system pressures there has been a delay to proceeding.
	3a 3b 3c 3d	S	Action plan to address issues raised in report (section 3 - Control 2) and appendix 1 to be developed and implementation progress to be reported to the Sharps Strategy Group and the Health and Safety Sub-Committee. The Health and Safety Sub-Committee to be reminded of their responsibility to escalate issues to the Clinical Governance Committee when required.	H&S Manager **Director of Estates, Facilities and Capital Planning**	a. 3-Feb-21 b. 3-Feb-21 c. 10-Feb-21 d. 30-Dec-20 30-Jun-21 28-Feb-22		Changes in staff roles. Current pandemic situation.
B20/21 Adverse Events Management	1	M A	Address concerns of DATIX Action Module users expressed by the comments made in this review regarding unfamiliarity with the DATIX Action Module and the lack of a full understanding of users' individual responsibilities Based on the findings of the initial review in B19/20 – Adverse Event Management, plus the additional comments made by users in this review, consideration should be given to a review of the framework and processes currently in place, to determine if any system changes could result in	Head of Quality and Clinical Governance **Medical Director**	31-May-21 30-Apr-22		An extension has been is requested due to do the time taken for the Lead for Adverse Events to commence in start post (commenced 15 November 2021). Preparatory work has commenced, including preparing an action plan to address issues raised in this report and previously in B19/20, however due to the system pressures there has been a delay to proceeding encountered.

			benefits and improvements, which would reduce the number of actions actually outstanding and those incorrectly recorded as outstanding.				
B22/21 Manual Handling Training	1	S	An annual manual handling training plan should be put in place to ensure that NHS Fife can effectively deliver manual handling training to all the necessary staff in line with government requirements.	H&S Manager **Director of Estates, Facilities and Capital Planning**	27-Aug-21 31-Mar-22		Sickness absence in MH Team and other changes in H&S management structure have not allowed for action plans to be implemented as originally envisioned. Focus has necessarily been on what training can be delivered given restrictions on personnel. Whilst some initial progress was made realistically the action plans for this audit are effectively on hold whilst the team rebuilds.
	2	S	A training needs exercise should be undertaken to determine manual handling training requirement.	H&S Manager **Director of Estates, Facilities and Capital Planning**	27-Aug-21 31-Mar-22		As per recommendation 1 above.
	3	S	Routine manual handling training management reports should be prepared detailing the number of courses held in comparison with the planned number, with explanations being provided for significant variations. High level reporting on this should be reported to the Clinical Governance Committee.	H&S Manager **Director of Estates, Facilities and Capital Planning**	30-Sep-21 31-Mar-22		As per recommendation 1 above.
	4	M A	Consideration should be given to changing the way courses are advertised, so that availability is more accessible and potentially a greater uptake in attendance.	H&S Manager **Director of Estates, Facilities and Capital Planning**	30-Jul-21 31-Mar-22		As per recommendation 1 above.
	5	M A	The introduction of the self-accreditation scheme should be revisited.	H&S Manager **Director of Estates, Facilities and Capital Planning**	30-Aug-21 31-Mar-22		As per recommendation 1 above.

	6	M A	Lesson plans should be created for all areas of manual handling training to ensure the content and suitability of each is considered.	H&S Manager **Director of Estates, Facilities and Capital Planning**	30-Jul-21 31-Mar-22		As per recommendation 1 above.
	7	M A	The risk assessment for manual handling training should be finalised to ensure that correct actions are in place to deal with the associated risks.	H&S Manager **Director of Estates, Facilities and Capital Planning**	30-Jun-21 31-Mar-22		As per recommendation 1 above.
B23/21 ITIL Processes	3	S	Digital and Information should engage with other services undertaking IT service management roles to assess their ITIL compliance and to offer assistance in introducing further ITIL processes to improve the efficiency of IT Service management in these areas. The timing of these actions will need to follow the cost benefit analysis and outcome referred to in action plan point 1 above and will also need to be sensitive to the impact the pandemic continues to have on the operation of other services.	Head of Digital Operations **Associate Director - Digital and Information**	31-Aug-21 31-Mar-22		Cost / Benefit paper presented to D&I Board 19/10/21. Time to allow for engagement with other services regarding introducing ITIL practices
	4	S	The NHS Fife Policy and Procedure for Change Management should be reviewed prior to the forthcoming change of IT Service Management software from Cherwell to ServiceNow. Part of this review should include determination of mandatory fields to be completed for all changes. Recording of risks related to changes should be undertaken in a consistent manner and should always include scoring of the risks based on impact and likelihood. The relevant staff should be reminded of the need to complete and attach the appropriate checklist for changes associated with server decommissioning.	Service Delivery Manager **Associate Director - Digital and Information**	30-Sep-21 31-Dec-21		Delays incurred regarding staffing the Transition Specialist post.

	5	S	The setting of required approvals should not be undertaken by the change requester. This should be automated as far as possible based on the type of change and its impacts and where the change is exceptional the approval requirements should be set by another member of the Digital and Information Team (eg the Change Manager). The move from Cherwell to ServiceNow should include determination of how approvals for changes are recorded so that this is clear and does not result in any doubt over whether the change has been appropriately authorised. Brief minutes of each Change Advisory Board meeting held should be recorded including listing those in attendance and decisions made.	Service Delivery Manager **Associate Director - Digital and Information**	31-Aug-21 31-Mar-22		Delays incurred going live with Service Now ITSM (Information Technology Security Management).
	6	S	A section should be added to the Service Management application (ServiceNow) to indicate whether the change falls into one or more of the 3 criteria listed in the Change Management Procedure as requiring the emergency change process to be invoked. A review of changes processed as emergency changes should be undertaken to identify changes that have been processed as such but do not meet the criteria for invoking the emergency change procedure. The IT Service Management application (ServiceNow) should include provision for the recording of approval by the D&I General Manager or their Deputy for emergency changes classified as high risk.	Service Delivery Manager **Associate Director - Digital and Information**	31-Aug-21 31-Mar-22		Delays incurred going live with Service Now ITSM.

B26/21 Financial Process Compliance	1	M A	The Financial Operating Procedure for Accounts Receivable should be updated to include the process for the authorisation of a cancellation or a credit note.	Head of Financial Services & Procurement **Director of Finance & Strategy**	31-Oct-21 31-Dec-21		FOPs being updated for presentation to ARC 9 Dec 21
B28/21 Digital & Information Governance Arrangements	3	M A	The new business case template for Digital and Information projects should be presented to the next Digital and Information Board for endorsement and to the next Finance, Performance and Resources Committee for approval. The SBAR supporting the new template should explain the reasons for changes made.	Head of Strategy and Programmes – Digital & Information **Associate Director – Digital & Information**	30-Nov-21 31-Mar-22		Need to agree Business Case and SBAR with Finance prior to presentation to EDG & FP&RC for approval.
20/21 Sub Total	**19**						
Total	**34**						

Report	Issue Date	Rec Ref.	Audit Finding & Recommendation	Responsible Officer & Executive Director	Original Management Response	Priority	Original Due Date
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Sub Total		**0**					
Total		**0**					

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*]
2019/20						
B21/20 Medicines Management	4c	**Finding** Issues regarding cold chain process compliance. **Recommendation** Management must introduce regular spot checks to confirm that responsibilities related to preserving the cold chain are being understood and undertaken in the transportation of medicines process. Action must be taken to address any areas of non-compliance identified.	Significant	Chief Pharmacy Technician **Director of Pharmacy & Medicines** 31-Mar-2020	Spot Checks have started in stores.	Evidence of spot checks of cold chain processes having been undertaken.
2019/20 Sub Total	**1**					
Total	**1**					

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

As our report format, including categorisation of audit opinion and report recommendations, changed in audit year 2018/19 the priority of the recommendations referred to in this report are quoted using two different systems. These are included in the table below:

Recommendation Priority	
Term	**Definition**
More Recent Reports	
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.
Older Reports	
Priority 1	Relate to critical issues, which will feature in our evaluation of the Governance Statement. These are significant matters relating to factors critical to the success of the organisation. The weakness may also give rise to material loss or error or seriously impact on the reputation of the organisation and require urgent attention by a Director.
Priority 2	Relate to important issues that require the attention of senior management and may also give rise to material financial loss or error.
Priority 3	Are usually matters that can be corrected through line management action or improvements to the efficiency and effectiveness of controls.
Priority 4	Are recommendations that improve the efficiency and effectiveness of controls operated mainly at supervisory level. The weaknesses highlighted do not affect the ability of the controls to meet their objectives in any significant way.

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:	**09 December 2021**
Title:	**Internal Control Evaluation (ICE)**
Responsible Executive/Non-Executive:	**M McGurk, Director of Finance & Strategy**
Report Author:	**T Gaskin – CIA / B Hudson – Regional Audit Manager**

1 Purpose

This is presented to the Audit and Risk Committee for:

- Assurance
- Discussion

This report relates to a:

- Local policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation and Background

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

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

2.2 Assessment

Key Themes

Our 2020/21 Annual Report noted that a number of the issues highlighted within that year's ICE were being addressed as part of a wide range of governance and strategic initiatives. This continues at pace and we were pleased to see good progress in:

- Development of an overall Health and Wellbeing Strategy and associated governance arrangements
- Continuing development of Risk Management arrangements
- Reflection on Active Governance and adoption of governance and assurance principles within working practises
- Update of Clinical and Care Governance framework and associated BAF
- Preparation for development of a workforce strategy
- Ongoing development of the SPRA process to link with and support the overall and financial strategies
- Addressing known issues in Information Governance and assurance
- Agreeing a revised Integration Scheme for submission to the Scottish Government

Many of these areas are subject to ongoing Internal Audit review and will not be complete until year-end, when we will be able to provide a final opinion. We are, however, pleased to note the significant progress made to date and the robust processes and principles adopted, as well as the very positive engagement with Internal Audit where we have provided input and advice on a wide range of issues at the outset. It is particularly encouraging that these developments have continued despite the enormous ongoing pressures created by Covid.

This report contains a number of recommendations, intended to enhance the processes referred to above, to embed good governance principles and to ensure coherence between Governance Structures, Performance Management, Risk Management and Assurance.

2.3.1 Quality/ Patient Care

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

2.3.2 Workforce

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

2.3.3 Financial

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

2.3.4 Risk Assessment/Management

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

2.3.5 Equality and Diversity, including health inequalities

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

2.3.6 Other impacts

N/A

2.3.7 Communication, involvement, engagement and consultation

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

2.3.8 Route to the Meeting

This paper has been produced by the Regional Audit Manager and reviewed by the Chief Internal Auditor prior to EDG consideration and approval, then presented to the Audit and Risk Committee.

2.4 Recommendation

The Audit and Risk Committee is asked to:

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

3 List of appendices

The following appendices are included with this report:

- Internal Control Evaluation (ICE)

FTF Internal Audit Service

Internal Control Evaluation 2021/22

Report No. B08/22

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

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

[Audit Follow-Up Co-ordinator]

[Audit and Risk Committee]
[External Audit]

Contents

Draft Report Issued	29 November 2021
Management Responses Received	TBC
Target Audit & Risk Committee Date	9 December 2021
Final Report Issued	**TBC**

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 principal objective of this review is to provide assurance to the Chief Executive, as Accountable Officer, that there is a sound system of internal control that supports the achievement of the Board's objectives.

3. This year's Internal Control Evaluation (ICE) was designed to coordinate with fieldwork to be undertaken within B13/22 Strategic Planning and B17/22 Workforce Planning, both of which will be carried out in two phases, with the initial work focussing on the adequacy of the arrangements in place to develop the Health and Wellbeing Strategy and the Workforce Plan. The second phases of both reviews will consider the effectiveness of these arrangements.

4. This ICE also provides a detailed assessment of action taken to address previous internal audit recommendations from the 2020/21 ICE and Annual Report, and assess the adequacy and effectiveness of internal controls, giving time for remedial actions to be taken before year-end, thereby allowing the year-end process to be focused on year-end assurances and confirmation that the required actions have been implemented.

5. This evaluation assessed the design and operation of the controls in place and specifically considered whether:

   - Governance arrangements are sufficient, either in design or in execution, to control and direct the organisation to ensure delivery of sound strategic objectives.

6. Whilst there was no overarching corporate/strategic risk relevant to this review, 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

7. Ongoing and required developments and recommended actions are included at Section 2.

8. The Annual Internal Audit Report issued 9 September 2021, was informed by detailed review of formal evidence sources including Board, Standing Committee, Executive Leadership Group (ELG), and other papers. 6 recommendations from the 2020/21 ICE remained outstanding at that point with all reported as being on track, and 2 of these now reported as completed.

9. As well as identifying key themes, the Annual Internal Audit Report made one specific recommendation on:

   - Increased risk of harm - a specific risk should be recorded, delegated to the CGC, to capture the clinical implications of Covid19 on waiting times and the associated impact on patient safety, clinical effectiveness and strategic prioritisation.

10. Completed actions from previous ICE and Annual Report recommendations are included under each strand of governance and ongoing recommendations from the 2020/21 ICE are detailed in table 1.

11. In this report, we have provided an update on progress to date and, where appropriate, built on and consolidated previous recommendations to allow refreshed action and completion dates to be agreed. This has culminated in 12 recommendations for which management have agreed

actions to progress by year end. Whilst this appears to be a large number given the overall positive conclusions within the report, these recommendations are primarily suggestions to enhance governance improvement activities already underway within NHS Fife.

12. 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

13. Our 2020/21 Annual Report noted that a number of the issues highlighted within that year's ICE were being addressed as part of a wide range of governance and strategic initiatives. This continues at pace and we were pleased to see good progress in:

    - Development of an overall Health and Wellbeing Strategy and associated governance arrangements
    - Continuing development of Risk Management arrangements
    - Reflection on Active Governance and adoption of governance and assurance principles within working practises
    - Update of Clinical and Care Governance framework and associated BAF
    - Preparation for development of a workforce strategy
    - Ongoing development of the SPRA process to link with and support the overall and financial strategies
    - Addressing known issues in Information Governance and assurance
    - Agreeing a revised Integration Scheme for submission to the Scottish Government

14. Many of these areas are subject to ongoing Internal Audit review and will not be complete until year-end, when we will be able to provide a final opinion. We are, however, pleased to note the significant progress made to date and the robust processes and principles adopted, as well as the very positive engagement with Internal Audit where we have provided input and advice on a wide range of issues at the outset. It is particularly encouraging that these developments have continued despite the enormous ongoing pressures created by Covid.

15. This report contains a number of recommendations, intended to enhance the processes referred to above, to embed good governance principles and to ensure coherence between Governance Structures, Performance Management, Risk Management and Assurance.

KEY DEVELOPMENTS SINCE THE ISSUE OF THE ANNUAL REPORT INCLUDED:

16. The introduction of the Public Health and Wellbeing Committee, which has developed Terms of Reference and a workplan and has met twice. The Committee will oversee the development of the new Health and Wellbeing Strategy, which will supersede the current Clinical Strategy, and is due to be presented to the Board for approval in March 2022.

17. The fourth iteration of the Remobilisation Plan RMP4 was considered by the Board in September2021, with Scottish G approval received November 2021.

18. An Active Governance Board Development Session was held on 2 November 2021 and an action plan developed.

19. A Risk Management maturity assessment has been undertaken with further risk management development planned including revision of the risk appetite.

20. Overall, there has been good progress on recommendations from the ICE from last year and the Annual Report for 2020/21. Where action is still to be concluded, the Board has been informed of the planned approach and timescales, as well as associated improvement plans.

ACTION

21. 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

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

A Gaskin, Bsc. ACA
Chief Internal Auditor

TABLE 1 - ICE 2020/21 (B08/21) - Update of Progress Against Ongoing Actions since Annual Report		
Agreed Management Actions with Dates	**Management Actions Updates with Dates**	**Assurance Against Progress**
ICE Report 2020/21 – B08/21		
1. Long term Strategy • The EDG should jointly agree how the various strands of work to inform and deliver the long term strategy for NHS Fife will be analysed and translated into a co-ordinated programme, building on the progress already made through the Strategic Planning and Resource Allocation (SPRA) as well as remobilisation planning, considering how best use can be made of existing expertise and data and understanding constraints on resources. • This review should also consider how best to ensure effective governance and oversight of this key area in advance of the Board Development Session • A timetable for development of the new Strategy and supporting strategies should be reported to the NHS Board. Reporting on progress should be clearly assigned to an Assurance Committee or the NHS Board and should include a broad overview of whether Recovery, Remobilisation and strategy development is on track, key achievements, challenges and risks and any significant implications for strategy and priorities. ***Action Owner: Chief Executive***	Not due until 31 March 2022 • Establishment of the Population Health and Wellbeing Portfolio Board to deliver strategic coordination of the emerging strategy, the first meeting was held in November 2021. This Board will report to the Public Health and Wellbeing Committee. • Public Health and Wellbeing Committee has been established to oversee the implementation of the Population Health and Wellbeing Strategy and oversee a number of related areas and held its introductory meeting on 15 October 2021. Wide-ranging Terms of Reference (ToR) and a comprehensive annual workplan have been approved.	 **On track**

2. Governance and Year end Assurances Coordination of the year-end governance reports and statements of assurance is well underway. This will conclude in the normal timeframes – **June 2021,** specifically • Adoption of Assurance Mapping principles **– June 2021** ***Action Owner: Director of Finance and Strategy***	Assurance Mapping Principles were adopted at the September 2021 Audit and Risk Committee and year-end governance reports and statements of assurance were concluded in the required year end timescales. Assurance mapping work continues, and the Board Secretary and Chief Internal Auditor are working together to ensure that local developments are congruent with national initiatives.	 **Completed**
3. Clinical Governance Framework Development of the Clinical Governance Strategy and Clinical Governance Assurance Framework with a focus on risk, informed by Committee Assurance and Integration Principles. ***Action Owner: Medical Director***	• As per internal audit report B19/21 the Clinical Governance Strategy and Framework are being revised. A revised strategy is scheduled to be presented to the Clinical Governance Committee (CGC) and Fife NHS Board towards the end of 2021/22. • The approach to presentation of the BAFs and corporate risks are currently being reviewed by the Director of Finance & Strategy (Executive Lead for RM) with full involvement of EDG. The content of the three BAFs presented to CGC is being reviewed and updated.	 **On track**
4. Whistle Blowing • An annual report from the Whistleblowing Champion (WBC) cannot be provided until a WBC is appointed to NHS Fife. In the absence of a WBC a report is being presented to the Board which includes whistleblowing data. The Staff Governance Committee (SGC) action plan 2021/22 will include the reporting requirement from the Whistleblowing Champion – **March 2021** ***Action Owner: Director of Human Resources***	An update report on NHS Fife's whistleblowing arrangements was presented to the March 2021 Board meeting, detailing NHS Fife's readiness for adopting the new standards from 1 April 2021. A new Non-Executive Director has been appointed whistleblowing champion. They attended the July 2021 SGC meeting and provided an update on their responsibilities to the September 2021 SGC meeting. The 2021/22 SGC workplan includes a report on whistleblowing incidents being presented to the SGC in March 2022. Arrangements are in place to present quarterly whistleblowing reports to the SGC, detailing the number of such incidents occurring within NHS Fife.	 **Completed**

5. Property Management Strategy • Property and Asset Management Strategy (PAMS) is on the Agenda for the NHS Board in March 2021. • We anticipate that there will be a requirement for an East Regional PAMS report in the near future. The data in this document represents NHS Fife position as at 1 April 2020. • The 2020 PAMS document is largely retrospective and represents the pre-Covid19 landscape, the Impact of Covid19 will be further considered as part of the 2021 full PAMS which will be compiled between April and July 2021 by NHS Fife and likely submitted as part of an East Regional PAMS report – August 2021 ***Action Owner: Director of Property and Asset Management***	The PAMs was approved by the FPRC at its November 2021 meeting and emphasises the need for the NHS Fife Property & Asset Management over the next few years to be revised to support the development and deliver the objectives of the Health & Wellbeing Strategy.	 **On Track**
6. Information Governance and Security • Establishment of IG&S Operational Group and Steering Group ToR • Digital and Information (D&I) Board to provide additional support and assurance to IG&S and its alignment to strategy and operational performance **– April 2021** • IG&S Assurance Report and Framework – **March 2021** • Assurance report will be made available for consideration at the next Clinical Governance Meeting, following the IG&S Steering Group meeting on 23 March 2021. • Risk associated with resources and requirement for business cases when delivering the Digital and	The IG&S Operational Group and Steering Group have approved Terms of Reference. Assurance reporting is evolving and the D&I BAF was updated to reflect resources risk regarding implementation of the NHS Fife D&I Strategy 2019-2024.	 **On track**

Information Strategy will be documented within the related BAF – **April 2021** ***Action Owner: Associate Director of Digital***		
Internal Audit Annual Report 2020/21 – B06/22		
6. Increased Risk of Harm • A specific risk should be recorded, delegated to the CGC, to capture the clinical implications of Covid19 on waiting times and the associated impact on patient safety, clinical effectiveness and strategic prioritisation. The risk should include clear controls and assurance sources looking at reducing avoidable harm caused by delays in diagnoses and treatment and should reflect: • The key priorities and aims for 2021/22 within the current remobilisation plan. • Other relevant controls, such as implementation of Royal College of Surgeons guidelines • A description of controls to address the current pressure on scheduled care as a result of imbalance in demand and capacity; additional pressures due to Covid19; possible pent up demand due to reduction in referral rates. • Identified requirements to redesign services.	The CGC agreed that the Quality and Safety BAF Risk should be reworded to reflect short, medium and long term impact of the pandemic on clinical services waiting times and the associated impact on patient safety, clinical effectiveness and strategic prioritisation as well as including new linked risks, related to pandemic impact (Paper 6.1 to 3 November 2021 CGC). Internal Audit have been asked to contribute to this process as part of their Board Assurance work.	 **On Track**

CORPORATE GOVERNANCE

BAF Risks:

- **Risk 1675 - Strategic Planning - There is a risk that the development and the delivery of the new NHS Fife Population Health and Wellbeing strategy is not adequately supported by the required planning and programme management capacity, capability and governance arrangements.**
- **Risk 1676 – Integration Joint Board - There is a risk that the Fife Integration Scheme does not clearly define operational responsibilities of the Health Board, Council and Integration Joint Board (IJB) resulting in a lack of clarity on ownership for risk management, governance and assurance.**

Strategy

Progress with the development of the Population and Wellbeing Strategy (PWS) is positive. The Public Health and Wellbeing Committee has been established to oversee the implementation of the PWS, with an initial meeting held on 15 October 2021. We commend the progress of the establishment of the Population Health and Wellbeing Portfolio Board to deliver strategic coordination of the emerging strategy, with the first meeting taken place in November 2021. Initial work is underway as follows:

- the Public Health and Wellbeing Assessment has been drafted;
- a public survey has been developed as part of the Communication Plan to engage with the citizens of Fife to direct and shape the strategy, this is planned for presentation to the November 2021 Board meeting and thereafter will be released online. The survey is aligned to NHS Fife 4 strategic priorities: Health and Wellbeing; Quality of Clinical Services; Staff experience and Wellbeing and Value and Sustainability, and,
- a review of the existing Clinical Strategy, where the initial meeting has been held on 24 November 2021.

A critical path plan with monthly timelines has been developed for the work on these workstreams. The planned completion date of 31 March 2022, will be challenging, especially given the pressures of Covid. We will review the development of the Strategy in detail within B13/22 - Strategic Planning.

Remobilisation Plans

The draft Remobilisation Plan 4 (RMP4) was considered and approved by the NHS Fife Board in Private session on 28 September 2021 prior to submission to the Scottish Government. The SBAR presented to the November 2021 Board meeting states that the RMP4 is aligned to the strategic planning in Fife and going forward, Annual Delivery Plans will reflect strategic developments including:

- Strategic Planning and Resource Allocation (SPRA) which has commenced for 2022/23, and will align with the development of the Population Health and Wellbeing Strategy;
- The development of NHS Fife's 5-year Population Health and Wellbeing Strategy.

Covid19 & Governance

NHS Fife has continued to monitor the governance arrangements whilst taking account of the pressures on management.
Regular Flu and Covid19 reporting to the Board has continued, the latest update to the November

2021 Board meeting included Covid19 testing, Covid19 cases, Vaccinations and Covid19 deaths.

Committee Assurance

NHS Fife has implemented the NHS Scotland Model Meeting Paper Template for all standing Committee and Board papers, enhanced to include papers for assurance. In particular we noted the comprehensive and informative narrative within the NHS Fife Annual report highlighting 'Key Issues and Risks that could affect the delivery of objectives'.

Standing Committee papers and workplans, demonstrate that Committees receive regular assurances in accordance with their remit and in line with the Committee Assurance Principles, although we noted that the workplans could better highlight and changes or delays to scheduled items and any potential impact on the Committee's ability to provide appropriate assurance.

A Board Development session was held on 2 November 2021 on Active Governance which focussed on improving how data presented to the Board and Standing Committees and explored how insights from intelligence can be used to assure quality and performance. An action plan was agreed following the session and includes a number of actions to improve reporting to Fife NHS Board and its committees, which link well with other developments within the Board.

Assurance Mapping

Internal Audit continue to facilitate the work of the Assurance Mapping group and to liaise with the Board Secretary to consider how the agreed principles can be adapted to the specific needs of NHS Fife and in particular, the actions arising from the November 2021 Active Governance Board Development Event. In addition, we are assisting Board Officers in their review and update of the Quality and Safety BAF and looking at how assurance mapping can be used to provide assurance on Best Value and on assurances required from Directors in accordance with the Scottish Public Finance Manual, as well as ensuring that all work is congruent with national governance initiatives. Whilst Best Value arrangements are in place with assurance statements received from all Standing Committees, there is scope for further improvement by increasing the focus on outcomes and through overt linkage to assurance mapping to avoid duplication.

Integration

The revised Integration Scheme was approved by NHS Fife Board on 28 September 2021 and has been submitted to the Scottish Government (SG) for approval. The revised Integration Scheme, which included input from FTF as the Internal Auditors of both the Health Board and IJB, has much greater clarity around the role of the IJB and that of its partners and now reflects national guidance received.

We previously noted that the Integration BAF was significantly out of date and needed to be reviewed. This has not yet taken place.

Performance

The Integrated Performance Quality Report (IPQR) Executive Summary report informs each meeting of the Board of performance against a range of key measures (Scottish Government and local targets) as well as RMP3 activity. The Board, the Finance, Performance and Resources Committee, the Staff Governance Committee and the Clinical Governance Committee have received regular performance reports to every meeting this year, the latest report presented with the (ESIPQR) at the November 2021 Board meeting highlights:

Cancer 31-Day Diagnostic Decision to first Treatment (DTT) and Antenatal are meeting target, with five indicators not achieving target but performing well above the Scotland average: 4- Hour Emergency Access; Cancer 62 Day RTT; Patient TTG; New Outpatients; Diagnostics. A further four areas are neither meeting the target nor the Scotland average: Smoking Cessation; Detect Cancer

early; 18 week RTT; Cancer 62 Day RTT; Delayed Discharge (% bed days lost). However, we recognise that this is a time of exceptional pressure and all Health Boards are facing considerable challenges.

NHS Fife are successfully delivering against the remobilisation plan for New Outpatient Activity; Elective Imaging Activity; Urgent Suspicion of Cancer; CAMHS and Psychological Therapies.

The Board has been less successful with activity against projected activity for TTG Inpatient /Daycase Activity; Elective Scope Activity; A&E Attendance, Emergency Admissions and 31 Day Cancer – First Treatment and the challenges are likely to increase given the ambitions around elective activity and the likely backlog of unrecognised need and higher case mix in relation to both targets.

The SBAR presented with the ESIPQR advised that the activity templates data for RMP4 will be incorporated for governance purposes in future versions of the IPQR.

Actions to improve data reporting to Fife NHS Board and its committees were identified as part of the Active Governance Board Development session on 2 November 2021. These included revising the IPQR to bring in other ways of presenting data and changes are to be made to the format of the IPQR going forward and this is an opportune time to link the corresponding risks to performance to provide a triangulation of assurance.

Risk Management

A review of overall Risk Management arrangements is underway as reported to the Audit and Risk Committee in September 2021 incorporating an externally facilitated risk maturity assessment including a presentation and self-assessment undertaken by the Executive Directors and other EDG members in September 2021. This will inform the development of a risk management improvement plan including revision of the Risk Management Key Performance Indicators reported to the Audit and Risk Committee. We would recommend that the action plan should be presented to the Audit and Risk Committee for approval and monitoring.

We welcome that the newly established Public Health and Strategy Committee is giving consideration to creating a stand-alone BAF, for the areas associated with the work of this Committee.

Committee papers reflected good discussion on the BAFs although this could be further improved. We did note that the risk section of many SBARs was not well completed, often did not reference BAFs or operational risk and did not facilitate discussion of the accuracy of the description and scoring of risks, nor the adequacy and effectiveness of key controls and actions. Some papers did not evidence a serious consideration of risk implications and this area could be improved overall.

B08/21 Internal Control Evaluation report highlighted that whilst a number of BAFs have been updated for Covid19, the Board has not received an overall Covid19 risk, nor have they been informed of how and when Covid19 risks will be incorporated into the BAF. Although we have seen detailed scrutiny of Covid risks at Gold Command, this has still not translated into full revision of the BAFs to reflect the impact of Covid.

Action Point Reference 1 – Board Assurance Framework (BAF)

Finding:

a) Committee papers evidenced discussion on the BAFs and there is further scope to improve the process by overt scrutiny of the accuracy of scoring of risks and the adequacy and effectiveness of key controls and actions which should be mitigating and reducing the risk.

b) In addition, B08/21 Internal Control Evaluation report highlighted that whilst a number of BAFs have been updated for Covid19, the Board has not received an overall Covid19 risk, nor have they been informed of how and when Covid19 risks will be incorporated into the BAF.

c) We have previously recommended the need for the Integration Joint Board BAF to be reviewed and revised once the Integration Scheme has been approved by SG and we reiterate this as a priority, to ensure the NHS Fife Board is apprised and updated of the current risks.

Audit Recommendation:

a) The inclusion of appropriate analysis in each SBAR supporting the BAFs regarding the adequacy and effectiveness of key controls and actions would promote/aid further scrutiny by committee members.

b) The Board Assurance Framework should encompass and link Covid19 risks, to ensure the NHS Board has appropriate oversight and transparency over these risks.

c) Once the revised Integration Scheme has been approved by the Scottish Government, the IJB BAF should be revised to ensure that it adequately describes the risk the mitigating controls and appropriately scored.

Assessment of Risk:

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

Management Response/Action:

The Board is currently reviewing the BAF process and the approach to risk management more generally. There is a planned session of the Audit and Risk Committee and the NHS Fife Board in December to consider this which will include responding to the audit points noted above. From this an action plan will be developed to support a range of improvement activitity which will inform our arrangements in this area.

Action by:	Date of expected completion:
Director of Finance and Strategy	**31 March 2022**

Action Point Reference 2 – Performance Reporting

Finding:

Actions to improve data reporting to Fife NHS Board and its committees were identified as part of the Active Governance Board Development session on 2 November 2021. These included revising the IPQR to bring in other ways of presenting data and changes are to be made to the format of the IPQR going forward.

Our review of Board and Committee papers highlighted that, whilst Board and Committee members are keen to discuss risk, many papers lack adequate, or sometimes any, detail on the associated risks. Where narrative is provided it does not overtly link to BAF or operational risks and does not overtly provide assurance on narrative, scores or the adequacy and effectiveness of key controls and actions.

Audit Recommendation:

As part of this Active Governance action plan, consideration should be given to how Performance Reports can provide overt assurance on the accuracy of the narrative and scores for related strategic (BAF) risks as well as the adequacy and effectiveness of key controls.

The risk section of Board and Committee papers should be given higher priority than at present and should contain basic information to facilitate a focused discussion on the risk implications, be overtly linked to any operational or BAF risks and contain enough information for members to be able to form a conclusion on whether the score narrative and other elements of the related risk are adequately described.

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:

Following discussion at EDG on 2 December 2021, the IPQR will undergo development in a range of areas.

- Creation of a "System-Wide Summary - Dashboard"/ "Balanced Scorecard" showing the overall position across health and social care
- Proposed alternative presentation of aspects of data
- Proposed additional content in some areas
    a. Workforce
    b. Patient Feedback
    c. Information Governance

Proposed section of the IPQR to report on Public Health and Prevention

As agreed with EDG, a review group will be created to lead the IPQR development process.

As a first priority the group will develop a working version of the System-Wide Summary/Balanced

Scorecard for the opening section of the report to be used in January 2022. This will include risk profiling aligned to our performance reporting. The final narrative supporting this will be approved in advance by the Chief Executive. This and all other changes proposed will be reported in an iterative way to EDG by the review group during the final quarter of 2021/22. Progress on the review will also be reported to the governance committees in January and March 2022.

The IPQR reports on the quality of patient care through a number of core targets, the targets are reported individually. The proposal to develop the System-Wide Summary/Balanced Scorecard will draw out the interdependencies across the system which impact on the effectiveness of patient pathways and flow.

Action by:	Date of expected completion:
Director of Finance and Strategy	**31 March 2022**

CLINICAL GOVERNANCE

BAF Risks:

Risk 1674 – Quality and Safety – High Risk (15)

There is a risk that due to failure of clinical governance, performance and management systems (including information & information systems), NHS Fife may be unable to provide safe, effective, person centred care.

Risk 1675 – Strategic Planning – High Risk (16)

There is a risk that the development and the delivery of the new NHS Fife Population Health and Wellbeing strategy is not adequately supported by the required planning and programme management capacity, capability and governance arrangements.

Clinical Governance Framework

A Clinical Governance Framework, to replace the Clinical and Care Governance Strategy, is currently in development and will be presented to EDG in January 2022 and then the CGC in March 2022 for approval. An associated delivery plan will be developed and its implementation monitored by the Clinical Governance Oversight Group (CGOG) with reports being provided to CGC.

The development of the framework is taking into account previous internal audit recommendations summarised in internal audit report B19/21 - Clinical Governance Strategy and Assurance including: clinical governance reporting routes, services delegated to the IJB, committee assurance principles and integration governance principles. Programmes of work in progress which support the development of the framework include reviews of the Risk Management Framework and Adverse Events Policy and Procedures.

Internal Audit have been consulted in a number of these developments and, we are extremely positive about the direction of travel, the process being adopted, and principles being applied to the development of the Framework.

Our IJB internal audit plan includes a review of Clinical and Care Governance arrangements for the services delegated to the IJB, which is intended to compliment the work undertaken in B19/21 and ensure that whole service assurances are in place with no omissions and no unnecessary duplication.

Clinical Governance Committee

No changes have been made to the CGC Terms of Reference since the period covered by the Internal Audit Annual Report (B06/22) and the CGC Workplan continues to be presented to each meeting of the CGC.

Clinical Risk Management

Following a review of the Quality and Safety (Q&S) BAF by Senior Management CGC were asked to consider proposals to improve the BAF including:

- work to improve the quality of Controls, Gaps in Control and Assurances recorded and to strengthen the assurances provided
- recommendations regarding risks currently linked to the BAF (whether these should continue to be linked or be managed in another way)
- linking new risks, associated with the impacts of the pandemic on the quality and safety of patient care and service delivery to the BAF
- revising the high level risk description for the BAF to reflect the impact of the pandemic on

clinical services (thereby addressing recommendation 1 from our annual report B06/22)

- reviewing all existing high risks related to Clinical Governance to consider which risks should be linked to the Q&S BAF
- engaging with Operational Directors and Senior Leadership Teams to identify key risks to operational delivery and ensure these are reflected on the appropriate risk registers and linked as appropriate to the BAF.

The CGC supported these recommendations and an updated Q&S BAF, will be presented to its January 2022 meeting. We commend this approach and are liaising with management on the revision of the Q&S risk as part of our Assurance Mapping work for 2021/22.

Clinical Performance Reporting

The IPQR was presented to both CGC meetings held since our annual report (September and November 2021). The latest report highlights that 7 of the 10 Clinical Governance targets measured are not currently being achieved and 5 of the 12 activity areas measures relating to NHS Fife's remobilisation plan are worse than predicted. The committee raised concerns regarding these areas and were reassured by the Director of Nursing that work is ongoing to achieve the targets, that the challenges inhibiting progress were recognised and the remobilisation plan will provide more context going forward. We highlight performance against the 4 hour wait target for A&E as an area of potential clinical risk, whilst recognising that Fife is out-performing the Scottish average.

The CGC has also received reports on Health Associated Infection, Complaints, Excellence in Care, Covid19 Testing, Remobilisation and the Covid19 and seasonal flu vaccination programmes.

External Review

An Organisational Learning Group has been established to share learning from incidents, adverse events and positive feedback so that all parts of NHS Fife benefit from lessons learned. This group is in its infancy but has the remit to consider issues identified from external reports to establish why these were not identified by existing internal control mechanisms and to recommend improvements to address issues identified and its terms of reference support this approach.

An unannounced inspection was undertaken by Healthcare Improvement Scotland at Victoria Hospital between 4 & 6 May 2021. The inspection considered compliance with existing Healthcare Associated Infection standards across a sample of wards and departments and found 7 areas of good practice and 2 requirements for improvement. The inspection report was presented to CGOLG in its activity tracker then to CGC on 17 September 2021 when the committee were informed that the 2 requirements for improvement had been addressed.

Significant Adverse Events

The new Adverse Events Lead is undertaking a full review of the Adverse Events Policy and Procedures which will incorporate the recommendations made in internal audit reports on Adverse Events Management (B19/20 and B20/21). We noted that although the CGC receives data on the number and nature of major and extreme adverse events it does not receive KPIs on the Board's performance in resolving these within required timescales.

Duty of Candour

In the Clinical Governance section of our Annual Report B06/22 we stated that due to the unavoidable delay in finalising duty of candour figures the Organisational Duty of Candour report could not be presented to CGC before that Committee's annual assurance statement/report was approved and we recommended that '*In future a short summary report should be provided to the CGC at year-end for consideration when concluding on its Annual Assurance Report and Statement*'. However, no such update on Organisational Duty of Candour has been scheduled for the CGC.

An interim Organisational Duty of Candour Annual Report for 2020/21 was presented to CGC on 3

November 2021 and indicated that between 1 April 2020 and 31 March 2021 there were 15 adverse events where the duty of candour applied with the most common related outcome being an increase to the person's treatment. The report was provided on an interim basis due to the backlog of adverse events reviews as a result of the pandemic meaning that the number is likely to increase. An updated report for 2020/21 is to be provided to the March 2022 CGC, but not, as noted above, a 2021/22 report.

Action Point Reference 3 – Organisational Duty of Candour

Finding:

In the Clinical Governance section of our Annual Report B06/22 we stated that due to the unavoidable delay in finalising duty of candour figures the Organisational Duty of Candour report could not be presented to CGC before that Committee's annual assurance statement/report was approved and we recommended that '*In future a short summary report should be provided to the CGC at year-end for consideration when concluding on its Annual Assurance Report and Statement*'. However, no such update on Organisational Duty of Candour has been scheduled for the CGC.

Audit Recommendation:

An update on the number of instances Organisational Duty of Candour has been applied in NHS Fife in 2021/22 should be scheduled for presentation to CGC prior to it concluding on its Annual Assurance Report and Statement, which should highlight any issues experienced and be sufficient allow it to conclude whether there were adequate and effective Duty of Candour arrangements throughout 2021/22.

The Committee should be informed when it can expect the final report on the year's activity and how arrangements will be developed in future to allow more timely reporting.

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:

An interim Duty of Candour Report was presented to the Clinical Governance Committee (CGC) in November 2021 with a further report scheduled for presenting in January 2022. The report was issued on an interim basis due to delays resulting from the impact of the pandemic. The report presented to CGC also includes a look back at previous years (2018/2019 and 2019/2020). Previous years have been included for completeness as Duty of Candour applied to cases which concluded review after submission of respective annual reports. The review of the Adverse Event Policy and Proceedure will identify actions to improve timely reporting.

Action by:	Date of expected completion:
Medical Director	March 2022

Action Point Reference 4 – Adverse Events KPIs	
Finding:	
Although the CGC receives data on the number and nature of major and extreme adverse events it does not receive KPIs on the Board's performance in resolving these within required timescales.	
Audit Recommendation:	
The revised approach for Adverse Events should include regular reporting of KPIs to CGC on the completion of adverse events within agreed timescales.	
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:	
A review of the Adverse Events Policy and Procedure has been initated. The improvement plan to support this review will include action to address visability of KPIs.	
Action by:	**Date of expected completion:**
Medical Director	30 April 2022

STAFF GOVERNANCE

BAF Risk:

Risk 1673 – Workforce Sustainability – High Risk (16)

There is a risk that failure to ensure the right composition of workforce, with the right skills and competencies will adversely affect the provision of services and quality patient care and impact on organisational capability to implement the new clinical and care models and service delivery set out in the Clinical Strategy and the future population Health & Wellbeing Strategy and the challenges and demands associated with the current Covid19 pandemic

Governance Arrangements

The March 2021 meeting of the Staff Governance Committee (SGC) approved a revised Terms of Reference and the changes therein have been formally reflected in the Code of Corporate Governance annual update, which was approved by the Board at its May 2021 meeting. As with other Committees, completion of the 2021/22 SGC workplan is not reported to each SGC meeting.

Covid19

During 2021/22, regular reports on NHS Fife's staff governance arrangements have included information on the impact of the Covid19 pandemic and providing assurance to the SGC on the measures being taken to ensure NHS Fife's workforce is being supported during the pandemic. Examples of this include reports on staff appraisals, health & wellbeing (including attendance management and support for staff shielding and working from home), all of which made specific reference to the impact of Covid19.

Workforce Strategy/Planning

An Interim Joint NHS Fife and Fife Health & Social Care Partnership Workforce Plan for 2021/22 was presented to the April 2021 SGC meeting prior to submission to the Scottish Government (SG). Arrangements are now in place to re-introduce a 3 yearly planning cycle across NHS Scotland with an NHS Fife Workforce Plan 2022-25 currently due to be completed by 31 March 2022. It is being prepared in consultation with the Health & Social Care Partnership and in conjunction with the NHS Fife Population Health & Wellbeing Strategy and its preparation is to take due regard of comments made by the SG on the 2021/22 Interim Joint NHS Fife and Fife Health & Social Care Partnership Workforce Plan. An audit review by Internal Audit of the arrangements for completing the Workforce Plan 2022-25is ongoing.

Risk Management

The SGC has been presented with an update on the BAF Workforce Sustainability risk at each of its meetings. As part of an overall review of risks being completed by the Executive Directors Group, the SGC approved a number of revisions to the BAF Workforce Sustainability risk at its October 2021 meeting, which, in our view, have improved the quality of the BAF and better reflect workforce challenges and the impact of Covid19. The current risk rating remains high.

The BAF Workforce Sustainability risk is to be further reviewed by management for any workforce pressures identified during the preparation of the Workforce Strategy 2022-25. This risk will be specifically considered by Internal Audit, in our review of the Workforce Strategy 2022-25. Currently, no updates are provided to either the SGC or RC on NHS Fife's succession planning arrangements. There would be benefit in recording and monitoring the Board's approach to mitigating the risks associated with recruiting to key positions.

Staff Governance Action Plan

Guidance is still awaited from the SG's review of staff governance standard monitoring arrangements and there is no requirement to prepare a SGAP for 2021/22.

The SGC workplan includes a mid-year and year end review of monitoring compliance with the Staff Governance Standards (SGS). At the September 2021 SGC meeting the Staff Governance Annual Monitoring Return on the application of SGSs was discussed and approved by the committee, with an update on the work underway to locally implement the SGSs provided by the Workforce Leadership team. Further updates on the SGSs are scheduled to be considered at the January and March 2022 SGC meetings to enable the committee to conclude on the implementation of the standards during 2021/22. To enable the SGC to fully ascertain the initiatives introduced during 2021/22 and provide a measure of their success in meeting the requirements of the SGSs, the assurances given at those meetings should give an equivalent level of detail to that previously provided by theStaff Governance Action Plan (SGAP), detailing the measures still to be introduced and the reasons for any delays in doing so.

Staff Experience

The SGC has received regular reports on staff health and wellbeing to highlight the impact of the Covid19 pandemic on staff and provide assurance on the action being taken to support staff. The September 2021 and October 2021 SGC meetings were provided with updates on the Joint Remobilisation Plan (RMP3/RMP4), which has workforce implications. As part of the continuous improvement process relating to staff experience, the results of the recently completed iMatters survey is in the process of being discussed by individual teams and management, with an update due to be given to the January 2022 SGC meeting.

Whistle Blowing

An update on the role of the whistle blowing champion was provided to the September 2021 SGC meeting, along with the a copy of the first quarter's Whistleblowing Quarterly Data Report for 2021/22 (April 2021 – June 2021). No instances of whistleblowing were reported during this period and the Committee discussed the potential reasons for this. The report for the second quarter (July 2021 to September 2021) and is being prepared and will be considered by the relevant fora, before presentation to the SGC. The current arrangements for returns to be considered by different groups is causing timescale issues and these arrangements will be reviewed after this cycle of reports has completed. A review of NHS Fife's whistleblowing arrangements is to be currently scheduled for the draft 2022/23 Annual Internal Audit Plan.

Remuneration Committee

In accordance with the 'Once for Scotland' approach the RC is now a full standing committee of NHS Fife Board. The Remuneration Comittee (RC) terms of reference are now formally reflected in the Code of Corporate Governance and as with other standing committees they will be standardised after the Once for Scotland team issue a new template.

Appraisals

The SGC was advised at its September 2021 meeting that all Executive and Senior Manager appraisals for 2019/20 and 2020/21 had been completed.

To reflect the impact of the Covid19 pandemic, the target for AfC appraisals was reduced from 80% to 55% and as at mid-November 2021, completed KSF/PDP appraisals stood at a 33%.

The Annual Report on Medical Consultant and GP appraisals for 2020/21 was presented to the SGC at its October 2021 meeting. It shows that although, as expected, the Covid19 pandemic did impact the number of appraisals that were completed; 94% of Medical Consultants and 99% of General Practitioners were either appraised or exempt from an appraisal. Apart from the impact of the

Covid19 pandemic, recruiting and retaining NES trained assessors is currently the greatest difficulty faced in completing appraisals, with the number of NHS Fife appraisers having to be supplemented by the use of bank appraisers.

Core Skills Training

Core Skills refers to those common training subject areas which organisations are required to deliver to their workforce, in order to meet either legal training requirements or to comply with key quality standards in accordance with organisational policy and regulatory requirements. The current overall completion rate for mandatory training is 70%. The Workforce Sustainability BAF recognises Core Skills Training as an area requiring improvement. An update on the completion of statutory/mandatory training for 2021/22 will be provided to the March 2022 SGC meeting.

Sickness Reporting

The rate most recently reported to the October 2021 SGC was 6.42% as at 30 September 2021 (5.69% at 30 September 2020,) with Covid19 contributing an additional 1.13% to absence levels, reflecting the trend for Scotland. The Health & Wellbeing Update report provides the committee with a detailed analysis of the causes of absenteeism, along with a summary of the actions being taken to reduce it and the other health and wellbeing initiatives being used. The Workforce Sustainability BAF also recognises sickness absence as an area for improvement and our Internal Audit recommendation in this area is currently outstanding due to the impact of Covid.

Action Point Reference 5 – Succession Planning	
Finding:	
Nationally, recruitment to senior posts have been difficult across NHS Scotland and this trend is likely to be exacerbated by workforce demographics and the impact of Covid. However, we could see no consideration of succession planning for NHS Fife within papers presented to the Staff Governance Committee or Remuneration Committee or in the risk registers.	
Audit Recommendation:	
The Staff Governance Committee and Remuneration Committee should be assured on succession planning arrangements within NHS Fife and of the potential risks associated with this area.	
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:	
NHS Fife is active in talent management and succession planning and has successfully appointed to all Senior posts over the 2021/22 period. Noting that the challenge to manage future turnover of senior staff is a sector wide issue, an overview paper on our talent management and succession planning arrangements will be outlined to Staff Governance Committee as part of our annual meeting cycle in 2022/23. If this became an issue for Executive Senior Managers then the matter would be considered by the Remuneration Committee. Workforce retention is recognised as risk on our current register and as part of our ongoing review of workforce risks, we will update actions and mitigations to specifically address work on succession planning.	
Action by:	**Date of expected completion:**
Director of Workforce	**October 2022**

Action Point Reference 6 – Staff Governance Standards

Finding:

The SGC will receive further updates on implementation of the staff governance standards at its January and March 2022 SGC meetings to enable it to conclude on the implementation of the standards during 2021/22. A review of the assurances provided to it so far during 2021/22 indicates that they have not provided the same level of detail or measurement criteria as the previously maintained SGAP did.

Audit Recommendation:

To enable the SGC to fully ascertain the SGS initiatives introduced during 2021/22 and provide a measure of their success in meeting the requirements of the SGSs, the assurances given at those meetings should give an equivalent level of assurance to that previous years, setting out actions and assurances still to be provided and the reasons for any delays.

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:

There have been three elements of review against the staff governance standards in 2021/22; Annual Reports from the Acute & Corporate Services and Health & Social Care Local Partnership Forum and the 2021/22 Staff Governance Monitoring return to Scottish Government which will be repeated for current activity during the 22/23 cycle. Additionally coverage of standards will be considered through the Staff Governance Committee review of the 2021/22 workplan and the proposals for the 2022/23 workplan at the January and March 2022 meetings respectively.

Action by:	Date of expected completion:
Director of Workforce	**March 2022**

FINANCIAL GOVERNANCE

BAF Risk:

Risk 1671 – Financial Sustainability – High Risk (16)

- There is a risk that the funding required to deliver the current and anticipated future service models, particularly in the context of the COVID 19 pandemic, will not match costs incurred.
- There is a risk that the organisation may not fully identify the level of savings required to achieve recurring financial balance.
- Thereafter there is a risk that failure to implement, monitor and review an effective financial planning, management and performance framework would result in the Board being unable to deliver on its required financial targets.

Risk 1672 – Environmental sustainability – High Risk (20)

There is a risk that Environmental & Sustainability legislation is breached which impacts negatively on the safety and health of patients, staff and the public and the organisation's reputation

Financial Planning 2021/22

The Financial Plan for 2021/22 was a key element of RMP3 which also serves as the Annual Operational Plan for 2021/22. Key financial and Covid assumptions were included as part of the overall financial plan. RMP4 which updates RMP3 and replaces the Annual Operational Plan for 2021/22 was considered by the NHSF Board on 28 September 2021 prior to submission to the SG on 30 September 2021.

In line with national guidance and reflecting difficulties in planning caused by Covid19, a one-year financial plan was provided instead of the intended medium term 3-year plan.

Strategic Planning and Resource Allocation

The Strategic Planning and Resource Allocation (SPRA) process was introduced during 2020/21 to support strategic, financial and organisational planning. It has evolved during 2021/22, learning from last year's iteration and will form the basis of a 3 year medium term financial plan.as well as informing and aligning with the development of the NHS Fife 5 year Population Health and Wellbeing Strategy.

Achievement of recurring savings needed for financial balance, will require both investment and disinvestment to support the delivery of the Population Health and Wellbeing Strategy and the SPRA process recognises the need to disinvest with the aim to further develop plans to achieve savings and efficiency opportunities.

The SPRA highlights the need to further develop the Project Management Office (PMO) to support service transformation and NHS Fife is investing in new posts in this department.

The SPRA process for 2022/23 has commenced with the EDG now reviewing returns, prior to a Board Development Session on 21 December 2021.

Budgetary Control

Each year all budget holders have to provide a signed statement as formal agreement and acceptance of the delegated budget. Budget holders have completed the annual financial 'grip and control' checklist which provides a continuing focus to identify savings opportunities and the way services are delivered due to Covid19.

This budget process provides a clear understanding to budget holders of their role and responsibilities for budgetary control.

Financial Reporting

Finance reporting to Board and FP&RC has been transparent with enhancements made to the IPQR in 2021/22. The content remains the same but the way information is presented has been enhanced. The Director of Finance has consistently and clearly articulated financial challenges and improvement actions. Specific challenges are:

- Achievement of savings;
- the financial impact of Covid in both the short and longer-term, and its impact on both service delivery and financial plans;
- Managing the underlying Acute Services core cost overspend;
- Recruiting to the Corporate PMO.

The Financial Sustainability BAF and the IPQR (Financial Performance) are not overtly linked, with the IPQR making no reference to the BAF. Key challenges are highlighted in the IPQR financial section; however there is no direct correlation to the current controls/gaps in control/mitigation actions within the BAF.

Savings

Savings targets were set out in the 2020/21 Financial Plan, as part of the RMP3. The 2021/22 financial plan reflects an overall savings target of £21.7m and assumes £8m is achievable in-year with £4m on a recurring basis and £4m on a nonrecurring basis. Discussions continue with Scottish Government in relation to supporting the remaining £13.7m this financial year.

For the latest reported figures to August 2021, recurring savings of £3.538m have been achieved, alongside £696k non-recurring. Achievement of financial balance for 2021/22 will be dependent on external funding and we note the ongoing work to identify potential recurring cost saving reduction schemes and programmes for both this year and the next 2 financial years.

Savings is an ongoing issue but with the evolving SPRA process and the development of the PMO capacity and capability, this will further support NHSF to achieve its longer term financial goals and drive service transformation.

BAF – Financial Sustainability – High Risk

The Financial Sustainability BAF, as reported to the FP&RC during 2021/22, recognises the ongoing financial challenges facing the Board, in particular Covid19 funding and savings gaps, which are being discussed with the SG.

The BAF has been developed in-year with the rationale and actions now clearer on the steps required to reduce the overall risk score. Clearer linkages to Strategy, PMO savings programme, and External Audit recommendations would further strengthen the BAF along with greater specificity around current controls.

The BAF has a mitigating action of “relentless pursuit of all opportunities identified through the transformation programme in the context of sustainability & value”; an area should be the subject of specific assurance in future.

Best Value

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

Other Areas covered by ICE Fieldwork

We also reviewed the following areas, none of which highlighted any issues of note:

- Standing Financial Instructions
- Standards of Business Conduct
- Anti-Fraud and Corruption Policy and Response Plan
- Financial Operating Procedures
- Control over the Acquisition, Use, Disposal and Safeguarding of Assets

Capital Plan and Property Strategy

Following updates on progress, the November 2021 FP&RC received the PAMS report for the year to 31 March 2021, which is good practice although not mandatory. The PAMs itself was largely retrospective but emphasised the need for a revised NHS Fife Property & Asset Management Strategy to support the development and deliver the objectives of the Health & Wellbeing Strategy.

The PAMS also reported changes to the governance of asset management. The appointment of the Director of Finance as the NHSF Asset Champion, charged with promoting and sustaining of good practice in Asset Management, reflects best practice.

We note the ambition for an NHS Fife PAMS Implementation Action Plan to be developed for 2021/22 which will include actions and outcomes. This Action Plan will be used by the Capital Groups to assess progress in achieving outcomes and objectives that reflect the PAMS requirements of NHS Fife.

Although risks to delivery of the Capital Plan are considered by the Fife Capital Investment Group, and the PAMS, which requires further development, will be essential to support the Health and Wellbeing Strategy, these risks are not recorded on the Risk Register and there is currently no BAF which focuses on Property and Capital.

The FP&RC receive regular updates on current major capital projects. The Elective Orthopaedic Project is on track and due for completion in October 2022with progress regularly reported to the FP&RC.

Environmental Reporting

A paper was presented to the September 2021 FP&RC detailing that NHS Fife is seeking to improve the energy efficiency of its buildings within the Estate, as part of the health sector's drive towards 'net zero carbon' with funding available from the SG as part of the Low Carbon Infrastructure Programme.

A Policy For NHS Scotland on the Climate Emergency and Sustainable Development - DL (2021) 38, was issued on 10 November 2021, with its requirements mandatory and with immediate effect. The DL requirements will almost certainly impact on all NHSF Board decision making.

Action Point Reference 7 – IPQR and Financial Sustainability BAF

Finding:

The Financial Sustainability BAF and the IPQR (Financial Performance) are not overtly linked, with the IPQR making no reference to the BAF. Key challenges are highlighted in the IPQR financial section; however there is no direct correlation to the current controls/gaps in control/mitigation actions within the BAF.

Clearer linkages to Strategy, PMO savings programme, and External Audit recommendations would further strengthen the BAF along with greater specificity around current controls.

Audit Recommendation:

Links between the Financial Sustainability BAF and IPQR should be clear and overtly linked so the controls/mitigations of the BAF provide assurance that challenges within the IPQR is being managed.

The financial sustainability BAF should be updated to include links to Strategy, PMO Savings Programme and relevant External audit recommendations.

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 improvement activity outlined in previous recommendations in relation to the BAF and Performance Management/IPQR will address a number of the points made in this finding. Additionally a Financial Improvement/Sustainability Programme was approved recently by the Portfolio Board which underpins the delivery of the new strategy for NHS Fife.

Action by:	Date of expected completion:
Director of Finance and Strategy	**31 March 2022**

Action Point Reference 8 – PAMs	
Finding:	
The PAMs and Capital Programme is a vital part of supporting the future Health and Wellbeing Strategy and delivering its prioritised outcomes. However there is currently no BAF risk or linked operational risk that covers the Capital Programme and Property Strategy.	
Audit Recommendation:	
The risks around delivery of the PAMs and capital programme would benefit from having a BAF or operational risk which would aid and support the delivery of the future Health and Wellbeing Strategy.	
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 Board is currently reviewing the BAF process and the approach to risk management more generally. There is a planned session of the Audit and Risk Committee and the NHS Fife Board in December to consider this which will include responding to the audit points noted above. Following this, an appropriate BAF or operational risk around delivery of the PAMs and capital programme will be developed which would aid and support the delivery of the future Health and Wellbeing Strategy	
Action by:	**Date of expected completion:**
Director of Property & Asset Management	**31 March 2022**

INFORMATION GOVERNANCE

Information Governance

BAF Risk:

Risk 1677 – Digital and Information – High Risk (15)

There is a risk that the organisation will fail to recognise and afford the financial investment necessary to deliver its D&I Strategy and current operational lifecycle commitment to enable transformation across Health and Social Care to deliver sustainable and integrated services that are safe, secure and compliant with governance frameworks and associated legislation.

Governance

The governance arrangements, including terms of reference and reporting lines, for Digital and Information were agreed at the beginning of 2021/22 with the Digital and Information Board (D&IB) and Information Governance and Security Steering Group (IG&SSG) identified as having responsibility for providing assurance to the Clinical Governance Committee (CGC) on Information Governance arrangements including assurance on delivery of the NHS Fife Digital and Information Strategy.

The CGC received an update from the IG&SSG in July 2021 regarding the assurance to be developed on key areas of Information Governance, including an activity tracker with target assurance measures. As the IG&SSG meeting scheduled for September 2021 was cancelled due to service pressures the CGC has not yet received a further assurance report from IG&SSG on progress.

The Information Governance and Security Steering Group (IG&SOG) has met twice in 2021/22 in October 2021 and November 2021 and now meets monthly. It has considered an Information Governance Assurance Dashboard which aims to provide assurance regarding the key areas of IG&S. We provided detailed comment on required improvements to the quality and scope of this assurance and the need for clarity regarding the reporting from this group to the IG&SSG and thence assurance reporting to CGC. Papers to the December IG&SSG show further improvement although there are still a number of areas to be resolved by year-end.

Assurance regarding the delivery of the NHS Fife Digital and Information Strategy has been provided to CGC in accordance with its 2021/22 workplan.

It is important that provision of regular assurances to the CGC on the key aspects of Information Governance are established to ensure that the CGC is in a position to conclude on the adequacy and effectiveness of these arrangements at year-end. This regular reporting should be scheduled in the CGC's workplan for the remainder of 2021/22 and in future year's workplans.

Risk Management

The processes for recording and managing risks related to Digital and Information continue to evolve and we were pleased to see that related risks are to be split so that the component parts of the risk and corresponding mitigations can be better understood. It is important that these processes are sufficient to provide CGC with assurance regarding these risks at year end on the accuracy of risk ratings, and the adequacy and effectiveness of key controls and actions. The impact of the pandemic on Digital and Information risks should be considered and specific assurance on this should be provided to CGC.

The Digital and Information BAF is regularly presented to the CGC, however as previously reported the minutes of its meetings do not record any discussion or assurance regarding whether mitigations, in place and planned, will be sufficient to reduce the risk to a tolerable level within an acceptable timescale.

The reporting on risk management to the Digital and Information Board is to change following the adoption of a new risk framework introducing new profiles and risk categorisation in line with ITIL standards.

The IG&SSG has not met since the publication of our annual report (B06/22). The risk report it received at its 1 June 2021 meeting advised that a full risk process and management review was underway with the support of Corporate and Clinical Governance teams, and we have been advised that this has been completed and a risk management report based on the new process is to be presented to the December 2021 IG&SSG.

Digital and Information Strategy

A report on the alignment of NHS Fife D&I Strategy key ambitions and deliverables to NHS Fife's overall strategy to CGC on 17 September 21 highlighted that prioritisation will required over the remaining term of the strategy through the SPRA process, as not all deliverables will be affordable.

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

Assurance provided regarding Information Governance Policies and Procedures since the publication of our annual report (B06/22) has been limited to a brief update provided to the Information Governance and Security Operational Group. This did not list the policies and procedures and their review dates (as historical assurances had done) but highlighted a risk regarding lack of resources for Information Governance and Security Policy Management.

The key Information Governance and Security policies, NHS Fife Information Security Policy [GP/I5] and NHS Fife Data Protection and Confidentiality Policy [GP/D3] both have lapsed review dates (01 November 2017 and 01 June 2021 respectively). It is imperative that these important policies are reviewed at the earliest opportunity. The review should specifically consider the impact of the pandemic and the increase in fraud risk and remote working implications.

Information Governance Incidents and Reporting

At this stage, we cannot be certain that that the CGC will receive appropriate and proportionate assurance on Information Governance Incidents. The assurance route for these needs to be clarified and streamlined and should, as a minimum, include the number of IG incidents reported to the Competent Authority, whether these were reported within the 72-hour deadline, feedback from the competent authority (No Further Action, Enforcement or Pending) and whether any of these should be considered for disclosure in the Board's Governance statement.

Action Point Reference 9 – IG&S Assurance Reporting to CGC

Finding:

The CGC has not received regular assurance reporting on the key aspects of IG&S in 2021/22 to date. Whilst it is accepted that this assurance was at the forming stage at the outset of 2021/22, and pandemic related service pressures have hindered progress, it is important that this regular reporting is established so that the CGC, in 2021/22 and future years, is in a position to conclude on the adequacy and effectiveness of Information Governance arrangements at year end.

Reporting to the IG&S Operational Group to date has not provided the necessary detail or quality of information to allow appropriate assurance reporting to the IG&S Steering Group and CGC.

Audit Recommendation:

Regular assurance reporting from the IG&SSG to CGC should be scheduled in the workplan of CGC for 2021/22 and future years.

This should include a regular Assurance Report as well as IG&SSG minutes.

The Assurance report should include clear, sufficient and reliable assurance on the key aspects of IG&S so that the CGC can conclude on the adequacy and effectiveness of Information Governance arrangements at year end.

Assessment of Risk:

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

Management Response/Action:

The Information Governance & Security (IG&S) assurance has been considered within the workplan of the CGC for 2021/22. An assurance report was presented to the July 2021 meeting of the committee with agreement that "a further report will come back to the Committee in due course." This additional report has been scheduled within the 2021/22 workplan for presentation in March 2022, in order to provide further assurance.

The minutes from the IG&S Steering group are consistently presented within the CGC's Linked Committee Minutes section of the agenda.

The provision of the next assurance report, linked committee minutes and annual report 2021/22 will allow the CGC to conclude on the adequacy and effectiveness of Information Governance arrangements.

Action by:	Date of expected completion:
Associate Director of Digital and Information	**28 April 2022**

Action Point Reference 10 – Information Governance and Security Policies

Finding:

The key Information Governance and Security policies, NHS Fife Information Security Policy [GP/I5] and NHS Fife Data Protection and Confidentiality Policy [GP/D3] both have lapsed review dates (01 November 2017 and 01 June 2021 respectively). Lack of resources for IG&S Policy Management was highlighted as a risk to the IG&S Operational Group (28 October 2021).

Audit Recommendation:

Assurance provided regarding Information Governance Policies and Procedures should be improved so that a list of all policies and procedures and their review dates is provided to the IG&S Operational Group and percentage compliance, regarding reviewed within scheduled review date, figures are reported to the IG&S Steering Group.

Progress towards mitigating the risk regarding lack of resources for Information Governance and Security Policy Management should also be reported to the IG&S Steering Group.

The NHS Fife Information Security Policy [GP/I5] and NHS Fife Data Protection and Confidentiality Policy [GP/D3] must be reviewed at the earliest opportunity. The review should specifically consider the impact of the pandemic and the increase in fraud risk and remote working implications.

Assessment of Risk:

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

Management Response/Action:

The revised list of policies and procedures was reviewed for all Digital and Information items. This work included the identification of all policies and procedures that were presented within NHS Fife, via Stafflink and publicly through the NHS Fife corporate website. Having identified multiple versions of policies and procedures in these two sources a revised process was introduced to identify a single source of truth for policies and procedures and appropriate tracking and remedial actions.

The revised Policy Review group reactivated their work and presented policy GP/I5 – Information Security to the Executive Director Group (EDG) on September 2021, following its review in February 2020. Given the 19 month delay in presenting the policy the Associate Director of Digital and Information requested that the policy be update to reflect the new management arrangements and change of name within the Digital and Information team.

The Information Security Policy (GP/I5) and the Data Protection & Confidentiality Policy (GP/D3) will be updated and presented to the Policy Review Group.

Action by:	Date of expected completion:

Associate Director of Digital & Information	**14 February 2022**

Action Point Reference 11 – Information Governance Incident Management

Finding:

The agenda of the IG&S Steering Group on 2 June 2021 did not include any reporting on IG related incidents. No further meetings of the IG&S Steering Group have taken place since the publication of our annual report (B06/22). The next meeting is scheduled for 1 Dec 21 and papers for this have just been distributed with the Activity Tracker report recording the latest data on reportable incidents.

The IG&SSG update report presented to CGC on 7 July 2021 did not include any reporting on IG&S incidents. At this stage, we cannot be certain that that the CGC will receive appropriate and proportionate assurance on Information Governance Incidents.

The process of assurance reporting to the IG&S Steering Group is still evolving and we cannot yet fully comment on the appropriateness of the differentiation in roles between this group and the IG&S Operational Group as the IG&S Operational Group only had its first meeting in October 2021.

Audit Recommendation:

The assurance route for reporting of assurances on Information Governance incidents needs to be clarified and streamlined to provide sufficient assurance to CGC. This should, as a minimum, include the number of IG incidents reported to the Competent Authority, whether these were reported within the 72-hour deadline, feedback from the competent authority (No Further Action, Enforcement or Pending) and whether any of these should be considered for disclosure in the Board's Governance statement.

Assessment of Risk:

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

Management Response/Action:

The most recent Activity Tracker and associated Quality Control Assurance Measures included a summary set of incidents, per month, for consideration at the December 2021 Information Governance and Security Steering Group. The summary provided, per month:-

- The number of incidents per category
- The number of total incidents
- The number escalated to SIRO
- The number reportable to the competed Authority
- The number by service area

The data items listed will be included as they are contained within the monthly SIRO report.

Action by:	Date of expected completion:
Associate Director of Digital and	**31 March 2022**

Information	

Action Point Reference 12 – D&I Risk Management

Finding:

The processes for recording and managing risks related to Digital and Information continue to evolve. The Digital and Information BAF is regularly presented to the CGC, however as previously reported the minutes of its meetings do not record any discussion or assurance regarding whether mitigations, in place and planned, would be sufficient to reduce the risk to a tolerable level within an acceptable timescale.

CGC has not been advised regarding whether the impact of the pandemic on Digital and Information risks has been considered.

Audit Recommendation:

It is important that the processes for recording and managing risks related to Digital and Information are sufficient to provide CGC with assurance regarding these risks at year end on the accuracy of risk ratings, and the adequacy and effectiveness of key controls and actions.

The impact of the pandemic on Digital and Information risks should be considered and specific assurance on this should be provided to CGC.

Assessment of Risk:

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

Management Response/Action:

A full risk review and revised risk management process has been implement. This review and process has been aligned to NHS Fife's Corporate Risk Management Framework and developing thinking in this area.

In addition presentational improvements have been developed to support groups and assurance committees understand the risks performance, and mitigations for high and emerging risk and impact on risk from these mitigations.

Action by:	Date of expected completion:
Associate Director of Digital and Information	**Complete – November 2021.**

Assessment of Risk

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

Risk Assessment		Definition	Total
Fundamental		Non Compliance with key controls or evidence of material loss or error. **Action is imperative to ensure that the objectives for the area under review are met.**	None
Significant		Weaknesses in control or design in some areas of established controls. **Requires action to avoid exposure to significant risks in achieving the objectives for area under review.**	Five
Merits attention		There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**	Seven

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**9 December 2021**
Title:	**Annual Accounts 2020/21– Progress Update on External Audit Annual Report Recommendations**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Report Author:	**Kevin Booth, Head of Financial Services**

1 Purpose

This is presented to the Audit & Risk Committee for:

- Approval

This report relates to a:

- Government policy/directive
- Legal requirement
- Local policy

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

- Effective

2 Report summary

2.1 Situation

This paper provides an update on progress against the recommendations from the External Audit Annual Report in the 2020/21 Accounts

2.2 Background

The table below sets out the recommendations and the latest position in terms of progress.

2020/21 recommendations

	Issue/risk	Recommendation	Agreed management action/timing
1	**Holiday pay accrual** The holiday pay accrual included in the financial statements is £5.2million. This is a significant increase of £3.7million on the prior year, due to COVID-19 and a change of methodology in how the accrual is estimated for Medical & Dental staff. **Risk –The process and coverage of staff still provides significant uncertainty in the estimate.**	NHS Fife should continue to develop the process used to calculate the accrual to ensure the medical and dental estimate is based on returns from a variety of services, reducing the risk that the estimate is subject to significant uncertainty. Exhibit 2	Agreed management action: NHS Fife will continue to develop the process as described in the recommendation. Responsible officer: Director of Finance and Strategy Agreed date: 31 March 2022
2	**Discounting of annual medical negligence payments** NHS Fife has correctly applied discount factors to calculate the provisions for ongoing medical negligence payments in accordance with annex c to PES (2020) 12. These estimates are subject to considerable uncertainty. The period over which they will be paid depends on individual life expectancy. However, we consider that the tables used to discount are flawed. **Risk –incorrect discounting understates the long term estimate.**	The duration of the annual cost commitment is subject to significant uncertainty and is reimbursed to NHS Fife via the CNORIS scheme. The application of discount factors to the ongoing payment should be reviewed by 31 March 2022. Exhibit 2	Agreed management action: NHS Fife will review the application of discount factors in relation to the CNORIS scheme. Responsible officer: Director of Finance and Strategy Agreed date: **31 March 2022**
3	**Recruitment of payroll staff** NHS Fife have been experiencing difficulties in recruiting payroll staff and some payroll officers are due to retire. Staff turnover (19.4%) has placed increased demands on staff. Risk: Increasing demand and payroll workforce issues will impact on the performance of payroll services.	**Recruitment issues in payroll services need to be addressed to prevent wider risks to service provision.** Paragraph 46.	Agreed management action: NHS Fife recognise the ongoing recruitment issues in relation to payroll services. The Board is working independently and also with the South East Region Payroll Consortium to explore options for both the short and medium term. Responsible officer: Director of Finance and Strategy Agreed date: 31 March 2022

4	**Savings for 2021/22 still need to be identified** The financial plan includes an in-year budget gap of £8.1million for 2021/22, and a total gap of £21.8 million. This includes unachieved legacy savings brought forward of £13.6 million. The plan includes the assumption that the full unachieved legacy savings brought forward will be funded by Scottish Government, however this has not yet been confirmed. Work is underway to develop recurring savings plans and so far NHS Fife has only identified £5 million savings on a recurring basis. Risk: NHS Fife is unable to deliver its budget for 2021/22 and beyond.	**NHS Fife needs to prepare contingency plans if the unachieved legacy gap is not to be funded by the Scottish Government.** Paragraph 57.	Agreed management action: NHS Fife is in discussion with the Scottish Government in relation to this matter. We are exploring all options to address this including requesting an acceleration of funding to support the current gap from NRAC parity. Responsible officer: Director of Finance and Strategy Agreed date: 31 March 2022
5	**Transformation** Fife's Transformation Programme was at an early stage when the Covid-19 pandemic began. The formal programme was paused in 2020 as the NHS responded to changing priorities directed by Scottish Government. NHS Fife plans to revisit the formal Transformation Programme as part of the new Strategic Planning and Resource Allocation (SPRA) process and the development of a new Health and Wellbeing Strategy for Fife (replacing the Clinical Strategy). **Risk: Delaying the transformation of services presents a risk to future financial sustainability and delivery of performance targets.**	**NHS Fife needs to ensure the transformation agenda is rebooted once priorities are no longer exclusively on responding to the Covid-19 pandemic.** Paragraph 60.	Agreed management action: NHS Fife have developed a range of improvement and change activity areas which will be aligned to the developing Population Health and Wellbeing Strategy and will deliver cash releasing savings and capacity increases over the medium term. The SPRA and PMO infrastructure will support, guide and report formally on this work. Responsible officer: Director of Finance and Strategy Agreed date: 31 March 2022

Follow-up of prior year recommendations

Issue/risk	Recommendation	Agreed management action/timing
4. Financial capacity and working papers 2019/20 AAR	Financial capacity issues should be addressed as a priority. Going forward, NHS Fife should ensure that the agreed timetable for presenting the unaudited annual report and accounts for audit is met, and that working papers are available and provided as required.	**Complete.**
5. Holiday pay accrual 2019/20 AAR	We recommend that a process is put in place to assist management in determining this estimate, which would make it less susceptible to bias.	**In progress** – superseded by Recommendation 1.
6. Savings for 2020/21 still need to be identified 2019/20 AAR	NHS Fife should ensure that detailed savings plans are developed identifying how the remaining £4.3 million of savings in 2019/20 will be made on a recurring basis.	**In progress** – refer to our 2020/21 Management Report. We found that NHS Fife continues to rely on non-recurring savings to deliver against their financial targets. This is linked to Recommendation 7.
7. Medium term financial plans **2019/20 AAR**	The new medium-term financial plan will need to consider the impact of COVID-19, which as well as affecting services, has had a significant impact on finances in 2019/20 and into 2020/21.	**In progress** – refer to our 2020/21 Management Report. We found that work is progressing on developing a Strategic Planning and Resource Allocation process which includes a medium-term financial plan but this is currently in its early stages. **Conclusion** - We recommended that NHS Fife should prioritise development of its medium-term financial plan to ensure savings are

Issue/risk	Recommendation	Agreed management action/timing
		identified, and a balanced budget is achievable on a recurring basis over the three-year planning and performance cycle.

2.3 Assessment

Good progress has been made in-year however a number of recommendations may require to be carried forward to 2021/22 to ensure completeness and that improvements are embedded. It should be noted that the recommendations carried over from the 2019/20 External Audit Annual Accounts recommendations are now all either completed or have been superseded by the 2020/21 recommendations.

2.3.1 Quality/ Patient Care

N/A

2.3.2 Workforce

Staffing Risks are covered in recommendation 3 relating to the Payroll Team capacity.

2.3.3 Financial

Financial risks are covered in recommendations 1,3 and 4.

2.3.4 Risk Assessment/Management

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

2.3.5 Equality and Diversity, including health inequalities

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

2.3.6 Other impact

N/A

2.3.7 Communication, involvement, engagement and consultation

The recommendations in the External Audit report are shared with the Finance Directorate and key members of staff across the team are involved in ensuring appropriate actions are undertaken.

2.3.8 Route to the Meeting

Progress on the 2020/21 External Audit Annual Accounts recommendations are regularly updated with the Director of Finance and Strategy.

2.4 Recommendation

The Committee is asked to note the progress made in this area and provide approval.

3 List of appendices

N/A

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

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**9 December 2021**
Title:	**Risk Management Key Performance Indicator (KPI) Report**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy and Dr Chris McKenna, Medical Director**
Report Author:	**Pauline Cumming, Risk Manager**

1 Purpose

This is presented to the Audit & Risk Committee for:

- Assurance

This report relates to a:

- Government policy/directive from Healthcare Improvement Scotland (HIS)
- Local framework and policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Audit and Risk Committee and by extension the Board, require assurance that risk management KPIs are in place and used to measure the organisation's success against a range of targets and objectives, to monitor progress and offer insights to inform decision making. This report provides an update on performance against the NHS Fife Risk Management KPIs since the last report to the Committee on 16 September 2021.

2.2 Background

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

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

2.3 Assessment

Appendix 1 provides an assessment of compliance against the KPIs. While some improvement is evident, there is scope for much more across each area of focus.

Additionally, the review of the KPIs will consider ways to improve the presentation of information.

The KPI framework and compliance going forward will be considered as part of the ongoing review of risk management across the organisation.

2.3.1 Quality/ Patient Care

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

2.3.2 Workforce

All staff require to have an awareness of risk management and to assess emerging risks, take action to mitigate or anticipate, and monitor and review progress to reduce or eliminate the risk. The Risk Manager with the support of Executive Directors, will continue to work with services to review and further develop effective risk management arrangements.

2.3.3 Financial

No issues identified.

2.3.4 Risk Assessment / Management

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

2.3.5 Equality and Diversity, including health inequalities

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

2.3.6 Other impact

None identified.

2.3.7 Communication, involvement, engagement and consultation

All KPI s were shared with the Director of Finance & Strategy and the Medical Director on 26 November 2021.

KPIs 1- 3 (Adverse Events) data will be discussed at the NHS Fife Adverse Events & Duty of Candour Group on 10 December 2021; the data will inform improvement actions and the ongoing review of the Adverse Events Policy and processes.

2.3.8 Route to the Meeting

EDG on 2 December 2021

2.4 Recommendation

This paper is presented for Assurance.

3 List of appendices

Appendix 1, Risk Management Key Performance Indicator Report to the Audit & Risk Committee, 09/12/21

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

Risk Management KPIs
Report to the Audit & Risk Committee on 9 December 2021

Report Criteria

Risks - KPI 1 to 3 - All Active Risks as at 24/11/2021
Risks - KPI 4 - BAF reports to Committees as at 24/11/2021
Adverse Events - KPI 5 - where event reported 01/11/2020 to 31/10/2021
Adverse Events - KPI 6a / 6b / 6c - where event closed 01/11/2020 to 31/10/2021
Adverse Events - KPI 7 - where event reported 01/04/2018 to 31/10/2021

KPI 1: All risks are within timescale for review

KPI	KPI Descriptor	Total number of active risks	Compliance		Target
			Number still within timeframe set for next review	%	%
1	All risks are within timescale for review	525 (537)	444	85 (70%)	100

1. **Note:** Improvement is noted in performance from that reported September 2021( ); while this is encouraging, continued action and support is required to sustain improvement. A review of the risk management arrangements in place across the organisation, and an assessment of education and support needs have commenced. As previously reported, the findings will form part of a detailed work plan going forward.

KPI 2: All risks must have a review date scheduled commensurate with the assessed risk level.

KPI	KPI Descriptor	Total number of active risks	Number of risks at each level		Number of risks with scheduled review date commensurate with level				Target
			Risk Level (Rating)	Number	Each Level		Overall		
					Number	%	Number	%	%
2	All risks must have a review date scheduled commensurate with the assessed risk level:* Very High: 25 at least monthly High: 15 - 20 at least quarterly Moderate: 8 -12 at least 6 monthly Low: 4 - 6 at least annually Very Low: 1 - 3 at least annually	525(537)	Very High (25)	2	0	0	301	57(49%)	100
			High (15-20)	83	52	63			
			Moderate (8-12)	333	183	55			
			Low (4-6)	98	66	67			
			Very Low (1-3)	9	0	0			
			No value	0	N/A				

2**. Note:** As per 1 above, there has been some improvement in performance from September 2021; as part of the previously mentioned review, interventions to support sustained improvement will be identified.

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

KPI	KPI Descriptor	Number of risks at each level: Risk Level (Rating)	Number of risks at each level: Number	Length of time risks have been open: Time period	Number	%	Initial risk level: Risk Level (Rating)	Number	%	Target %
3a	Length of time 'Very High' level risks have been at that level	Very High (25)	2	Number of risks open <= 1 year	1	50	Very High (25)	0	0	100
							High (15-20)	1	100	
							Moderate (8-12)	0	0	
							Low (4-6)	0	0	
							Very Low (1-3)	0	0	
				Number of risks open >1 year	1	50	Very High (25)	1	100	100
							High (15-20)	0	0	
							Moderate (8-12)	0	0	
							Low (4-6)	0	0	
							Very Low (1-3)	0	0	
3b	Length of time 'High' level risks have been at that level	High (15-20)	83	Number of risks open <= 1 year	39	47	Very High (25)	1	3	100
							High (15-20)	38	97	
							Moderate (8-12)	0	0	
							Low (4-6)	0	0	
							Very Low (1-3)	0	0	
				Number of risks open >1 year	44	53	Very High (25)	3	7	100
							High (15-20)	33	75	
							Moderate (8-12)	8	18	
							Low (4-6)	0	0	
							Very Low (1-3)	0	0	

3**. Note**: As previously reported, KPI 3 still requires to be reviewed as it is not a true KPI.

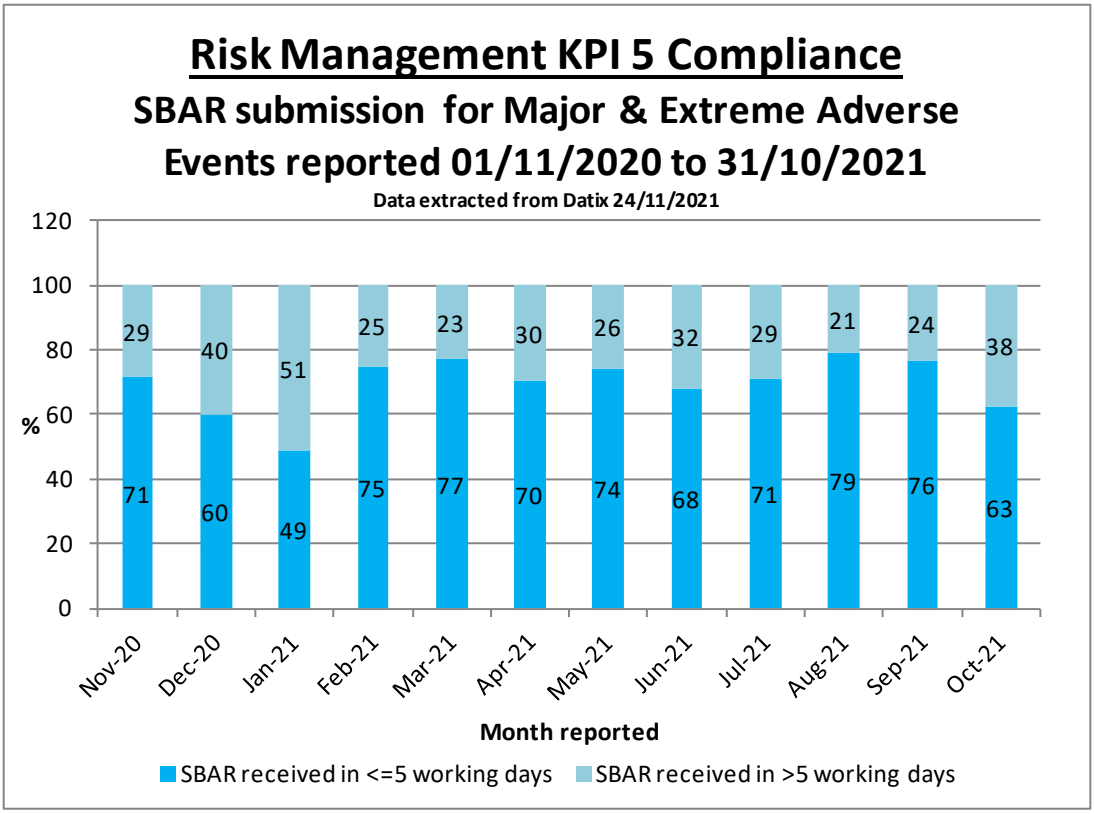
KPI 4: A Board Assurance Framework (BAF) report is required to be submitted bi monthly to the aligned governance committee.

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

Note:
* March 2021 meetings took place but no BAFs were included on the agenda's

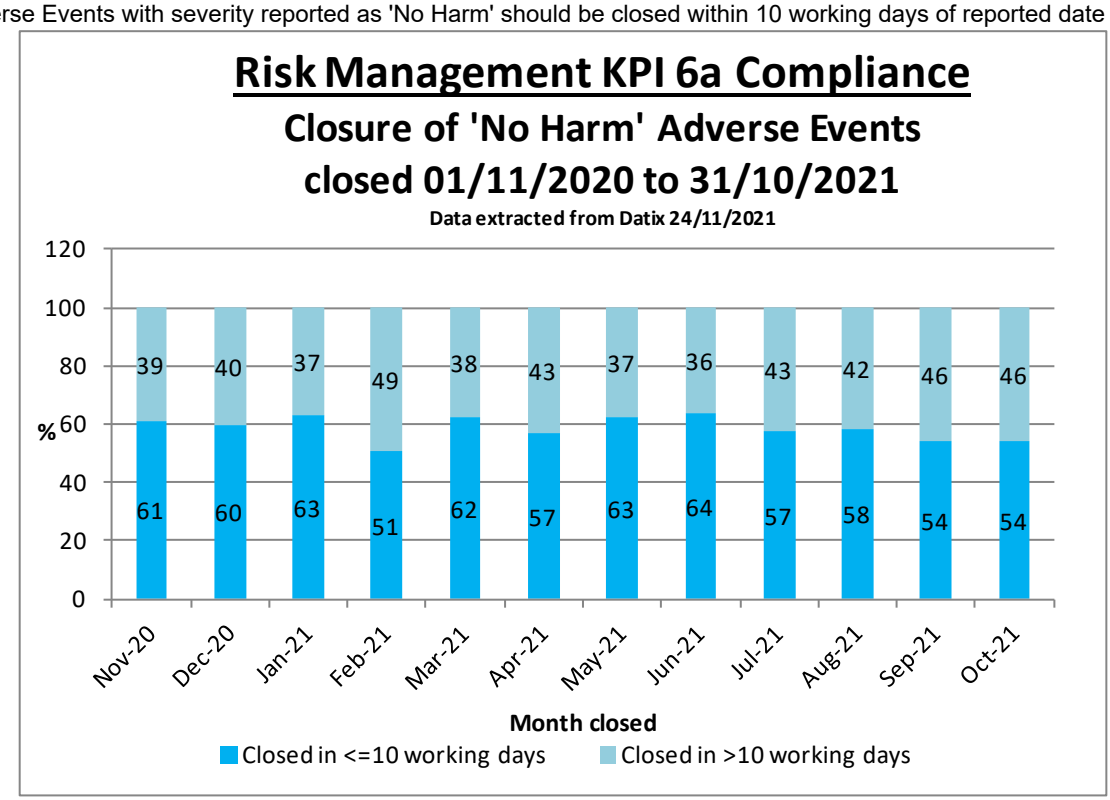
4. **Note:** Since the last report to the Committee, there has been 100% compliance. .

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

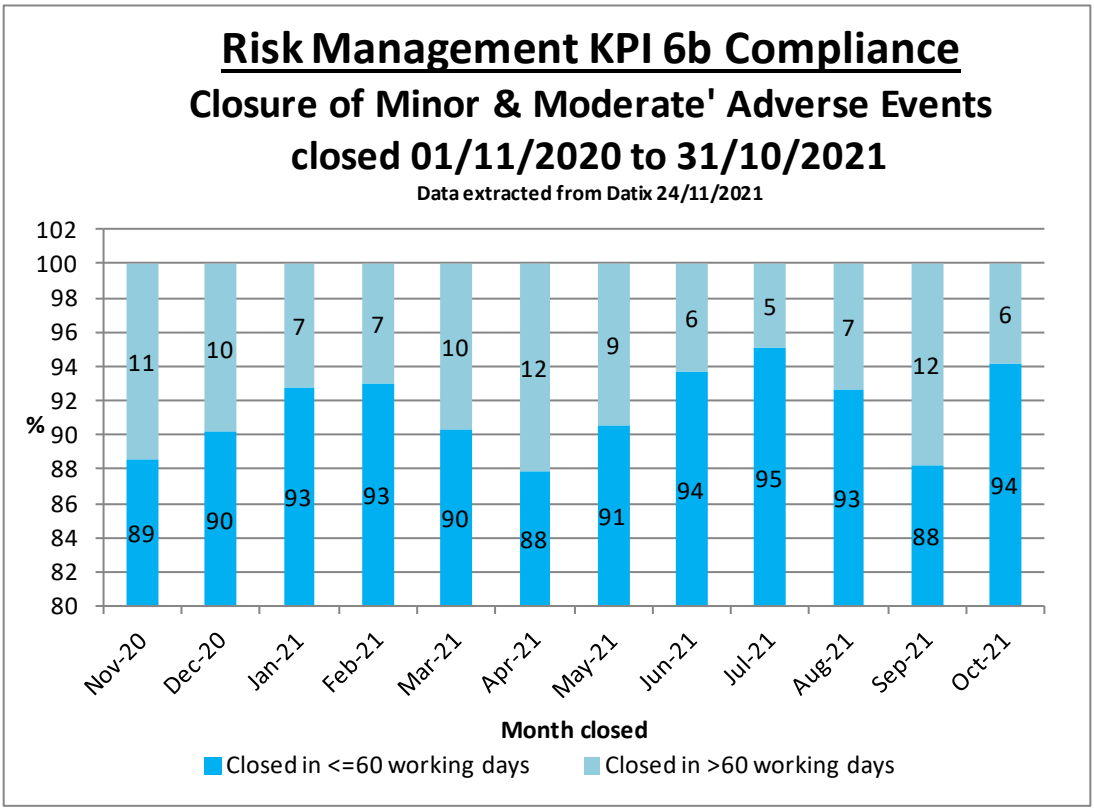


5. **Note:** There is nothing remarkable to highlight in the above data. Specific reasons for sub optimal performance have not been investigated but are likely to be attributable in part to activity and workload. The NHS Fife Adverse Events & Duty of Candour Group continues to monitor compliance at an organisational level. . The Adverse Events KPIs will be reviewed as part of the Adverse Events process review which is currently underway.

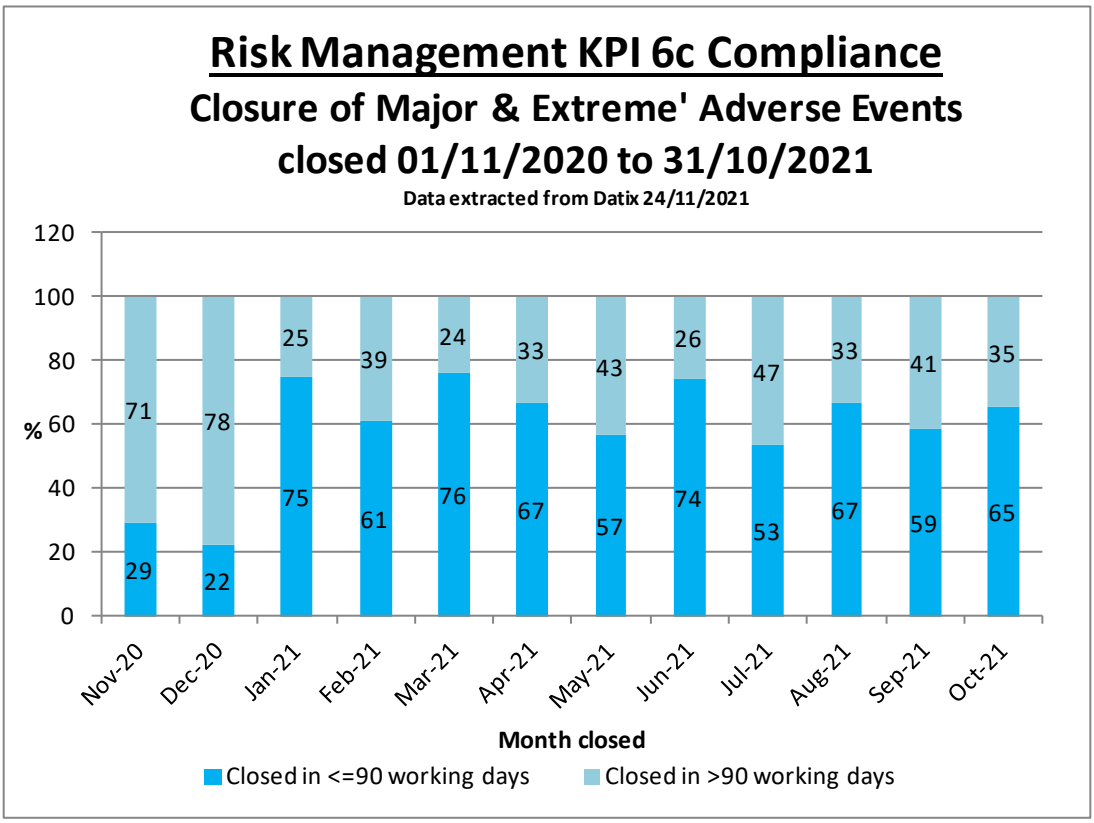
KPI 6a: Adverse Events with severity reported as 'No Harm' should be closed within 10 working days of reported date



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

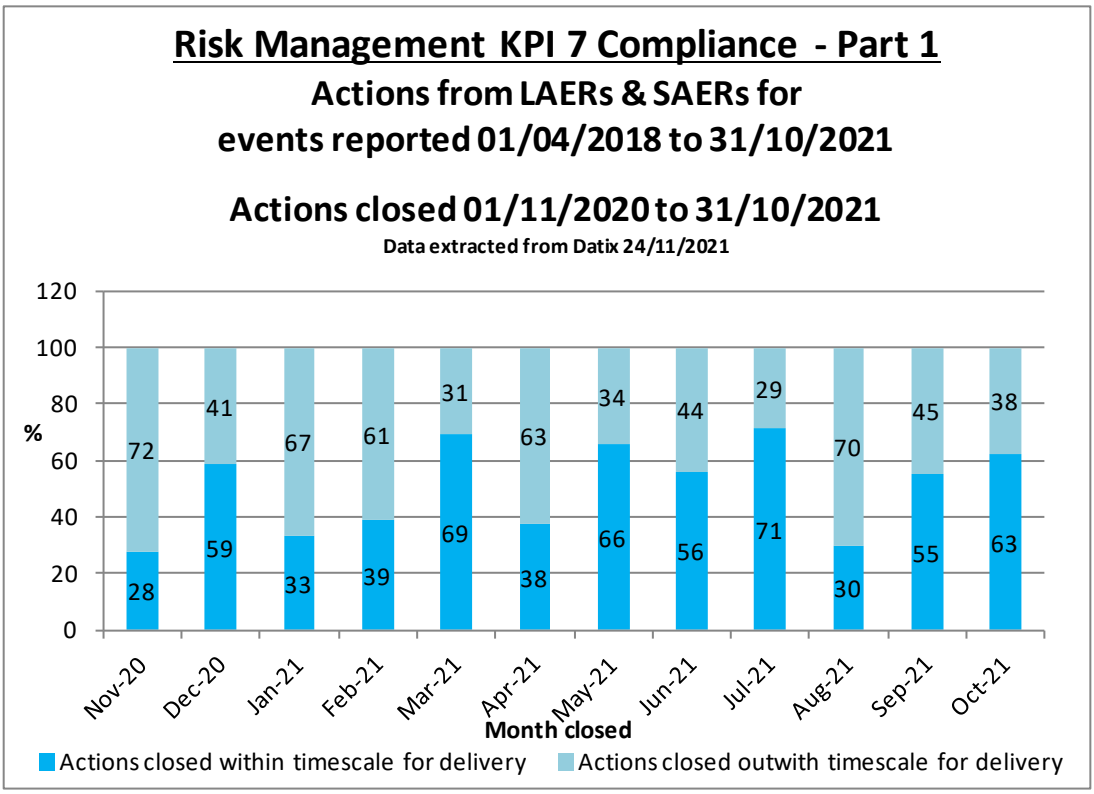


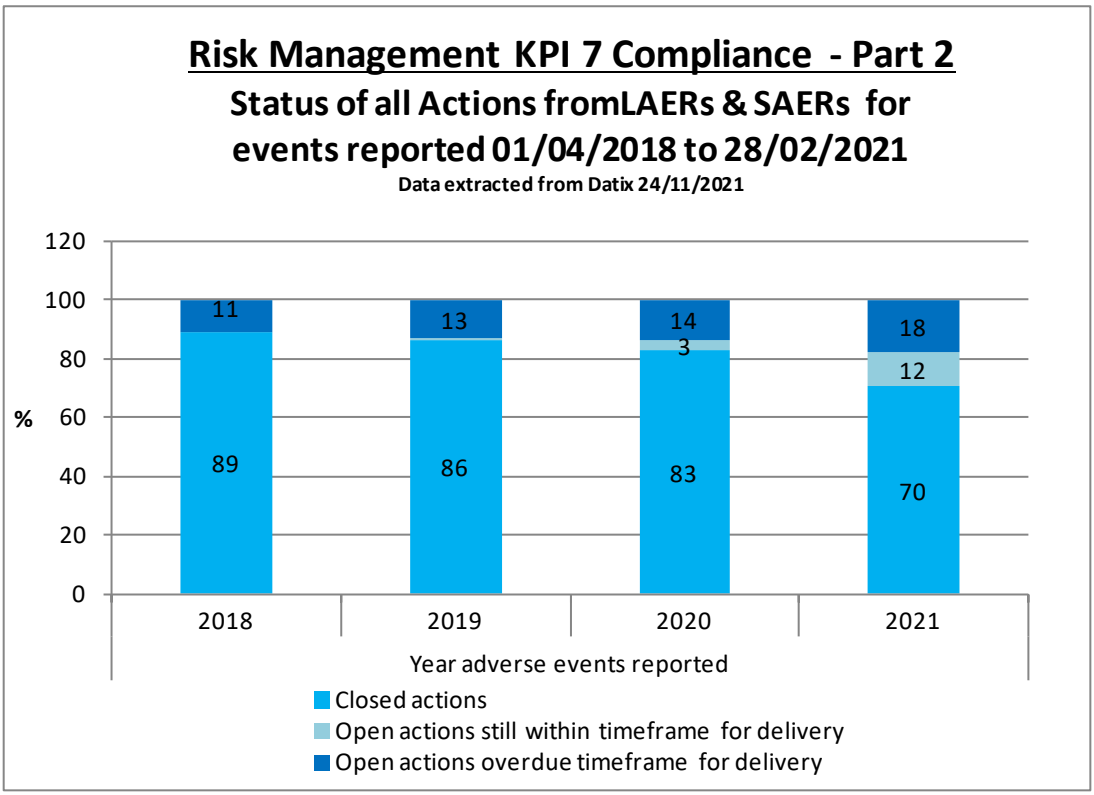
KPI 6c: Adverse Events with severity reported as 'Major' or 'Extreme' should be closed within 90 working days of commissioned date



6a, 6b & 6c **Note:** Across the organisation, there is a well established understanding that all adverse events require timely reviews, action completion and closure, in accordance with local policy and the national framework. Oversight and monitoring of performance continues at operational and divisional levels. The Adverse Events & Duty of Candour Group provide organisational oversight.

KPI 7: Actions resulting from LAER and SAER reviews should be completed by target date (LAER & SAER review requirements set out in Policy GP/I9 from 01/04/18)





7. **Note:** As above, the NHS Fife Adverse Events & Duty of Candour Group receive and review reports on performance against these indicators. The KPIs will be considered as part of the Adverse Events process review. As previously reported, a highlight report is being developed for services which will provide them with clearer oversight of what is happening within their departments.

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**9 December 2021**
Title:	**Board Assurance Framework (BAF)**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Report Author:	**Pauline Cumming, Risk Manager**

1 Purpose

This is presented to the Audit & Risk Committee for:

- Assurance

This report relates to a:

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

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Board Assurance Framework (BAF) identifies risks to the delivery of NHS Fife's strategic objectives and priorities, including the NHS Fife Strategic Framework, the NHS Fife Clinical Strategy and the Fife Health & Social Care Integration Strategic Plan. The BAF integrates information on strategic risks, related operational risks, controls, assurances, mitigating actions and an assessment of current performance. This is an update to the Committee since the last report on 16 September 2021. It reflects the content of the BAF components reported through the October and November governance committee cycle. An earlier version of this paper has been reported to the Board on 30 November 2021.

2.2 Background

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

2.3 Assessment

Since the last report to the Committee, there has been a focus on reviewing the effectiveness of our existing Board risk management arrangements, including the processes for providing assurance through our governance framework. The Board will consider this at the Development Session in December 2021.

This session will build on the ongoing review of risk management at EDG and will provide the opportunity to examine the baseline of the BAF and consider if the current BAF model fulfils the Board's requirements in terms of active governance of risk, or if other approaches should be considered. One specific area of improvement focus will be how to overtly connect risk assessment and reporting to the delivery of our strategic objectives and our operational performance management.

The BAF currently has 7 components.

- Financial Sustainability
- Environmental Sustainability
- Workforce Sustainability
- Quality & Safety
- Strategic Planning
- Integration Joint Board (IJB)
- Digital and Information

The risk levels and ratings are summarised in Table 1.

Table 1 - Risk Level and Rating over time

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

Since the last report to the Committee, the BAF risks have been reviewed and considered as part of the July, September, and October/ November 2021 committee cycles. This update summarises the key points from the most recent reports to the committees. The BAFs are provided separately in appendices.

Financial Sustainability BAF
The Deputy Director of Finance & Strategy reported on the above to the Finance, Performance & Resources (FP&R) Committee on 9 November 2021.

The Scottish Government has confirmed no funding will be allocated to support the under achievement of legacy savings.

However, in-year support will be provided to deliver break-even on a non-repayable basis subject to the continuing development of savings plans to reduce the request for support as much possible. Moreover, Scottish Government have requested the board develop savings plans which will reflect 50% of the 2022-23 funding gap by the end of quarter 3 of this financial year. Given this clarity on funding has been confirmed, the BAF risk will reduce to moderate in the next iteration. The focus is on delivering the agreed in-year saving and working through the SPRA process to agree the medium-term plan to address delivery of the legacy savings.

Environmental Sustainability BAF
The Director of Property & Asset Management reported on the above to the FP& R Committee on 9 November 2021, providing assurance on risks linked to the BAF and the following updates.

Of note, he advised the committee, that following a review of the extensive mitigations undertaken, a risk relating to fire evacuation from the Phase 2 Tower Block had reduced from High 20 to High 15. Moving forward, theatres and inpatient wards for orthopaedics will be located in the new Fife Orthopaedic Elective Centre building that is currently under construction. This will be completed by October 2022. Once the Centre is operational, there will be no inpatients remaining within the tower block, which will significantly reduce this risk.

There were no other substantive changes to this component of the BAF.

Workforce Sustainability BAF
The Director of Workforce reported on the above to the Staff Governance (SG) Committee on 28 October 2021 and provided the following updates.

Of note, the Committee had previously requested the BAF risk description be revised to more accurately reflect the current position of workforce planning and resourcing, the development of the Workforce Plan for 2022 to 2025, which will be aligned to the new NHS Fife Population Health & Wellbeing Strategy and associated changes, together with the on-going managerial and service activity to mitigate current workforce challenges.

Existing wording:

“There is a risk that failure to ensure the right composition of workforce, with the right skills and competencies deployed in the right place at the right time will adversely affect the provision of services and quality patient care and impact on organisational capability to implement the new clinical and care models and service delivery set out in the Clinical Strategy.”

Proposed wording:

“There is a risk that failure to ensure the right composition of workforce, with the right skills and competencies will adversely affect the provision of services and quality patient care and impact on organisational capability to implement the new clinical and care models and service delivery set out in the Clinical Strategy and the future Population Health & Wellbeing Strategy and the challenges and demands associated with the current COVID-19 pandemic.”

The committee approved the proposed rewording.

The Director of Workforce also reported that a full review of workforce risks had been undertaken, feedback was being provided to risk owners and the respective services requested to update their risk registers in Datix.

Of note, she advised that a risk relating to medical staff recruitment and retention in Cameron & Glenrothes community hospitals had reduced from High to Moderate following the appointment of Clinical Development Fellows to cover the hospitals.

She also reported that following discussion at a previous committee, a new risk relating to Nursing and Midwifery staffing levels had been raised. Similar to other NHS Boards, NHS Fife is experiencing critical nursing and midwifery shortfalls due to high levels of vacancies, sickness absence and activity related to consequences of the pandemic. There is a continuing heavy demand on supplementary staffing and consequential concerns about the impact on quality of care.

The risk is assessed as High 20. A range of mitigations are in place.

Discussion took place on this risk, particularly around the determination of criticality, terminology around staffing levels and linkages to the Board’s RAG status. It was noted that the word ‘critical’ is used to highlight the position of nurse staffing levels which are currently reported as “red with a black circle”. This was noted to be subjective and challenging, as there is no formula in use to objectively describe staffing levels. There was also discussion on the criteria that would trigger a shift to ‘black’. The Chief Executive advised that EDG Gold Command review the RAG status. A Black RAG position would apply when all avenues of support have been exhausted. While we are maintaining our elective programme, a Code Black for workforce would not be declared. The committee was assured that decisions to move staff are taken on a daily, shift by shift and hour by hour basis, through Hubs and Control Teams, to ensure areas are as safe as they possible.

There were no other substantive changes to this component of the BAF.

Quality & Safety BAF
The Medical Director provided an update on the above to the Clinical Governance Committee (CGC) on 3 November 2021.

He reported on progress to revise the BAF risk description to more accurately capture the principles essential to providing assurance that safe, quality and effective care is being delivered, to reflect risks associated with the impact of the pandemic, and to ensure that its future development aligns with the evolving Population Health & Wellbeing Strategy.

Existing wording:

"There is a risk that due to failure of clinical governance, performance and management systems (including information & information systems), NHS Fife may be unable to provide safe, effective, person centred care".

Proposed wording:

Four options were considered. The committee agreed that an adapted version of the following wording would be the preferred option.

"There is a risk that due to failure of clinical governance, performance and management systems (including information & information systems), NHS Fife may be unable to provide safe, effective, person centred care". In particular, in the current context, there is a risk that the effects of the COVID - 19 pandemic, including reduced elective & non essential services, clinical prioritisation, patients' ability/ willingness to attend for consultation / treatment, restricted capacity due to enhanced infection control measures, and workforce pressures, will impact on the quality & safety of patient care and service delivery resulting in: Short - Medium term: backlog of demand, patients waiting beyond national timescales for appointments, increased mortality & morbidity due to delayed diagnosis & treatment, including deterioration in long term conditions, later presentations of health problems and increased treatment needs" .

The Medical Director also summarised work that had been undertaken in recent months to review risks linked to quality and safety. This has resulted in several risks being closed or risk levels reduced. It has also informed further work required to refresh the BAF which includes:

- updating all components to align with the proposed new description
- strengthening content on assurances
- identifying risks including those from the SPRA and the RMP 4, for linking to this BAF

There were no other substantive changes to this component of the BAF.

Strategic Planning BAF
The Director of Finance & Strategy provided an update on the above to the CGC on 3 November 2021.

She advised that a review had recently been carried out which highlighted similar issues with the risk description as in the Quality & Safety BAF, and that work would be undertaken to revise the description to more accurately reflect the current risk.

She reported activity was underway to mitigate the risk and a range of actions over the coming six months should move the risk score towards moderate or low. It was recognised that risks in relation to governance of and project management capacity for the Population Health & Wellbeing Strategy development, require to be fully scoped out and captured as necessary. A Portfolio Board to support the development and delivery of the Strategy, has recently been established and should mitigate such risks; its first meeting was scheduled for 4 November 2021.

Consideration will be given to adding a risk relating to the need to ensure strategy delivery is aligned to recognised priorities for the population of Fife.

It was confirmed that existing 'strategies' will become strategic frameworks; these will underpin and support the overarching Population Health & Wellbeing Strategy.

The Associate Director of Planning & Performance provided an update on this component of the BAF to the FP&R Committee on 9 November 2021.

She advised that as part of the ongoing development of the Population Health & Wellbeing Strategy, a Community Conversation/Survey will be considered for approval at the November Board meeting. She reported work is also underway to review the outcomes and delivery of the existing Clinical Strategy.

Digital and Information BAF

The Associate Director of Digital & Information provided an update on the above to the CGC on 3 November 2021.

He advised this BAF highlights the financial implications and delivery of the Digital & Information (D&I) Strategic Framework.

He reported that following the completion of the Internal Audit report, B23/21 (Information Technology Infrastructure Library (ITIL) Processes), a new D&I risk has been raised. The risk is that the lack of governance and procedures aligned to the maintenance of ITIL standards will result in increased periods of system unavailability and adverse impact to clinical and corporate functions in NHS Fife.

Due to the scale and complexity of an ITIL framework implementation, the risk has been assessed as high. By mitigating this risk, there is an opportunity to develop operational processes focused on service and value, and further support the Digital Strategy (2019 - 2024) delivery.

Assurance was provided on the delivery of the strategy, which was discussed at the previous committee and is also on the committee's work plan as a regular update item.

In terms of financial priorities, it was noted that there are areas which are desirable, if subject to securing funding, and areas which are essential to support the D&I Strategy.

He reported that the ongoing review of risks related to D&I has resulted in several risks being closed or risk levels reduced.

The BAF current risk level remains at High, with the target score remaining Moderate.

Integration Joint Board (IJB) BAF
The Director of Health and Social Care provides the following update to the Committee.

The partner bodies, NHS Fife and Fife Council, developed the Fife IJB Integration Scheme in 2015 and it received Scottish Ministers' approval in October of that year.

The Integration Scheme was reviewed in March 2018 to reflect the implementation of the Carers (Scotland) Act 2016 as required by SG.

All Integration Schemes are scheduled to be reviewed every five years, however, SG allowed additional time for the review to take cognisance of the disruption caused by the COVID -19 pandemic.

The review of the Fife Integration Scheme concluded through NHS Fife and Fife Council governance structures in September 2021. Thereafter it was submitted to SG for approval. This is anticipated towards the end of the year. Until the revised scheme is approved the current Scheme will remain in place.

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

This risk will be reviewed following receipt of ministerial approval. The risk remains moderate.

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

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2.3.1 Quality/ Patient Care

Risks to quality and safety are detailed in Appendix 4.

2.3.2 Workforce

Risks to workforce sustainability are detailed in Appendix 3.

2.3.3 Financial

Risks to financial sustainability are detailed in Appendix 1.

2.3.4 Risk Assessment/Management

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

2.3.5 Equality and Diversity, including health inequalities

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

2.3.6 Other impact

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

2.3.7 Communication, involvement, engagement and consultation

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

2.3.8 Route to the Meeting

Via Margo McGurk, Director of Finance and Strategy on 26 November 2021

2.4 Recommendation

The paper is presented for members' information.

3 List of appendices

The following appendices are included with this report:

- Appendix 1, NHS Fife BAF Financial Sustainability - FP& RC 091121
- Appendix 2, NHS Fife BAF Environmental Sustainability - FP& RC 091121
- Appendix 3, NHS Fife BAF Workforce Sustainability - SGC281021
- Appendix 4, NHS Fife BAF Quality & Safety - CGC 031121
- Appendix 5, NHS Fife BAF Strategic Planning - CGC 031121& FP&RC 091121
- Appendix 6, NHS Fife BAF Integration Joint Board (IJB) at 161121
- Appendix 7, NHS Fife BAF Digital and Information - CGC 031121

Report Contact
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NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Financial Sustainability																											
1671	Sustainable	16/09/2021	31 October 2021	There is a risk that the funding required to deliver the current and anticipated future service models, particularly in the context of the COVID 19 pandemic, will not match costs incurred. There is a risk that the organisation may not fully identify the level of savings required to achieve recurring financial balance. Thereafter there is a risk that failure to implement, monitor and review an effective financial planning, management and performance framework would result in the Board being unable to deliver on its required financial targets.	4 – Likely – Strong possibility this could occur	4 – Major	16	High Risk	4 – Likely – Strong possibility this could occur	4 – Major	16	High Risk	2021/22 Covid-19 funding will be assessed post formal Quarter 1 review of Boards' financial performance. Hence this uncertainty impacts the risk rating and moves it to high risk.	Margo McGurk Director of Finance	Finance, Performance & Resources (F,P&R) Rona Laing	*Ongoing actions designed to mitigate the risk including:* We await the outcome of our formal Q1 review meeting held with SG colleagues on 6 September 2021. SG has indicated that: Covid-19 funding; treatment of offsetting cost reductions; and any potential funding of 'long covid' unachieved efficiency savings will be considered following a formal Quarter 1 review of Boards' financial performance. The financial gap for 21/22 is £21.7m. We have plans in place to deliver £8m on a recurring basis; and whilst we continue to develop further plans, we have signalled to SG the requirement for support for our long Covid unachieved savings of £13.8m. To that end, SG support for our financial gap is at this point uncertain and our BAF risk reverts to high risk rating level.	Nil	1. Continue a relentless pursuit of all opportunities identified through the transformation programme in the context of sustainability & value. Responsible Person: Director of Finance / Director of Acute Services / Director of Health & Social Care Timescale: Ongoing 2. Continue to maintain an active overview of national funding streams to ensure all NHS Fife receives a share of all possible allocations. 3. Continue to scrutinise and review any potential financial flexibility. 4. Engage with H&SC / Council colleagues on the risk share methodology and in particular ensure that EDG, FP&R and the Board are appropriately advised on the options available to manage any overspend within the IJB prior to the application of the risk share arrangement Responsible Person: Director of Finance Timescale: Ongoing	1. Produce monthly reports capturing and monitoring progress against financial targets and efficiency savings for scrutiny by all responsible managers and those charged with governance and delivery. 2. Undertake regular monitoring of expenditure levels through managers, Executive Directors' Group (EDG), Finance, Performance & Resources (F,P&R) Committee and Board. As this will be done in parallel with the wider Integrated Performance Reporting approach, this will take cognisance of activity and operational performance against the financial performance.	1. Internal audit reviews on controls and process; including Departmental reviews. 2. External audit review of year end accounts and governance framework.	1. Enhanced reporting on various metrics in relation to supplementary staffing. 2. Confirmation via the Director of Health & Social Care on the the social care forecasts and the likely outturn at year end.	Whilst full Covid-19 funding was received for 2020/21 and we delivered a small underspend £0.340m subject to external audit review; funding for 2021/22 will be determined post formal quarter 1 review of Boards' financial performance.	3 – Possible – May occur occasionally – reasonable chance	4 – Major	12	Moderate Risk	Financial risks will always be prevalent within the NHS / public sector however it would be reasonable to aim for a position where these risks can be mitigated to an extent.

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
1513	Financial and Economic impact of Brexit	Active Risk	High Risk	20	McGurk, Margo
522	Prescribing and Medicines Management - Prescribing Budget	Active Risk	High Risk	15	McKenna, Christopher

Previously Linked Operational Risk(s)

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

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Environmental Sustainability																											
1672	Clinically Excellent, Sustainable	15/09/2021	12 November 2021	There is a risk that Environmental & Sustainability legislation is breached which impacts negatively on the safety and health of patients, staff and the public and the organisation's reputation.	4 – Likely – Strong possibility this could occur	5 - Extreme	20	High Risk	4 – Likely – Strong possibility this could occur	5 - Extreme	20	High Risk	Estates currently have significant high risks on the E&F risk register; until these have been eradicated this risk will remain. Action plans have been prepared and assuming capital is available these will be reduced in the near future.	Neil McCormick Director of Property & Asset Management	Finance, Performance & Resources (F,P&R). Rona Laing.	*Ongoing actions designed to mitigate the risk including:* 1. Operational Planned Preventative Maintenance (PPM) systems in place 2. Systems in place to comply with NHS Estates 3. Action plans have been prepared for the risks on the estates & facilities risk register. These are reviewed and updated at the monthly risk management meetings. The highest risks are prioritised and allocated the appropriate capital funding. 4. The SCART (Statutory Compliance Audit & Risk Tool) and EAMS (Estates Asset Management System) systems record and track estates & facilities compliance. 5. Sustainability Group manages environmental issues and Carbon Reduction Commitment(CRC) process is audited annually. 6. Externally appointed Authorising Engineers carry out audits for all of the major services i.e. water safety, electrical systems, pressure systems, decontamination and so on.	Nil	1. Capital funding is allocated depending on the E&F risks rating Responsible person: Director of Estates, Facilities & Capital Services Timescale: Ongoing as limited funding available 2. Increase number of site audits Responsible person: Estates Compliance Manager Timescale: Ongoing	1. Capital Investment delivered in line with budgets 2. Sustainability Group minutes. 3. Estates & Facilities risk registers. 4. SCART & EAMS. 5. Adverse Event reports.	1. Internal audits 2. External audits by Authorising Engineers 3. Peer reviews.	None.	High risks still exist until remedial works have been undertaken, but action plans and processes are in place to mitigate these risks.	1 – Remote – Can't believe this event would happen	5 - Extreme	5	Low Risk	All estates & facilities risk can be eradicated with the appropriate resources but there will always be a potential for failure i.e. component failure or human error hence the target figure of 5.

Linked Operational Risk(s)

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

Previously Linked Operational Risk(s)

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

1352	Pinpoint malfunction	Closed Risk	High Risk	16	Pirie, Margaret
1384	Microbiologist Vacancy	Closed Risk	High Risk	20	JGARDN
1473	Stratheden Hospital Fire Alarm System	Closed Risk	High Risk	20	Keatings, Gordon

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Workforce Sustainability																											
1673	Exemplar Employer	01/10/2021	12 November 2021	There is a risk that failure to ensure the right composition of workforce, with the right skills and competencies will adversely affect the provision of services and quality patient care and impact on organisational capability to implement the new clinical and care models and service delivery set out in the Clinical Strategy and the future population Health & Wellbeing Strategy and the challenges and demands associated with the current COVID-19 pandemic.	Almost certain	Major	20	High Risk	Likely	Major	16	High Risk	Workforce failures may have consequences for patients' health outcomes. NHS Fife has an ageing workforce, with recruitment challenges in many disciplines. Failure to ensure the right composition of workforce with the right skills and competencies continues to give rise to a number of organisational risks including: reputational and financial risk; a potential adverse impact on the safety and quality of care provision; staff engagement, staff absence, staff attrition and morale. Failure may also adversely impact on the implementation of the current Clinical Strategy and the future NHS Fife Population Health & Wellbeing Strategy. The current scores reflect the existing controls and mitigating actions in place.	Linda Douglas Director of Workforce	Sinead Braiden Staff Governance	*Ongoing actions designed to mitigate the risk including:* WORKFORCE – GENERAL • Implementation of the Workforce Strategy to support the Clinical Strategy and Strategic Framework; development of Workforce Strategy and Workforce Plans for 2022 to 2025. • Implementation of the Health & Social Care Workforce Strategy to support the Health & Social Care Strategic Plan for 2019 to 2022, the integration agenda and the development of the H&SCP Workforce Strategy and Workforce Plan for 2022 to 2025. • Implementation of the NHS Fife Board Strategic Objectives, particularly the "exemplar employer / employer of choice" and the associated values and behaviours. • Implementation of the NHS Fife / H&SCP Joint Interim Workforce Plan for 2021/2022. WORKFORCE CAPACITY • Current resourcing actions include: active local and international recruitment campaigns and expansion of bank and supplementary staffing resources, including recrutiment of newly qualified nurse practitioners in all disciplines, Band 4 pre-registered nurses, additional Band 2 bank HCSWs, fast track process to support appointable candidates being appointed to other vacancies and admin support roles as part of a commitment to support Senior Charge Nurses and nursing teams. • Planning and delivery of actions undertaken by respective COVID-19 and Workforce Groups at various levels, including inter alia local workforce groups, workstreams associated with new programmes of work, for example, Community Treatment and Care, Vaccination and Implementation of the General Medical Services contract. • Planning to meet future service needs, applying workforce planning forecasting skills in support of service delivery, using the workforce modelling and abstraction techniques learned during the pandemic and managing staff availability to respond to escalation requirements. • Supporting service delivery through implementation and integration of systems and joint working with services. WORKFORCE CAPABILITY • eLearning and training offers aligned to current work modes • Continuation of fast track induction and related activity, including new welcome and orientation package. • Implementation of Practice Development initiatives to support changes in service delivery and preparation for further escalation requirements, for example training for non-clinical staff to support clinical service delivery. • Ensuring managers and staff are prepared for the implementation of and compliance with the Health & Care (Staffing) (Scotland) legislation within the clinical workforce. • Develop and deliver Phase 1 of the framework to improve leadership capability and embed talent management and succession planning. • To prioritise staff personal / professional development needs that have been delayed or restricted due to COVID-19 response as restrictions are eased, through Directorate development delivery plans. • To progress actions in support of the employability agenda. WORKFORCE ENGAGEMENT • Working in partnership with staff side and professional organisations across all sectors of NHS Fife to ensure staff engagement opportunities are maximised. • iMatter – supporting action planning and Board actions arising from the 2021 cycle of feedback and reporting. • Supporting staff through changes in ways of working and providing access to new and different career opportunities. • Realising the benefits of the Internal (Staff) Communication Strategy and ensuring that StaffLink and other mediums for example the weekly Team and Chief Executive Briefings, joint managerial / partnership walkabouts support organisational objectives. • Scoping a Staff Experience and Engagement Framework that sets out our key ambitions and commitments for improving staff experience, which will help to develop a culture that values and supports our workforce. WORKFORCE SUPPORT & WELLBEING • Provision of support and wellbeing initiatives which contribute to staff maintaining and enhancing their personal health and wellbeing at work and creating a great place to work. • Access to OH, H&S, Peer Support, Psychology, Spiritual Care, Staff Listening • Integration of Mindfulness, Good Conversations and Our Space support for staff as part of Going Beyond Gold Programme, contributing to a culture of kindness and staff recovery. • Consistent application of NHS Fife and Once for Scotland employment policies • Provision of a healthy and safe working environment, including access to refreshments in the workplace and ongoing development of Staff Hubs, Pause Pods and rest areas. Management of leave and encouraging rest and recuperation.	Nil	WORKFORCE – GENERAL • Implementation and review of workforce plans and strategies to ensure that these support service delivery and the provision of appropriate and safe care to the population of Fife. • Ensuring workforce preparedness for any further COVID-19 escalation requirements, working in partnership through the respective Workforce Groups and command structure. • Support for capacity building within and across the organisation to make sure we make the best use of the skills of all of our workforce and to foster an environment for staff development. WORKFORCE CAPACITY • Consideration of redesign of roles and services, for example: expansion of Health Care Support Worker and Nursing Associate roles, Advanced Practitioners, Pharmacy Technicians and Physicians Associates, combined with targetted ward administrative support, to enable clinical time to be released. • Consideration of alternative ways to attract and recruit staff, or redesign of job roles to support service delivery models and the future supply pool. • Realising the benefits of implementation of the regional recruitment model. • Harnessing the benefits of digital technology and automation. WORKFORCE CAPABILITY • Consideration of and implementation of learning and development activities in support of skill mix and associated actions. • Contributing to NHS Scotland developments in Learning and Development. • Realising benefits from the implementation of and compliance with the Health & Care (Staffing) (Scotland) legislation within the clinical workforce. • Supporting managers to harness the benefits of Tableau, TURAS and other systems integration aligned to workforce planning. • Provision of workforce planning training and support for managers. • Develop and deliver further phases of the framework to improve leadership capability and embed talent management and succession planning. • Consideration of the functionality of TURAS Learn to support capture and to facilitate reporting and analysis of training and development data. WORKFORCE ENGAGEMENT • Continuation of active partnership working through APF and LPFs, with staff side colleagues key stakeholders in the development of the next Workforce Strategies and Action Plans. • Continue to promote NHS Fife as an employer to enhance our ability to recruit and retain staff, utilising positive Communication support and social media. • To develop mechanisms which enable everyone to feel more valued and involved on a collaborative basis throughout health and social care. WORKFORCE SUPPORT & WELLBEING • Review of Staff Health & Wellbeing Strategy to take account of COVID-19 lessons learned and evaluation of activities to establish which are most appreciated by staff. • Provision of additional staff support and wellbeing initiatives which contribute to staff health and wellbeing, staff resilience and staff retention, showcasing NHS Fife as an exemplar employer in the local labour market. • Continue to hold Gold HWL Award status and deliver on HPHS commitments. • Consideration of support for the ageing workforce and opportunities for job redesign. Responsible Person/s: Director of Workforce	1. Regular performance monitoring and reports to Executive Directors Group, Area Partnership Forum, Local Partnership Fora and Staff Governance Committee 2. Staff Governance activities are reported to EDG, APF, LPFs and Staff Governance Committee	1. Use of national data for comparative purposes 2. Internal Audit reports 3. Audit Scotland reports 4. Bench - marking against other NHS Boards	Full implementation and utilisation of eESS, Job Train, Tableau and TURAS will provide integrated workforce systems which, alongside access to national data via the NES Portal will capture and facilitate reporting, including all learning and development activity.	Overall NHS Fife has robust workforce planning, learning and development, governance and risk systems and processes in place. Continuation of the current controls and full implementation of mitigating actions, in particular the Workforce Strategy supporting the Clinical Strategy and the future Population Health and Wellbeing Strategy for Fife and full implementation and use of eESS, should provide appropriate levels of control.	Unlikey	Major	8	Moderate Risk	Continuing improvements in current controls, ongoing review and full implementation of mitigating actions will reduce both the likelihood and consequence of the risk to moderate, taking account of current and potential future workforce challenges.

Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
1652	Lack of Medical Capacity in Community Paediatric Service	Active Risk	High Risk	25	Dobson, Claire
2214	Nursing and Midwifery Staffing Levels	Active Risk	High Risk	20	Owens, Janette
90	National Shortage of Radiologists	Active Risk	High Risk	16	Dobson, Claire
1324	Medical staff recruitment and retention	Active Risk	High	16	Kennedy, John

Previously Linked Operational Risk(s)

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

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Quality & Safety																											
16	Clinical	17/03		There is a risk that due to failure of clinical governance, performance and management systems (including information & information systems), NHS Fife may be unable to provide safe, effective, person centred care.	4	5	20	High	5	5	25	High	Failure in this area could have a direct impact on patients' health, organisational reputation and exposure to legal action. While it is recognised that several adverse events ranging from minor to extreme harm can occur daily, the proportion of these in relation to overall patient activity is very small.	Chief Nurse	Clinical Governance	*Ongoing actions designed to mitigate the risk including:* Oversight and monitoring of strategy / framework / policy and procedure implementation and impact including: 1. Strategic Framework 2. Clinical Strategy 3. Clinical Governance Structures and operational governance arrangements 4. Clinical & Care Governance Strategy 5. Participation & Engagement Strategy 6. Risk Management Framework 7. Governance arrangements established to support delivery of the UK Coronavirus (COVID-19) action plan 8. Processes established for reporting and escalation of COVID-19 related incidents & risks 9. Remobilisation plan 3 These are supported by the following: 10. Risk Registers 11. Integrated Performance and Quality Report (IPQR), Performance reports dashboard data 12. Performance Reviews 13. Adverse Events Policy 14. Scottish Patient Safety Programme 15. Implementation of SIGN and other evidence based guidance 16. Staff Learning & Development 17. System of governance arrangements for all clinical policies and procedures 18. Participation in relevant national and local audit 19. Complaints handling process 20. Using data to enhance quality control 21. HIS Quality of Care Approach & Framework, Sept 2018 22. Implementing Organisational Duty of Candour legislation 23. Adverse event management process 24. Sharing of learning summaries from adverse event reviews 25. Implementing Excellence in Care 26. Using Patient Opinion feedback 27. Acting on recommendations from internal & external agencies 28. Revalidation programmes for professional staff 29. Electronic dissemination of safety alerts	1.Reviewing together of patient experience, complaints, adverse events and risk information to provide an overview of good practice, themes, trends, and exceptions to the norm. 2.Weaknesses in the process for recording completion of actions from adverse event reviews including evidence of steps taken to implement and share learning from actions. 3.Weaknesses in related oversight and monitoring processes at operational level. 4. Risk Management Framework requires review, update & plan for implementation.	1. Give due consideration to how to balance the remobilisation of clinical services and manage staff and public expectations, while dealing with the ongoing COVID-19 pandemic. 2. Continually review the Integrated Performance and Quality (IPQR) to ensure it provides an accurate, current picture of clinical quality / performance in priority areas. 3. Refresh the extant Clinical Governance structures and arrangements to ensure these are current and fit for purpose. 4..Review the coverage of mortality & morbidity meetings in line with national developments and HIS guidance. 5. Review and refresh the current content and delivery models for key areas of training and development e.g. corporate induction, in house core, quality improvement, leadership development, clinical skills, interspecialty programmes, risk management,clinical effectiveness 6. Review annually, all technology & Digital & Information systems that support clinical governance e.g. Datix / Formic Fusion Pro./ Labs systems 7. Review our position against the Quality of Care Framework and understand our state of readiness for a review. 8. Further develop the culture of a person centred approach to care. 9. Executive commissioning of reviews as appropriate e.g. internal audit, external peer and 'deep dives'. 10. Align the developing Clinical Governance Framework with the NHS Fife Corporate Objectives and the developing Population Health & Wellbeing Strategy . 11.Identify improvements within the adverse events process taking into consideration communication, roles, use of DATIX and lines of reporting 12. Build a risk culture which ensures that there is engaged risk leadership and proactive measures with focus in place to address risks. 13 .Build risk culture which links the identification of risk to organisational objectives and strategic priorities. 14.Identify and implement an electronic system/ quality management system …	1. Assurance statements from clinical & clinical & care governance groups and committees. 2. Assurances obtained from all groups and committees that: i. they have a workplan ii. all elements of the work plan are addressed in year 3. Annual Assurance Statement 4. Annual NHS Fife CGC Self assessment 5. Reporting bi annually on adequacy of systems & processes to Audit & Risk Committee 6. External accreditation systems e.g.. Unicef - Accredited Baby Friendly Gold. UKAS Inspection for Labs. 7. External agency reports e.g. GMC 8. Quality of Care review 9.Compliance and monitoring of policies & procedures to ensure these are up to date 9. Locally designed subject specific audits. 10. National audits	1. Internal Audit reviews and reports on controls and process; including annual assurance and governance review / departmental reviews. 2. External Audit reviews 3. HIS visits and reviews 4. Healthcare Environment Inspectorate (HEI) visits and reports 5. Health Protection Scotland (HPS) support and feedback 6. Health & Safety Executive visits and reports 7. Scottish Patient Safety Programme (SPSP) visits and reviews 8. Scottish Govt Organisational DoC Annual Report 9. Scottish Public Service Ombudsman (SPSO) reports 10. Patient Opinion 11. Specific National reporting 12. Mental Welfare Commission (MWC) reviews	1.Key performance indicators relating to corporate objectives e.g. person centred, clinically excellent, exemplar employer & sustainable. 2.We require additional assurances that there is a system in place for oversight and monitoring of actions from a variety of sources e.g. audit, adverse events, SPSO, MWC reviews. 3.We require additional assurances that there are systems in place for oversight of operational and strategic risks.	Overall, NHS Fife has in place sound systems of clinical governance and risk management as evidenced by Internal Audit and External Audit reports and the Statement of Annual Assurance to the Board.	2	5	10	High	The organisation can identify the actions required to strengthen the systems and processes to reduce the risk level.

for managing policy and procedures to improve efficiency and assurance of document management

15.Use the Essentials of Safe Care framework as the basis of an organisational self assessment to understand status quo and support development of CG Framework

16..Ensure linkages with Patient Relations Team to allow for shared learning and identification of organisational themes

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

Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
1652	Lack of Medical Capacity in Community Paediatric Service	Active Risk	High Risk	25	Dobson, Claire
43	Vascular access for haematology/Oncology	Active Risk	High Risk	20	Savage, Shirley-Anne
529	Information Security Risk	Active Risk	High Risk	16	McGurk, Margo
1296	Emergency Evacuation, VHK Phase 2 Tower Block	Active Risk	High Risk	15	McCormick, Neil
1365	Cancer Waiting Times Access Standards	Active Risk	High Risk	15	Couser, Gemma

Previously Linked Operational Risk(s)

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

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Strategic Planning																											
1675	Clinically Excellent, Exemplar Employer, Person Centred, Sustainable	23/09/2021	30 November 2021	There is a risk that the development and the delivery of the new NHS Fife Population Health and Wellbeing strategy is not adequately supported by the required planning and programme management capacity, capability and governance arrangements. Key Risks from previous BAFs will remain until committees are content they are covered in renewed PHW Strategy. 1. Community/Mental Health redesign is the responsibility of the H&SCP/IJB which hold the operational plans, delivery measures and timescales 2. Governance of the transformation programmes remains between IJB and NHS Fife. 3. Regional Planning - risks around alignment with regional plans are currently reduced as regional work is focussed on specific workstreams 4. Clinical Strategy does not reflect that the strategic direction of the organisation following the COVID-19 pandemic.	4 – Likely – Strong possibility this could occur	4 – Major	16	High Risk	4 – Likely – Strong possibility this could occur	4 – Major	16	High Risk	Following period of COVID-19, portfolio management is being put in place. Programme management approach being refreshed through Strategic Planning Resource Allocation (SPRA) process.	Margo McGurk Director of Finance	Clinical Governance. Christina Cooper.	*Ongoing actions designed to mitigate the risk including:* 1.Progress has been made setting up the PHW Portfolio Board 2. Public and Staff Survey being developed for PHW Stragy and will be released in November 21 assuming sign off. 3. SPRA for 22/23 is planned for distribution in October 2021	EDG Strategy meetings will provide the required leadership and executive support to enable strategy development.	23/9/21 PHW Portfolio Board is being established and will meet monthly. TOR ready for sign off. Governance route will be Public Health and Wellbeing Committee 27/5/21 EDG will engage in monthly sessions to ensure the ongoing development of the new strategy. The NHS Fife Board and Governance Committees will be fully engaged in this process throughout 2021/22 and will be responsible for approval of the emerging strategy. Work is ongoing to develop clarity on the system-wide governance arrangements in terms of the developing strategy. Joint session planned with NHS Fife and Fife Council Executive Teams for May 2021. Responsible Person: Director of Finance Timescale: 31/03/2022	1. Minutes of meetings record attendance, agenda and outcomes. 2. Reporting of key priorities to governance groups from the SPRA process. .	1. Internal Audit Report on Strategic Planning (no. B10/17) 2. Governance committee scrutiny and reporting. .	Governance of new arrangements will be agreed to deliver the required assurance.	Corporate Objectives agreed for 21/22. SPRA process 22/23 will commence in October 21 and will inform the strategy and corporate objective for 22/23. RMP4 due to be submitted on 30 September 21.	3 – Possible – May occur occasionally – reasonable chance	4 – Major	12	Moderate Risk	Once governance and monitoring is in place and transformation programmes are being realised, the risk level should reduce.

Linked Operational Risk(s)

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

Previously Linked Operational Risk(s)

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

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Integration Joint Board																											
1676	Sustainable	10/11/2021	14 January 2022	There is a risk that the Fife Integration Scheme does not clearly define operational responsibilities of the Health Board, Council and Integration Joint Board (IJB) resulting in a lack of clarity on ownership for risk management, governance and assurance.	4 – Likely – Strong possibility this could occur	4 – Major	16	High Risk	3 – Possible – May occur occasionally – reasonable chance	4 – Major	12	Moderate Risk	The level of risk has been actively reviewed and, following feedback from colleagues, as there is considerable work ongoing to support the conclusion of the review and this is being regularly monitored, the risk score has been maintained at a moderate level	Nicky Connor Director of HSCP	NHS Fife Board. Tricia Marwick.	*Ongoing actions designed to mitigate the risk including:* Nov 21 1. The partner bodies, NHS Fife and Fife Council, developed the Fife IJB Integration Scheme in 2015 and it received Scottish Ministers' approval in October of that year. 2. The Integration Scheme was reviewed in March 2018 to reflect the implementation of the Carers (Scotland) Act 2016 as required by the Scottish Government. 3. The Audit Scotland report, Health and Social Care Integration – Update on Progress, published on 15 November 2018, was the second in a series of three national performance audits following the introduction of the Public Bodies (Joint Working) (Scotland) Act, 2014. It examined the impact public bodies are having as they integrate health and social care services. The report set out six areas which needed to be addressed if integration is to make a meaningful difference to Scotland. 4. This report was followed by the Ministerial Strategic Group for Health and Community Care's report – Review of Progress with Integration of Health and Social Care published in February 2019 which set out a number of proposals in each of the six key areas and allocated a timescale for completion of these. These were reviewed by Fife IJB and its partners to ensure they were incorporated into the work that was ongoing within Fife and an action plan was produced to drive forward changes. This was submitted to the Scottish Government in August 2019. The action plan set out actions to improve governance arrangements including the need to provide further clarity on the Integration Scheme. 5. All Integration Schemes are scheduled to be reviewed every five years, however, Scottish Government have allowed additional time for the review to take cognisance of the disruption caused by the coronavirus outbreak. 6. The review of the Fife Integration Scheme concluded through NHS Fife and Fife Council governance structures in September 2021. Thereafter it was submitted to Scottish Government for approval. This is anticipated towards the end of the year. Until the revised scheme is approved the current Scheme will remain in place. 7. Following the approval of the revised Integration Scheme work will be required to ensure governance arrangements for NHS Fife, Fife Council and the IJB clearly reflect the position set out in the Integration Scheme. Work has begun on review of the IJB Governance Manual and review of risk management arrangements within NHS Fife and the IJB is being progressed.	Nil	Nothing more to be done than the ongoing actions set out. Responsible Person: Director of Health & Social Care	1. Through regular updates to SLT and EDG about the progress of the reviews. 2. Updates to Audit & Risk Committees, the Integration Joint Board (IJB) and NHS Fife. .	1. • The views of auditors will be the key independent assurance mechanism around this risk. We will involve them in the work to clarify governance arrangements as it progresses. 2. • Scottish Government will also provide useful advice and an independent perspective on the work to be carried out.	None.	The problem should be largely resolved with the action taken.	1 – Remote – Can't believe this event would happen	4 – Major	4	Low Risk	Once resolved and given effect to in IJB integration scheme and NHS Fife corporate governance arrangements, the issue should largely be resolved. But given maturity of relationships and dynamics around regional approaches a remaining risk will remain..

NHS Fife Board Assurance Framework (BAF)

Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Initial Score: Likelihood (Initial)	Initial Score: Consequence (Initial)	Initial Score: Rating (Initial)	Initial Score: Level (Initial)	Current Score: Likelihood (Current)	Current Score: Consequence (Current)	Current Score: Rating (Current)	Current Score: Level (Current)	Rationale for Current Score	Owner (Executive Director)	Assurance Group Standing Committee and Chairperson	Current Controls (What are we currently doing about the risk?)	Gaps in Control	Mitigating actions - what more should we do?	Assurances (How do we know controls are in place and functioning as expected?)	Sources of Positive Assurance on the Effectiveness of Controls	Gaps in Assurance (What additional assurances should we seek?)	Current Performance	Target Score: Likelihood (Target)	Target Score: Consequence (Target)	Target Score: Rating (Target)	Target Score: Level (Target)	Rationale for Target Score
Board Assurance Framework (BAF) - Digital & Information																											
1677	Clinically Excellent, Exemplar Employer, Person Centred, Sustainable	17/09/2021	11 October 2021	There is a risk that the organisation will fail to recognise and afford the financial investment necessary to deliver its D&I Strategy and current operational lifecycle commitment to enable transformation across Health and Social care to deliver sustainable and integrated services that are safe, secure and compliant with governance frameworks and associated legislation.	4 – Likely – Strong possibility this could occur	5 - Extreme	20	High Risk	3 – Possible – May occur occasionally – reasonable chance	5 - Extreme	15	High Risk	Failure in this area could have a direct impact on patients care, organisational reputation and exposure to legal action. While it is recognised that several adverse events ranging from minor to extreme can occur daily, the proportion of these in relation to overall activity is very small and reporting to competent authorities is minimal.	CMK Medical Director	Clinical Governance, Finance Performance & Resources (FP&R) Christina Cooper (CGC), Rona Laing (FP&R)	*Ongoing actions designed to mitigate the risk including:* 1. Consistent alignment of the D&I Strategy with the NHS Fife Corporate Objectives and developing Health & Wellbeing Strategy 2. Digital & Information Board Governance improvement with ongoing review 3. Information Governance & Security Governance improvement with assurance activity plans reviewed by Steering Group and Improvement measures agreed 4. Caldicott - register maintained and reviewed 5. Review of financial impact of D&I Strategy as part of annual deliver planning and areas of exposure quantified 6. Operational governance lead through SLT focusing on operation controls (finance & resource), lifecycle management, policy/procedure implementation a workforce development 7. Risk management arrangements underpinned by: Policy & Process, Adverse event management, Asset Management Controls, Monitoring and Detection, Defence in Depth security measures and technology; all of which are receiving a higher percentage of budget allocation. 8. Directive on security of network and information systems (NIS) & Cyber Essentials Compliance – Action Plan developed prioritising a series of Cyber workshops informing technical controls and organisational response to Cyber attacks 9. Additional resilience planning and disaster recovery work underway to update alignment to current operating priorities 10. FOI, records management, DPA improvements being lead through IG&S Steering and Operational Groups 11. Senior Management Team consideration of policy and procedure impact and associated implementation 12. Monthly risk reviews with Operational Leads and escalation/reporting to Governance Groups as necessary 13. Performance Review 14. Participation in national and local audit e.g. NISD Audit 15. Commitment to ensure appropriate implementation of Cyber Defence Measures, including support of national centralised cyber incident reporting and coordination protocols. 16. Staff Learning & Development, both Digital staff and the wider organisation including leadership skills. 17. Business Case development to include costed resilience by design and ongoing support activities. 18. Enhancing monitoring of our digital systems.	Lack of formal quantification of the financial impact of the Digital Strategy, inline with the current baseline of D&I Operating Costs Lack of long term financial, lifecycle and workforce planning. Lack of evidence of assurance now that systems to maintain ongoing monitoring of compliance and control are established: GDPR/DPA 2018 - Improvements noted in IG&S Assurance Report (Target March 2022) Lack of consideration and commitment to unification of business process on strategic applications and the associated remove of duplicate or legacy systems Lack of training and education resource to ensure our staff and patients are digitally ready - Business Case in consideration Lack of resilience of key digital systems and technical recovery procedures and regular failover (DR) testing. - Plan to address agreed with EDG - April 2021- project now in initiation – Oct 2021 Governance and procedures do not fully follow ITIL professional standards - Internal Audit Findings responded to	1. Improving and maintaining strong governance, risk management and operating procedures following Information Technology Infrastructure Library (ITIL) professional standards within early adoption of continuous improvement assessment. (ITIL implementation - Phase 1 October 2021) 2. Updated baseline of current operating financial commitments and assessment of financial implementation of Digital Strategy. (Target completion October 2021) 3. Develop long term financial, lifecycle and workforce planning - plan to address is in development (Target completion October 2021) 4. Work to become fully compliant with GDPR, DPA 2018, NIS Directive, Information Security Policy Framework and thereafter maintain compliance. (Target completion February 2022)	Second line of Assurance: 1. Reporting to D&I SLT, D&I Board, Information Governance & Security Steering Group (IG&SG), EDG & Clinical Governance groups and committees. 2. Annual Assurance Statements for the D&I Board and IG&S Steering Group. 3. Locally designed subject specific audits. 4. Compliance and monitoring of policies & procedures to ensure these are up to date via D&I Senior Management Team. 5. Reporting bi annually on adequacy of risk management systems and processes to Audit & Risk Committee. 6. Monthly SIRO report 7. SGHSCD Annual review 8. SG Resilience Group Annual report on NIS & Cyber compliance 9. Quarterly performance report. 10. External Assurance on Delivery Plan by Scottish Government 12. Update to Assessment following June 2019- Digital Maturity Assessment 13 Periodic Benchmarking for areas of focus	Third line of Assurance : 1. Internal Audit reviews and reports on controls and process; including annual assurance and governance review / departmental reviews. 2. External Audit reviews. 3. Formal resilience testing / DR testing using an approved scope and measured success and mechanism for lessons learned and action plans. 4. Cyber Essentials/Plus Assessments. 5. NISD Audit Commissioned by the Competent Authority for Health. 6. Benchmarking with NHS Scotland's Boards	1. The D&I Strategy has not undergone a financial assessment against delivery. This work is now being progressed - target completion October 2021 2. Continual development of data assured performance is ongoing across all D&I Domains. Development of workplans aligned to risk continue to be developed. 3. Assurance reports are consistently provided to D&I SLT monthly and development of data/KPI reports to Governance Groups continue to be developed. These reports will ensure trend and analysis to highlight potential vulnerabilities and provide assurances (including assurances that confirm compliance with GDPR, DPA 2018, NIS Directive, the Information Security Policy Framework is being maintained). 4. Implementation of improvements as recommended in Internal and external Audit ongoing. Adverse Events review to be included 5. Improvements to SLA's (in line with 'affordable performance')is that output still awaited from 4 to provide assurance or otherwise 6. Assurance on patients' readiness/equality impact in the adopt ion of digital care provision 6. Assurance on organisational readiness for further Digital Adoption	Overall, NHS Fife Digital has in place a sound systems of 1. Governance - agreed ToR and reporting 2. Improving security defences and risk management as evidenced by Internal Audit and External Audit reports 3. Attainment of the ISO27001 standard in the recent past and the Statement of Annual Assurance to the Board. 4. Investment has been made to support NIS, GDPR and Cyber resilience and some tools which will improve visibility of the Network. 5. Clear articulation of digital aspiration via the Digital Strategy 2019-2024 5. Extended corporate governance including EDG attendance 6. Meeting visibility through provision of minutes and delivery plans to EDG/CGC	2 – Unlikely – Not expected to happen – potential exists	5 - Extreme	10	Moderate Risk	1. Difficulty in securing investment in people, tools and maintaining systems that are resilient and always within support cycles. 2. Fully implementing resistance to attack through 'resilience by design', well practised response plans and recovery procedures. 3. Reduce the 'human factor' through ongoing 'user base education' and improving organisational digital readiness. 4. Enhanced controls and continuing improvements to systems and processes for improved usage, monitoring, reporting and learning are continually being put in place. Aim for Moderate Risk as target rather than Low Risk is due to the fact that likelihood whilst unlikely may still happen and consequence will be extreme due to level of fines that may be imposed, reputational damage and patient harm.

Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
885	Digital & Information Financial Position	Active Risk	High Risk	20	Graham, Alistair
1338	NHS Fife is at increased risk to a targetted cyber intrusion - due to legacy systems	Active Risk	High Risk	20	Young, Allan
1996	Office 365 - Unknown Financial Consequence and so risk to licence availability	Active Risk	High Risk	20	Graham, Alistair
2192	Risk that Digital & Information Service Management activities are not aligned to ITIL	Active Risk	High Risk	20	Graham, Alistair
1422	Unable to meet NIS & Cyber Essentials compliance	Active Risk	High Risk	20	Graham, Alistair
1424	End of support lifecycle for Microsoft Server Products	Active Risk	High Risk	16	Young, Allan
529	Information Security Risk	Active Risk	High Risk	16	McGurk, Margo
1934	Loss of Email & Collaboration Services	Active Risk	High Risk	16	Young, Allan
1576	Risk of not meeting SaMD full compliance	Active Risk	High Risk	16	McKenna, Christopher
1932	T4 - User error (including those supporting system)	Active Risk	High Risk	16	Fowles, Malcolm
537	Failure of Local Area Network causing loss of access to IT systems	Active Risk	High Risk	15	Young, Allan

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Risk Status	Current Level	Current Rating	Risk Owner
226	Security of data being transferred off/on site	Active Risk	High Risk	16	Graham, Alistair
1393	Patch Management Risk	Active Risk	Moderate Risk	12	Young, Allan
1504	Lack of a central IT location to store guidance documents	Active Risk	High Risk	20	McKenna, Christopher
1746	O365 May Cause Disruptive Network Overhead	Active Risk	Moderate Risk	9	Young, Allan
1927	T1 - Deliberate unauthorised access or misuse by insiders (staff, contractors etc.)	Active Risk	Moderate Risk	12	Fowles, Malcolm
1928	T2 - Deliberate unauthorised access or misuse of O365 Email by outsiders (e.g. hackers)	Active Risk	Moderate Risk	12	Young, Allan
913	MIDIS replacement	Closed Risk	Moderate Risk	9	Donovan, Lesly
1929	T7 - Inadequate or absent audit trail	Closed Risk	High Risk	25	Young, Allan

Reviewing Board Risk Appetite and Board Assurance Framework

NHS Fife

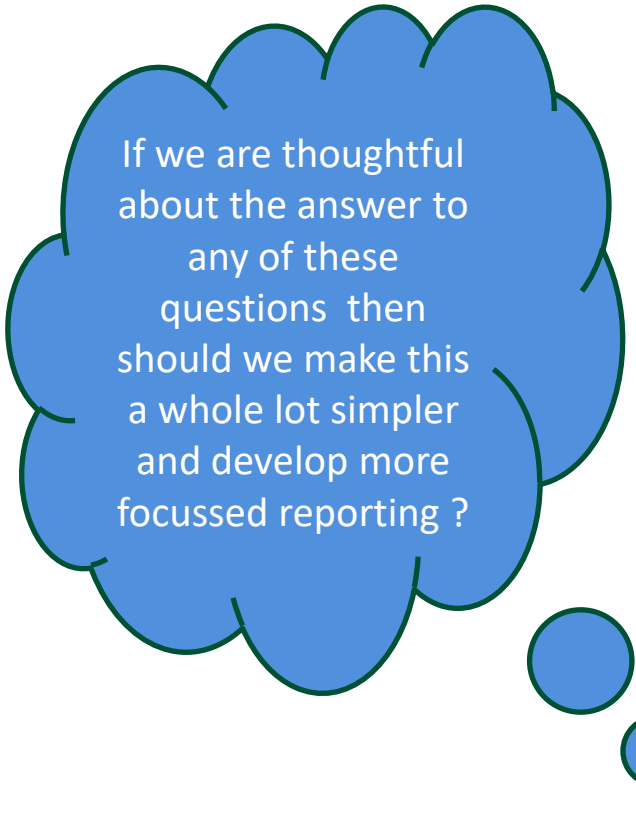
Audit and Risk Committee
9 December 2021

Risk Management - Board Responsibilities

- Deciding the level of risk acceptable;
- Monitoring sources of assurance;
- Monitoring the level of performance required to achieve the objectives;
- Determining the organisation's overall approach to risk appetite;
- Horizon scanning for future risks;
- Setting a strong risk management culture; and
- Gaining assurance on the risk management approach.

Risk Management and BAF

- Risk management is integral to performance management, do we always make that link?
- 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?
- Does the linked risk approach overly complicate reporting?
- Is the corporate Board Risk Profile visible - can we see the wood from the trees?



Risk Dashboard Reporting

Reinstate Corporate Risk Register to underpin this summary view?

TOP LEVEL VIEW (Corporate Risk Register Supporting this)

Categorisation	Total Risks	Current Risk Level Breakdown
Strategic Risk Area 1	11	High Risk – 2 Moderate Risk – 7 Low Risk - 2
Strategic Risk Area 2	2	High Risk – 2 Moderate Risk – 0 Low Risk - 0
Strategic Risk Area 3	9	High Risk – 2 Moderate Risk – 6 Low Risk - 1
Strategic Risk Area 4	2	High Risk – 0 Moderate Risk – 1 Low Risk – 1
Strategic Risk Area 5	3	High Risk – 2 Moderate Risk – 1 Low Risk - 0
Strategic Risk Area 6	4	High Risk – 1 Moderate Risk – 3 Low Risk - 0

Risk Dashboard Reporting

How is the risk profile improving or deteriorating?

VIEW STRATEGIC RISK AREAS BY RISK LEVEL

	Total	Improvement Number of High Risks (Initial) now with a reduced risk level (Current)	Deterioration Number of High Risks (Current) that had a lower risk level when identified (Initial)	Accept/Monitor Number of High Risks (Initial) that now have a risk level (Current) that matches the planned risk level (Target)
High Risk Initial	16			
High Risk Current	9	8	1	7 2 x High to High 2 x Moderate to Moderate 3 x Low to Low

Deep dive into deteriorating risks

FOCUSSED VIEW ON SPECIFIC RISKS

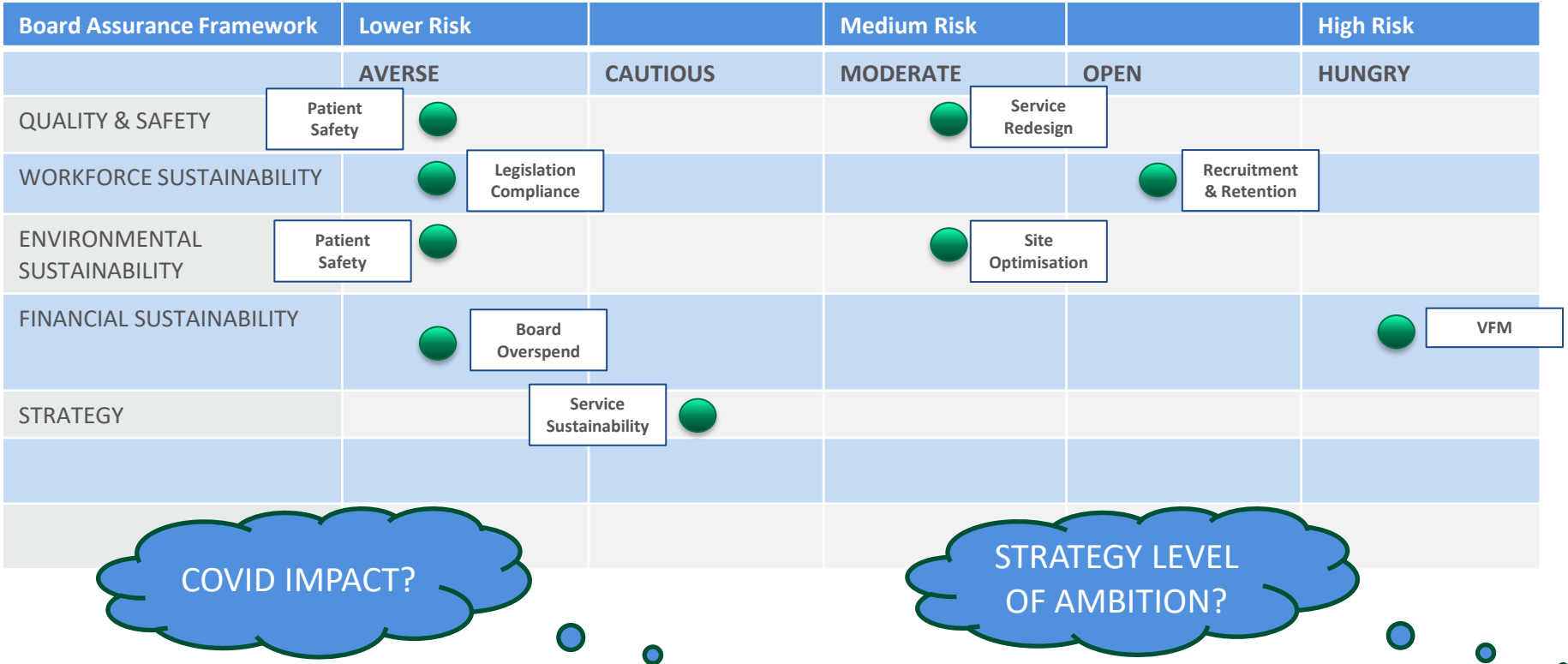
Risk Item			
Insert Risk Description Risk Description as per Datix		Current Risk Level High 20 Likelihood 5 – Almost Certain Consequence 4 - Major Target Risk Level Low Risk 4	
Risk Velocity Speed at which the risk will impact NHS Fife	Rapid		
Root Cause		**Management Actions**	**Status**
Root Cause 1 - description		Management Action 1 - description	Ongoing December 2022
Root Cause 2 - description		Management Action 2 - description	Ongoing October 2022
Root Cause 3 - description		Management Action 3 - description	Not Started
Root Cause 4 - description		Management Action 4 - description	Not Started
Root Cause 5 - description		Management Action 5 - description	Ongoing October 2022

Risk Appetite

Reflecting on Board current position on Risk Appetite, some key points to consider

- What have we learnt in the past 18 months?
- What have been the key risks and opportunities over this period, will they continue to present in the future?
- Are there additional risks we are willing to take as we consider the development of the new strategy?

Risk Appetite – November 2019



Keep in touch

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