Audit & Risk Committee

17 September 2020, 10:00 to 12:00
Via MS Teams

Agenda

1
Apologies for Absence
2
Declaration of Members' Interests
3
Minutes of Previous Meeting held on 13 July 2020

Martin Black

Item 3 Audit and Risk Minutes 13 July 2020.pdf (9 pages)

4
Action List

Martin Black

Item 4 A&R Action List 0920.pdf (1 pages)

5
Matters Arising
5.1
Clinical Governance update on Adverse Events Internal Audit

Gillian MacIntosh

Item 5.1 B19-20 Adverse Events Update.pdf (4 pages)

5.2
Sharing Intelligence for Health & Care Group – Feedback letter on NHS Fife

Carol Potter

Item 5.2 SBAR SIHCGletterA&R.pdf (3 pages)

Item 5.2 Appendix SIHCG Feedback Fife v1.0.pdf (4 pages)

6
ANNUAL ACCOUNTS
6.1
Annual Accounts Update

Margo Mcgurk

7
GOVERNANCE - GENERAL
7.1
Update on Board Action Plan for the implementation of the NHS Scotland 'Blueprint for Good Governance'

Gillian MacIntosh

Item 7.1 SBARBlueprintActionPlanSep20.pdf (4 pages)

Item 7.1 Appendix BlueprintActionPlanSept20update.pdf (5 pages)

7.2
Annual Review of Code of Corporate Governance

Gillian MacIntosh/Robert Mackinnon

Item 7.2 SBAR ARC Revised Code of Corp Gov.pdf (3 pages)

Item 7.2 CodeofCorporateGovernance wTRACKED.pdf (120 pages)

7.3

Corporate Calendar / Committee Meeting Dates 2021/22

Gillian MacIntosh

- Item 7.3 ARC Schedule of Future Meeting Dates to 2022.pdf (1 pages)

8
GOVERNANCE - INTERNAL AUDIT

8.1

B25/21 – Post Transaction Monitoring

Barry Hudson

- Item 8.1 SBAR PTM B25-21.pdf (2 pages)
- Item 8.1 B25-21 PostTransaction Monitoring.pdf (9 pages)

8.2

Draft Internal Audit Annual Report 2019/20

Tony Gaskin

- Item 8.2 SBAR Annual Report.pdf (5 pages)
- Item 8.2 Appendix B06-21 AIAR Draft FINAL.pdf (35 pages)

9
RISK

9.1

Risk Management Annual Report 2019/20

Helen Buchanan

- Item 9.1 SBAR Risk Management Annual Report 2019-20 to Audit and Risk Committee 170920 V1.0.pdf (3 pages)
- Item 9.1 NHS Fife Risk Management Annual Report 2019-2020 V1.0.pdf (19 pages)

9.2

Risk Management Framework

Helen Buchanan

- Item 9.2 SBAR Risk Management Framework V2.pdf (5 pages)
- Item 9.2 Appendix Draft update of NHS Fife Risk Management Framework V1.1 110920.pdf (30 pages)

9.3

Risk Management Key Performance Indicator Report

Helen Buchanan

- Item 9.3 Risk Management Key Performance Indicator Report to Audit and Risk Committee 170920 V1.0.pdf (3 pages)
- Item 9.3 Appendix 1 Risk Management Key Performance Indicators (KPIs) Summary V1.0.pdf (2 pages)
- Item 9.3 Appendix 2 Compliance with Risk KPI 4 V1.0.pdf (1 pages)

9.4

Update on Risk Management Workplan

Helen Buchanan

- Item 9.4 SBAR Risk Management Workplan Update to Audit and Risk Committee on 170920 V1.0.pdf (3 pages)
- Item 9.4 Appendix 1, Risk Management Workplan 2019 - 2020 Update to NHS Fife Audit and Risk Committee 170920 V1.0.pdf (1 pages)
- Item 9.4 Appendix 2, Risk Management Workplan (2 pages)

2020 - 2021 Update to NHS Fife Audit and Risk Committee 170920 V1.0.pdf

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ANNUAL ASSURANCES

10.1
Annual Assurance Statements for 2020/21

Gillian MacIntosh

Item 10.1 SBAR Committee Statement of Assurances.pdf (3 pages)

Item 10.1 Board Committee Assurance Statements 2019-20 & IJB.pdf (61 pages)

10.1.1
Clinical Governance Committee

10.1.2
Finance, Performance & Resources Committee

10.1.3
Remuneration Committee

10.1.4
Staff Governance Committee

10.1.5
Fife Integration Joint Board

10.2
Draft Audit & Risk Committee Annual Statement of Assurance

Martin Black

Item 10.2 SBAR A&R Annual Statement of Assurance.pdf (3 pages)

Item 10.2 Draft A&R Annual Statement of Assurance 201920.pdf (15 pages)

10.3
Significant Issues of Wider Interest / Draft Governance Statement

Robert Mackinnon

Item 10.3 Significant Issues Letter Draft Gov Statement ARC.pdf (2 pages)

Item 10.3 Annex 1 2019-20 - Annual Accounts - Significant issues letter - NHS Board Chairs and Mental Welfare Commission Chair - 15 Jul 20 (1).pdf (2 pages)

Item 10.3 Annex 2 Draft Wider Issues Reponse Letter20200901001.pdf (11 pages)

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OTHER

11.1
Issues for escalation to NHS Board

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Any Other Competent Business

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Date of Next Meeting: December 2020 (date TBC)

MINUTE OF THE AUDIT & RISK COMMITTEE MEETING HELD ON 13 JULY 2020 AT 1300 VIA MS TEAMS

MARTIN BLACK
Chair

Present:

Mr M Black, Chair
Cllr D Graham, Non Executive Member
Ms J Owens, Non Executive Member
Ms S Braiden, Non Executive Member
Ms K Miller, Non Executive Member

In Attendance:

Mrs C Potter, Chief Executive
Mrs M McGurk, Director of Finance
Mr T Gaskin, Chief Internal Auditor
Mr B Hudson, Regional Audit Manager
Dr G MacIntosh, Head of Corporate Governance & Board Secretary
Ms P Fraser, Audit Scotland
Mrs P Cumming, Risk Manager (for Helen Buchanan)
Ms L Donovan, eHealth General Manager (for Item 6.3 only)

1. Welcome / Apologies for Absence

The Chair welcomed to their first formal meeting Katy Miller. Apologies were received from Helen Buchanan, Director of Nursing. Pauline Cumming, Risk Manager, was attending in her place.

2. Declaration of Members' Interests

There were no declarations of interest made by members.

3. Minute of the last Meeting held on 13th March and 18th June 2020

The minutes of the last meetings were **agreed** as an accurate record.

4. Action List

Mrs McGurk advised the two outstanding items would be picked up during the later agenda item regarding the Internal Audit Progress Report.

5. MATTERS ARISING

5.1. Revised Committee Workplan 2020-21

Dr MacIntosh advised that the Audit & Risk Committee had previously agreed its Annual Workplan for 2020-21 in March 2020, to plan effectively the work of the Committee throughout the year. As a consequence of the cancellation of the planned May 2020 meeting due to the Covid-19 pandemic, and also to reflect the extension to the annual accounts timetable, the plan now requires to be revised to appropriately reflect these circumstances. She advised that the current draft of the workplan would remain a live document and will be revised with new priorities as and when required. The workplan will thus be brought to future meetings should it change.

The Audit & Risk Committee **approved** the revised version of the Committee's Workplan.

5.2. Internal Audit Governance Checklist Update

Mrs McGurk gave a verbal update, advising the Committee that all of the Board's Governance Committees have all agreed to use the governance checklist (as reviewed at the last meeting) in supporting their agenda setting and planning their activity throughout the remainder of the year.

6. GOVERNANCE – INTERNAL AUDIT

6.1. Internal Audit Progress & Summary Report

Mr Hudson reported that the Internal Audit team continues to deliver the remaining reviews from 2019/20 workplan; work on the 2020/21 programme has also commenced.

He drew attention to Section 2.3 on the SBAR, which provided details of the plan in relation to the number of days. All days have been used from the 2019/20 workplan. There are two audits that remain to be finalised and will be completed using the clearance of prior review code for the 2020/21 audit plan.

Appendix A provided detail of the work undertaken, including:

- Final Internal Audit Reports issued since the last Audit & Risk Committee
- Internal Audit Reports issued in draft at the time of submission of papers for today's Audit & Risk Committee
- Internal Audit Work in Progress and Planned
- 2019/20 Internal Audits to be Risk Assessed for potential inclusion in the 2020/21 Internal Audit Plan
- Internal Audit improvement activities
- Summary of Internal Audit findings in final Internal Audit reports issued since the last Audit & Risk Committee
- Internal Audit Performance against Service Specification Key Performance Indicators

In answer to a question raised by Ms Braiden around the timing of completing the risk share review, Mrs McGurk advised that appraisal and full review of the current Fife Integration Scheme had been taken forward in the last quarter of 2019/20. A range of issues were progressed and agreed in those series of meetings, but there were a couple of areas where further discussion needed to be undertaken, including the risk share arrangement. She noted that the integration scheme review had been paused during the Covid-19 pandemic. However, meetings have recommenced in July, with a view to concluding the work by the end of the calendar year. Members welcomed the update.

The Audit & Risk Committee **noted** the ongoing delivery of the 2019/20 audit plan.

6.2 Internal Audit Report – B13/20 Risk Management Framework

Mrs Cumming introduced the report, noting that this gave an update on where the Risk Management Framework has reached. The report outlines in considerable detail the work that has been done over the last year and the engagement that Internal Audit has undertaken in support.

Section 2.3 of the SBAR provided a brief summary of where things stand at the moment, in respect of the actions that need to be completed. She stated that the framework and revised policy had recently been circulated for comment. She added that the project plan which had previously been recommended was in development and will be finalised by the end of the current month. Mr Hudson advised that he has received the framework documents and would provide comments back in due course.

In answer to a question raised by Mr Black around timescales, and a follow-up query by Ms Miller around risk management resource, Mrs Cumming noted that the intention is to bring an update to the Audit & Risk Committee in September and finalised policy documents to the Board thereafter. She added that, over that last few years, a considerable amount of team's resource has been targeted towards Adverse Events management and how this national programme was implemented locally. This has taken a considerable amount of input, but now many of the systems and processes relating to the adverse events work have been embedded and established. Currently, a review is being undertaken at to how the risk management resource can be more targeted and redeployed as necessary to support more strategic work, particularly around the implementation of the framework.

The Audit & Risk Committee **noted** the agreed management actions within the report and the update provided at the meeting.

6.3 Internal Audit Report – B31/20 eHealth Strategic Planning & Governance

Mrs Donavan explained that there had been an audit review of the NHS Fife Digital & Information Strategy 2019-24. The audit provided six recommendations, three of which were assessed as 'Merits attention' (green) and three assessed as 'Significant' (amber).

An update was given for each of the recommendations as follows:

1. The new strategy has not yet been presented to the Board for approval - eHealth have taken account of the need to make a number of amendments to the strategy, following initial review by Clinical Governance, and a revised version is now being presented to the NHS Fife Board on the 29 July.
2. Risks are not stated in a manner that links them to strategy implementation and not all of the challenges and disruptors are covered - this is a piece of work that has been delayed due to Covid-19 but will now start to be taken forward.
3. The Terms of Reference of the eHealth Board, the Clinical Governance Committee and the Finance, Performance & Resources Committee do not include appropriate responsibilities for recommending approval of the NHS Fife Digital & Information Strategy 2019-24 and monitoring its implementation - this work is in progress with a completion date of the end of December 2020.
4. Limited detail in reporting of the eHealth Delivery plan in regards to assurance that the delivery plan is being managed in line with expectations - there was recognition that the reporting had been evolving and improving over the period. This has been revised and a new report is going to the eHealth Board meeting this week. Mrs Donovan shared an example with the Audit & Risk Committee on the screen for members' information.
5. Business cases should include clear explanations of how they aligned to and supported the NHS Fife Digital & Information Strategy and the Transformation Programme - there was recognition that the HEPMA Business case was a good example of what should be included, but it was also recognised this strictly followed the SCIM. A completion date has been set for the end of September 2020 for revising the business case format.
6. Understanding of the impact of Covid-19 and the accelerated implementation of elements of the Digital & Information Strategy - a review is currently in progress with a completion date of September 2020.

Mr Gaskin commended the response from eHealth to the report's findings and the further actions detailed within the report. He added that eHealth will require a full review fundamentally of its activities, as with the pandemic there is an opportunity to revisit and do things differently.

The Audit & Risk Committee **noted** the agreed management actions within the report and the update provided at the meeting.

6.4 Internal Audit – Follow-Up Report

Mr Hudson reported that further enhancements had been made to the audit follow-up report since the last meeting, which now includes an appendix for validating the evidence from responding officers to confirm that the original control weakness has been addressed.

Section 2.3 of the covering paper highlights that there are currently 53 actions that have been extended, with revised dates provided by Responsible Officers, and there are 16 outstanding actions.

Responding officers have reported a number of delays in progressing outstanding actions due to the prioritisation of Covid-19 duties. Where Covid-19 has impacted on progress, it has been highlighted in the report.

It was recognised that, at a previous meeting, the Committee had raised concern around the number of outstanding recommendations, and this position had now worsened. It had been agreed with the Chief Executive and the Director of Finance that the audit follow-up report will go to a future EDG meeting, who will scrutinise the outstanding actions and commit to getting them completed in a quicker timescale.

In answer to a question raised by Ms Miller around workforce implications, Mr Hudson advised that there had been none specifically. There has been an impact closing off outstanding actions over the last few months due to Covid-19, but he felt confident going forward that the role of the Executive Directors in scrutinising any outstanding recommendations will help to resolve the outstanding actions in a quicker timeframe.

The Audit & Risk Committee **noted** the current status of recommendations detailed in the report.

6.5 Draft Internal Audit Operational Plan 2020/2021

Mr Gaskin reported that Internal Audit have produced an operational plan and updated the five-year strategic plan based on the extant Board Assurance Framework risk register and existing materiality scores, with no major revisions for the impact of Covid-19. However, the operational plan will require revision later in the summer and possibly ongoing throughout the year to reflect the impact of Covid-19 on NHS Fife's overall strategy, supporting strategies, resources, objectives and risk profile.

It was highlighted that this is an interim plan, which will be reviewed again by EDG once the situation is clearer. The work plan would be brought back to future meetings of Audit & Risk for further review, to make sure the real issues are being addressed. It was also noted that it would be beneficial to also look at areas where Internal Audit can help the organisation, as existing processes have changed and are being delivered differently due to the impact of the pandemic.

Mrs McGurk reported that EDG had reviewed the plan against that background. There are useful linkages across to the internal audit committee checklist, which has previously been discussed. That might also be a helpful tool to help support the reviewing and refreshing of the audit plan going forward. It was agreed there is also significant merit to linking this work to the Board's remobilisation plan that will be submitted at the end of this month, which effectively details what the organisational response will be operationally until the end of March 2021.

The Audit & Risk Committee **approved** the interim measures detailed in the 2020/21 Internal Audit Plan.

7. GOVERNANCE – EXTERNAL AUDIT

7.1. NHS Fife Interim Management Report 2019/20

Ms Fraser advised that the report provided a summary of the work carried out in Audit Scotland's interim audit. All of the work was carried out prior to the pandemic and the auditors were able to complete all the testing in accordance with the annual audit plan.

The work performed involved testing all the key controls in the main financial system and has also encompassed a review of governance arrangements and some wider scope work in relation to financial management and financial sustainability. It was highlighted in the report the areas of improvement.

Ms Fraser drew attention to Exhibit 1 of the report and highlighted the key findings from the report.

PECOS and ledger access controls (2018/19)
The first two points in the action plan related to matters that had been raised in previous years in relation to access to purchasing system and also the ledger. A number of the users that were tested in the sample were people who had already left the organisation, but still had access to the systems. This was the same for the ledger - one user had left the Health Board but still had access to the system.

Changes to supplier details (2017/18)
From the sample tested, there were some compliance issues following the revised procedures that had been put in place by the Health Board.

Changes to the payroll
This was in relation to the national HR system, where managers are required to provide data information on a timely basis so that the information can remain up-to-date. It was found that not all mangers were always doing this. There was a risk that somebody might leave the Health Board and were still being paid. There are informal procedures are in place to try and mitigate the risk; however, the risk of fraud or error still applies.

Authorisation of journals
It was found that out that a number of journals tested had not been properly authorised.

Additional testing will be carried out during the audit of the financial statements to mitigate the risks rising from the issues found in testing above.

Finance Team Capacity
This point highlighted the number of changes there have been to the senior Finance team during 2019/20. Audit Scotland is now expecting to receive the financial statements at the end of July as opposed to the start of July.

Financial management and financial sustainability
Issues found in the wider scope work highlights the challenging year that it has been for the Health Board and specifically references the continued reliance on non-recurring savings.

Governance and Transparency
The last two points in the report related to service transformation and this was covered earlier in meeting. Ms Fraser reiterated that the transformation board need to ensure that sufficient information is provided to ensure effective scrutiny by members of the Board.

The last point related to the continuing levels of high sickness absence in the Board, with a note that NHS Fife are looking understand the reason behind the high levels.

Audit Scotland have obtained management responses in relation to all the points raised and will monitor the implementations of the recommendations.

The Committee **noted** the interim management report.

7.2. NHS Fife – Audit Timescales 2019/20

Ms Fraser explained that the letter provided detailed the revised timetable for the audit of the financial statements. It was issued in June in response to the current pandemic and includes the revised deadlines for submission and audit of the financial accounts.

Attention was drawn to Exhibit 1, where the revised timetable indicated that Audit Scotland had thought that draft accounts were initially going to be received by the end of May. This timescale had been put back to the 1 July and a further delay has followed, with Audit Scotland now expecting to receive the financial statements by the end of July. Staff should be available to accommodate this revised timetable. The report has also incorporated the revised deadlines of the Audit & Risk Committee and the NHS Fife Board in September. This delay to the production of the annual accounts of three months is as a direct result to the impact on staff and audit resources in light of the impact of the pandemic.

The Committee **noted** the revised audit timescales.

7.3. Audit Planning Memorandum - Endowment Funds

Mrs McGurk explained that this report set out the timeframe and proposed approach for the audit of the charitable Endowment Funds for NHS Fife. The planned approach to this audit is in line with national guidelines and standards. The audit will be carried out by Thomas Cooper Accountants.

Attention was drawn to section 2.3 in the cover paper, which highlighted two material changes during the financial year. The first related to the transfer of the investment portfolio, and the impact of Covid-19 on its value. The impact is not limited to NHS Fife and will have affected all the charitable funds across all Boards. The second change related to the valuation and cataloguing of the Board's artwork around its various sites.

Patient funds, endowment and exchequer statutory financial statements will all be presented to the NHS Fife Board in September for approval.

In response to a question raised by Ms Braiden Mrs McGurk offered to provide training on the annual accounts review and scrutiny process, if members would find helpful, and this was welcomed.

The Audit & Risk Committee **noted** the audit planning memorandum for the Endowment Funds.

7.4. Audit Planning Memorandum - Patients Private Funds

Mrs McGurk noted that this report was similar in content to the previous paper. She drew attention to Section 2.3 of the covering SBAR which referred to the term "limitation of scope". This meant that the auditors are unable to do the level of testing that they would normally do to validate the financial position of the Patients Private Funds, as there are restrictions around access to clinical areas due to Covid 19. This will be a national issue and there will be a national co-ordination of how this is reflected in the annual accounts.

The Audit & Risk Committee **noted** the audit planning memorandum for the Patients Private Funds.

8. RISK

8.1. Board Assurance Framework

Mrs Cumming reported that, since the last report to the Committee, the BAF risks have been considered at the appropriate governance committees, most recently in March 2020. They were not considered as scheduled in May 2020 due to Covid-19 and the temporary suspension of committee meetings. A summary of key points on the BAFs submitted to the March committees, as reported by the responsible Executive Directors, were provided. The BAFs were provided separately as appendices. The current BAFs are progressing through the July 2020 committee cycle.

Further to the last Audit & Risk Committee, where it was noted that a number of areas for improvement within the BAF in terms of presentation, quality and content could be made, it has been since recognised that there is a need to reconsider everything we do in the context of Covid-19 going forward. For the BAFs, this will mean building in to each Covid-specific risks, in preference to having a standalone Covid BAF. This is a piece of work that still needs to be done.

The intention is also to use Datix as a repository for the BAF, so that any changes are made within this system and it will provide an audit trail going forward.

8.2. Risk Management Policy & Framework Update

Mrs Cumming reiterated that the draft documents have recently been issued for comment / feedback, to a wide group of recipients. Further iterations will progress through EDG, Audit & Risk Committee and then the Board.

9. ISSUES TO BE HIGHLIGHTED

9.1. To the Board in the IPR & Chair's Comments

There were no issues of escalations to be highlighted from the current meeting.

10. ANY OTHER BUSINESS

Mr Gaskin noted that, in relation to an issue raised earlier in the agenda relating to training, there will be an e-Learning module being issued for all Audit Committee members soon via NES. He asked if the Committee were content for him to supply the e-Learning team with the audit plan as an example of a document of that nature. This would be anonymised. The Committee agreed for the document to be shared for this purpose.

In closing, Mr Black expressed his thanks, on behalf of the Audit & Risk Committee, for all the work that has been undertaken by dedicated staff in his period of crisis. This was greatly appreciated.

Date of Next Meeting: 17 September 2020 at 10am within the Boardroom, Staff Club, Victoria Hospital (location TBC).

ACTION LIST FROM AUDIT & RISK COMMITTEE – 2020-21

	Title	Action	Lead	Outcome
1	Internal Audit reporting 19/20 -7.2 - Audit Report – B19/20 Adverse Events	A position statement on B19/20 – Adverse Events was requested for the next Audit and Risk meeting.	CMcK	On agenda for September meeting, having been reviewed by Clinical Governance at their meeting on 7 September.
2	Internal Audit reporting 19/20 – 7.3 - Follow Up Report	Consult with EDG around the validated information and evidence of completion of audit actions, and dates of dates of the outstanding actions, which were considerably out-of-date and still remained open with limited evidence of progress. Further work was also required on the follow-up process, to ensure this was timely and robust.	MM	EDG now consider the progress on internal audit actions quarterly. Directors have been reminded of the need to ensure good progress is made in clearing outstanding issues.
3	Governance - 20/20 -8.1 - Annual Accounts – Progress Update on Audit Recommendations	Further work required in relation to the monitoring and reporting of outstanding actions.	MM	Good progress is being made in relation to the outstanding actions with all due to be complete by the end of October 2020.
4	Risk – 20/21 – 9.1 BAF	Risk Management – Board Development Session	GM	Has been included on revised list for future Board Development Session topics.

Completed Updated

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**17 September 2020**
Title:	**Clinical Governance update on Adverse Events Internal Audit B19/20**
Responsible Executive:	**Dr Chris McKenna, Medical Director**
Report Author:	**Helen Woodburn, Head of Quality and Clinical Governance**

1 Purpose

This is presented to the group for:

- Awareness

This report relates to a:

- Emerging issue identified through the above report (the rating of this report has raised concerns at the Audit and Risk Committee)

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

- Safe
- Effective

2 Report summary

2.1 Situation

This report was reported at the 8th July Clinical Governance Committee. The overall rating in audit opinion for this review is limited. The review identifies several actions to address the weaknesses within the system which require to be addressed. The Audit and Risk Committee have requested further assurances to be provided to the NHS Fife Clinical Governance Committee on the progress made to address said weaknesses.

2.2 Background

This review evaluated the design and operation of the controls relating to implementation of actions to address issues identified from Adverse Event Reviews - Significant Adverse Event Reviews (SAER) and Local Adverse Event Reviews (LAER). Specifically, this audit looked at process and procedures in place to manage actions to full implementation, as well as the ongoing monitoring of actions implemented to confirm they remain in operation and are effective.

2.3 Assessment

The NHS Fife Adverse Event Group / Duty of Candour Group oversee the actions identified in this report through to implementation. This group under normal circumstances meet every 2 months. However, during the months of April through to end of July, these meetings were cancelled in order for the organisation to respond to the Covid -19 pandemic. The first meeting was re-convened 18 August 2020 and an update was provided on all of the actions identified.

There were 4 action points within the report as follows:

Action point reference 1

Responsibility for completing actions arising from SAERs and LAERs lies with service management and, although there previously was, there is currently no regular reporting to relevant committees on the SAER and LAER actions implemented and those still outstanding. This prevents follow-up of overdue actions and because there is no reporting on such, it prevents the standing committees from fully discharging their responsibilities as outlined in GP/I9 – Adverse Events Policy to ensure action plans have been completed and contribute to organisational learning by sharing and adopting key learning points.

Progress to date

- Risk Management Key Performance Indicators (KPI) have been developed and agreed.
- The adverse events related indicators will be reported to the Adverse Events / Duty of Candour Group on 18 August 2020, EDG on 20 August 2020 and as part of the IPQR to the NHS Fife Clinical Governance Committee on 4 November 2020
- A report of status on overdue actions will be reported to each meeting of the NHS Fife Adverse Event / Duty of Candour group. Reports in Datix will be established for Divisions and Directorates to have access to information relating to their areas of responsibility

Action point reference 2

In a large number of instances, officers to whom actions are being assigned to are not fully completing them by the respective due dates. Also, Lead Officers responsible for ensuring all actions are implemented are not fully completing follow up reviews as required by GP/I9 – Adverse Events Policy and the additional guidance provided.

Progress to date

- Status on actions will be a standard item on the agenda for Adverse Events group.
- Since March 2020 and the response to the emerging Covid-19 pandemic, a report has been provided every month to the Acute Services Division and Health and Social Care Partnership which contained detailed information on Adverse Events, Duty of Candour and the status of actions since 2017 to present. This report supports the service management to manage the completion of actions, which is within their responsibility.
- Status report of actions and overdue actions is to be reported through local clinical governance groups.

Action point reference 3

Internal Audit identified there is a lack of detail contained in Datix on the steps taken to implement actions; to show an action is closed is not sufficient. This was also identified for actions relating to sharing learning.

Progress to date

- Needs further discussion with the Adverse Events group and feasibility.

Action point reference 4

Strengthen the trail of identifying officers when actions are closed and signed off

Progress to date

- Fields within Datix have been identified and will prompt the user to confirm if an action is complete. Further discussions to take place with regard to additional evidence required as reports and learning summaries are in the system.

2.3.1 Quality/ Patient Care

The quality and safety of patient care and experience has been impacted by an adverse event. The systems and processes outlined above are important to have in place so assurances can be provided to demonstrate change and improvements to mitigate against such events reoccurring.

2.3.2 Workforce

The impact may that some additional requirement to entry more details into Datix and run reports.

2.3.3 Financial

Not applicable

2.3.4 Risk Assessment/Management

This is part of a response to an audit which outlines a gap in the controls. Specific risk assessment for this report is not required.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment has not been completed on this element of reporting and managing adverse events. An assessment is completed as part of the policy.

2.3.6 Other impact

None identified.

2.3.7 Communication, involvement, engagement and consultation

This report was first discussed at the Adverse Events / Duty of Candour group in February 2020.

This paper has not been considered by other groups as part of its development.

2.3.8 Route to the Meeting

This report has been presented at the NHS Fife Adverse Event/Duty of Candour Group 18 August 2020, EDG 20th August 2020 and Clinical Governance Committee on 7 September 2020.

2.4 Recommendation

- **Awareness**

Report Contact
Helen Woodburn
Head of Quality and Clinical Governance
helen.woodburn@nhs.scot

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**17 September 2020**
Title:	**Feedback from the Sharing Intelligence for Health & Care Group**
Responsible Executive:	**Carol Potter, Chief Executive**
Report Author:	**Gillian MacIntosh, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive
- National Health & Well-Being Outcomes

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This paper provides the Audit & Risk Committee with the feedback received from the Sharing Intelligence for Health & Care Group's recent review of NHS Fife. The Group is a mechanism that enables seven national organisations to share, consider and respond to intelligence about care systems across Scotland, in particular NHS Boards. The seven organisations, each of which has a Scotland-wide remit, are: Audit Scotland, Care Inspectorate, Healthcare Improvement Scotland, Mental Welfare Commission for Scotland, NHS Education for Scotland, Public Health & Intelligence (part of NHS National Services Scotland), and Scottish Public Services Ombudsman. The Group considers information already held by the various organisations, including a range of information that is already in the public domain.

2.2 Background

The establishment of the Sharing Intelligence for Health & Care Group (SIHCG) was an important part of Scotland's response to a recommendation to improve intelligence sharing

within and amongst national agencies. This recommendation was made in 2013 following a public inquiry into the serious failings at Mid Staffordshire Foundation NHS Trust. The Group was established in 2014 with the aim of supporting improvement in the quality of care provided for the people of Scotland by making good use of existing data and intelligence. Its main objective is to ensure that, when any of the seven agencies on the Group have a potentially serious concern about a care system, then this is shared and acted upon appropriately. Sharing concerns at the right time can help identify emerging problems which can then be acted upon.

It is important to note that this does not allow the Group to make a comprehensive assessment of the quality of care in an individual Board, nor is it the role of the Group to do so. The agencies on the Group report that there is now much better sharing and consideration of key pieces of intelligence, and they are now much better prepared to take additional action when this is required.

The Group provide feedback to each of the NHS Boards they consider, initially in the form of a feedback letter. A follow-up meeting with the respective NHS Board is then scheduled, at which is considered key issues raised within the written report. NHS Fife received their written feedback letter on 23 July and a follow-up meeting to discuss this, between Directors and representatives from the Group, took place on 1 September. A note of this meeting will be provided to the Board in due course.

2.3 Assessment

The feedback letter on NHS Fife is enclosed for the Committee's information. There were two main issues highlighted: the quality of the estate / buildings used to deliver care in a Mental Health setting; and the ongoing financial and governance challenges in the operation of the Health & Social Care Partnership / IJB. Follow-up discussion was held on these points when representatives from the Group met with Directors.

Positive progress was also highlighted, namely in the enhancement of medical education and training; the Board's engagement in quality improvement work; and strong partnership working in children's and young people's services. The Board's response and leadership in the context of the Covid-19 pandemic was recognised at the feedback meeting, as was progress in a number of other key areas.

2.3.1 Quality / Patient Care

Consideration of the SIHCG feedback is an important indicator of our quality and safety standards, it being indicative of the findings of, and information held by, various external regulators.

2.3.2 Workforce

There are no workforce implications from this paper.

2.3.3 Financial

There are no financial implications from this paper.

2.3.4 Risk Assessment/Management

N/A.

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

As described within the feedback letter, the written report summarises the findings of the Group's review of information held by seven external agencies. This letter is expected to be published by the SIHCG at the start of October.

2.3.8 Route to the Meeting

This feedback from the SIHCG letter has been considered by relevant Directors and reviewed in detail with the SIHCG at a meeting on 1 September.

2.4 Recommendation

The paper is provided to the Audit & Risk Committee for:

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

3 List of appendices

The following appendices are included with this report:

- Appendix – SIHCG Feedback Letter, 23 July 2020

Report Contact
Gillian MacIntosh
Board Secretary
gillian.macintosh@nhs.scot

OFFICIAL: SENSITIVE – DRAFT AND NOT FOR FURTHER CIRCULATION

Date: 23 July 2020

All enquiries:
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0131 623 4375

Ms Carol Potter
Chief Executive
NHS Fife
Hayfield House
Hayfield Road
KIRKCALDY
Fife KY2 5AH

Dear Ms Potter

Feedback from the Sharing Intelligence for Health & Care Group

The Sharing Intelligence for Health & Care Group (referred to as 'the Group') considered NHS Fife at our meeting on 22 June 2020, as part of our routine annual programme of work. We are writing now to summarise the main points we discussed collectively as seven national organisations[1].

First we wish to acknowledge, and show our appreciation for, the great efforts of staff from NHS Fife and Fife Health & Social Care Partnership in response to the Covid-19 pandemic. In our annual report for 2018-19, we highlighted the committed workforce in Scotland that has continued to deliver high-quality care. Colleagues' expertise, professionalism, commitment and compassion is needed now more than ever. We also understand that local health and care systems are currently in the process of restarting many services, and the Covid-19 pandemic will continue to impact on front line services for a considerable time to come.

[1] The Sharing Intelligence for Health & Care Group is a partnership involving: Audit Scotland; Care Inspectorate; Healthcare Improvement Scotland; Mental Welfare Commission for Scotland; NHS Education for Scotland; Public Health Scotland, and: Scottish Public Services Ombudsman.

The seven national organisations on the Group have also made changes to our work programmes, with the ultimate aim of supporting front line services during the Covid-19 pandemic. This is having some impact on the intelligence that is readily available to us. We are, however, continuing to share and consider intelligence regularly throughout the current pandemic – as we have a duty to make the best use possible of existing data, knowledge and intelligence. One of our main objectives is to ensure that, when any of the seven agencies on the Group have a potentially serious concern about a care system, then this is shared and responded to as necessary. Sharing concerns at the right time can help identify emerging problems which can then be acted upon.

Thank you for the information you provided in advance of our meeting on 22 June 2020. The intelligence considered by the Group should already be known to NHS Fife, including a range of information which is already in the public domain. It is important to note that we only consider data/information that is held by the seven agencies represented on the Group. This sort of intelligence helps us identify things that are working well, as well as emerging problems. It does not, however, allow us to make a comprehensive assessment of the quality of care – nor is it the role of the Group to do this. Furthermore, we are prioritising the points that we feed back to individual NHS boards during 2020-21, with the aim of drawing attention to points that continue to be relevant at the time of the current pandemic.

NHS Fife

When we considered NHS Fife on 22 June 2020, the partner agencies on the Group found it helpful to learn from each other about various aspects of the health and social care system in Fife. This will help inform the work we carry out as national organisations. As described below, we were pleased to note aspects of your local system that are working well. We also discussed some risks to the quality of care delivered for the residents of Fife. We acknowledge that work is already being carried out locally to respond to these issues, sometimes with input from one or more of the partner agencies on the Group.

In recent years, the Mental Welfare Commission for Scotland has highlighted some concerns to the Group about the three adult acute mental health wards in Fife – in particular about the older nature of the buildings/environments. At our meeting on 22 June 2020, we were told by the Commission that these ward environments are not conducive to recovery, and continue to be in need of redesign and refurbishment. For example, the high number of beds (30) and traditional layouts of these wards create challenges for staff, including maintaining appropriate observational levels. The Commission reported that it has raised concerns through its local visit programme, but there has been limited evidence of progress in relation to some recommendations.

We also learned that a number of significant incidents have been reported to the Commission over the past two years for the Fife area. The findings from an investigation by the Commission into a death at Whyteman's Brae Hospital highlighted some concerns, including risk assessment processes and response to recommendations from the Health & Safety Executive about potential ligature points within a ward.

NHS Education for Scotland explained that there is good engagement from NHS Fife in relation to postgraduate medical education and training. Following its 2019 Quality Review Panels, NHS Education for Scotland identified the need for a relatively high number of quality management triggered visits to NHS Fife given the number of training posts. These included a further visit to General Medicine at Victoria Hospital, which was the third visit there since 2016 due to ongoing concerns (a visit to Cardiology at Victoria Hospital was postponed because of Covid-19). Earlier this year there was also a Fife-wide quality management visit to assess the quality of training in Psychiatry (Queen Margaret Hospital, Lynebank Hospital, Stratheden Hospital, Victoria Hospital &

Whyteman's Brae Hospital). This was necessitated by poor engagement with a previous visit in 2018 at which a number of concerns had been identified regarding the quality of training. The follow up visit to Psychiatry in 2020 was much more positive, noting the supportive training environment and the commitment to address the concerns raised previously. We also learned that NHS Fife continues to have some workforce challenges for mental health services, and that two of the areas where your consultant vacancy rate is relatively high are General Psychiatry and Old Age Psychiatry. We understand that mental health is one of your priority areas for restarting services following the first wave of Covid-19.

The other main area of concern the Group highlighted when we considered Fife in recent years is the operation of your Health & Social Care Partnership, including financial and governance challenges. At our meeting in June 2020, we noted that the Accounts Commission recently highlighted some important progress that Fife Health & Social Care Partnership has made. This includes updating its strategic plan, and progressing reviews of its integration scheme and of its medium-term financial strategy. However, the Accounts Commission also emphasised the need for Fife Health & Social Care Partnership to strengthen its financial management and performance reporting, and for there to be greater clarity of its responsibilities and relationships with NHS Fife and Fife Council. We also noted that there has been significant and ongoing change in the partnership's leadership team since it became operational in April 2016, with three chief officers and four chief finance officers. In your letter dated 19 June 2020, you explained that plans for system-wide leadership development have been disrupted by the Covid-19 pandemic. We also learned that while 2019-20 has been a challenging year financially for NHS Fife, you are expecting to break even.

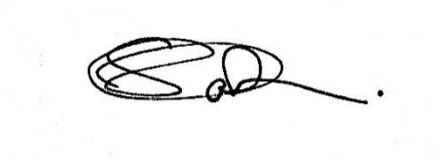
When we considered Fife in 2019, we highlighted the findings from a joint inspection of services for children and young people in need of care and protection. These included evidence of strong partnership working at strategic and operational levels, and a culture of learning was helping to drive forward identified improvements. We also noted that there has been a sustained deterioration in bed days lost to delayed discharge in Fife, following a previous sustained improvement.

Our meeting on 22 June 2020 provided an opportunity for the partner agencies on the Group to share information with each other about the quality of other front line services in Fife. For example, we found it helpful to learn from Healthcare Improvement Scotland of some examples of where NHS Fife has engaged well with nationally-led quality improvement work. The acute care portfolio highlighted that NHS Fife is one of the most engaged NHS boards in Scotland – and successes include sustained improvements in the rates of cardiac arrest and falls with harm. As you explain in your letter, you have more to do to reduce your rate of pressure ulcers.

In summary, the Group acknowledged that there are concerns about mental health services in Fife, together with concerns about aspects of integrated health and social care. Challenges in these areas have been ongoing for a number of years, and they need to be addressed as a matter of some urgency – even at this time when health and social care services are under significant pressures as a result of the Covid-19 pandemic. In the first instance, we wish to meet with you and your team (including input from Fife Health & Social Care Partnership) to learn about your assessment of these issues and how you are responding to these. In addition, a number of our partner agencies will continue to work closely with each other to ensure their work in these areas is co-ordinated and mutually supportive – and to decide whether or not there are any additional actions beyond any already planned that any of these agencies need to take.

We hope you find this summary of our discussions helpful. As a Group, we will continue to share intelligence in order to inform the work we carry out as seven national agencies. If you have any suggestions for how our Group can better support your work to deliver high quality care for the residents of Fife then please don't hesitate to let us know.

Yours sincerely



Alastair McLellan
Co-Lead for Quality
NHS Education for Scotland

Simon Watson
Medical Director
Healthcare Improvement Scotland

CC: Nicky Connor, IJB Chief Officer
Helen Woodburn, Liaison Co-ordinator

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**17 September 2020**
Title:	**Update on Board Action Plan for the implementation of the NHS Scotland 'Blueprint for Good Governance'**
Responsible Executive:	**Carol Potter, Chief Executive**
Report Author:	**Gillian MacIntosh, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

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', authored by John Brown CBE and Susan Walsh OBE. 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.

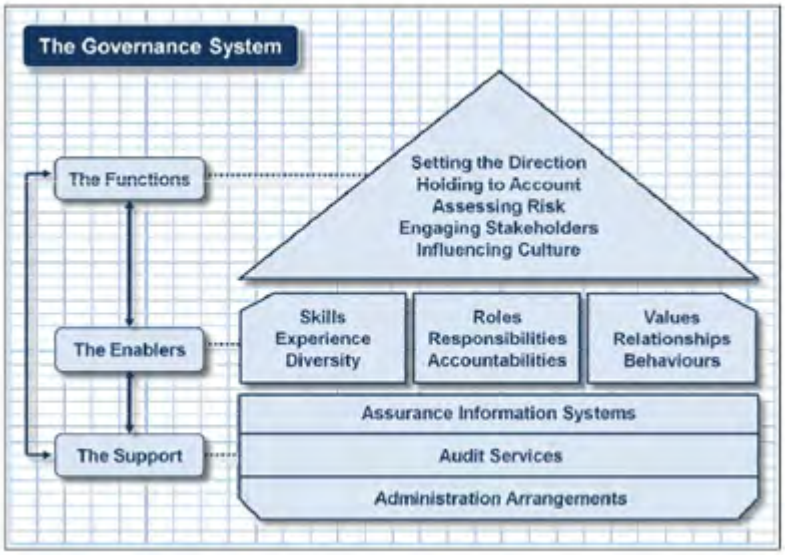
Practical implementation of the Blueprint and its supporting suite of documents is being overseen through the NHS Scotland Chairs' sub-group, the Corporate Governance Steering Group, on which the NHS Fife Chair, Tricia Marwick, serves as a member.

The NHS Scotland Board Secretaries' Group is also leading on a number of supporting workstreams, including the creation of various 'Once for Scotland' templates to inform key governance documents such as Standing Orders, Schemes of Delegation / Standing Financial Instructions, Terms of Reference for key governance committees, and Induction

programmes and material. Some of this material has been issued and adopted by the Board over the past year.

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 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 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 within the overall governance structure and has been enhanced via the introduction of an online survey.

Facilitated by national colleagues, a follow-up questionnaire was to be undertaken annually, with the next iteration of the Blueprint survey expected to be released for members' completion in early 2020. This, however, has been delayed, principally due to

the Covid-19 pandemic, and the next survey is now not expected to be released until early 2021.

2.3 Assessment

In reviewing last year's results both from the 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. It was then agreed an update would be provided after six months, and a follow-up paper providing that assessment was reviewed by the Board in November 2019.

As previously agreed, regular updates on the Blueprint workstreams have been given to the Audit & Risk Committee, which has a key role in approving key governance documentation such as Standing Orders and ensuring that systems of corporate governance are fit for purpose and operating according to relevant regulations. In March, Audit & Risk considered a number of outputs, including the new Model Standing Orders for Boards and agenda paper templates and guidance, which have now been adopted.

Given that the next national survey is expected to be released in early 2021, it is thought useful to provide the Board with a further update on the previously agreed Action Plan. The attached document has been expanded to provide further information on the improvement activities that are being taken forward in delivery of these improvements. From the document, a number of individual actions have been completed; others have a programme of activity underway to address the previous recommendations. Full details are provided in the enclosed appendix to this paper.

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 will be met from existing resource.

2.3.3 Financial

There are no financial implications from this work.

2.3.4 Risk Assessment/Management

Implementing and completing the enclosed action plan will mitigate any risks of non-compliance with the Blueprint's requirements. Compliance evidences that NHS Fife has robust corporate governance practices in place that help deliver and support organisational objectives.

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 will address 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 and Chief Executive, prior to submission to the Committee.

2.4 Recommendation

The Audit & Risk is invited to:

- **Discuss** – the information provided in this paper and recommend that it be submitted to the Board's next meeting for assurance purposes.

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
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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 Report (IPR), to enhance the clarity of information contained therein and remove potential areas of duplication or stasis.	The IPR 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 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).			
	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 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.			

NHS FIFE ACTION PLAN – UPDATE ON THE IMPLEMENTATION OF BLUEPRINT FOR GOOD GOVERNANCE

Area for Improvement	No.	Action	Improvement Activity / Evidence	Who / When
	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. <u>Update</u> 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).			
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. <u>Update</u> 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.			

NHS FIFE ACTION PLAN – UPDATE ON THE IMPLEMENTATION OF BLUEPRINT FOR GOOD GOVERNANCE

Area for Improvement	No.	Action	Improvement Activity / Evidence	Who / When
	5	Reduce the amount 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 **Ongoing– revised completion date of December 2020**
	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. <u>Update</u> 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.			
	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 **Ongoing– tied to timings of national workstreams in 2021**
	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. <u>Update</u> 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.			

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 **Work ongoing to further strengthen – revised completion date by January 2021**
	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. <u>Update</u> 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.			
	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 **Work ongoing to further strengthen – revised completion date by December 2020**
	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. <u>Update</u> 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.			

NHS FIFE ACTION PLAN – UPDATE ON THE IMPLEMENTATION OF BLUEPRINT FOR GOOD GOVERNANCE

Area for Improvement	No.	Action	Improvement Activity / Evidence	Who / When
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 **Work ongoing to further strengthen – revised completion date March 2021**
	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. <u>Update</u> 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.			
	10	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.	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.	Chair & Board Secretary **Work ongoing to further strengthen – to be reviewed January 2021**
	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. <u>Update</u> 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.			

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**17 September 2020**
Title:	**Annual Review of Code of Corporate Governance**
Responsible Executive:	**Margo McGurk, Director of Finance**
Report Author:	**Gillian MacIntosh, Board Secretary / Robert MacKinnon, Associate Director of Finance**

1. Purpose

This is presented to the Board 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, Scheme of Delegation, Standing Financial Instructions and Code of Conduct for Board Members. It is therefore important that it remains current and correct.

The amended Code of Corporate Governance, provided as an appendix to this paper, incorporates the Board's approval of the new Model Standing Orders for Boards in NHS Scotland and recent reviews by each Board Committee of their individual Terms of Reference. Also proposed are a number of clarifying changes to the Standing Financial Instructions, recommended by the Director of Finance. These amendments seek to bring the current version of the Code up-to-date and reflective of current practice.

2.2 Background

The most recent version of the Board's Code of Corporate Governance was formally approved in May 2019. At agreed at that date, an annual update of the Code is considered by the Audit & Risk Committee and thence the Board.

2.3 Assessment

In addition to containing the approved version of the Board's new Standing Orders and each Board Committee's reviewed remits, the attached version of the Code has been reviewed to ensure that the current text reflects present structures, terminology and job titles. Proposed textual changes of note have been tracked in the document for ease of identification.

The Committee should note that further changes to the Code will be required in the near future to reflect the work currently underway aligned to the ongoing implementation of the NHS Scotland Blueprint for Good Governance. It is expected that this will produce 'template' Schemes of Delegation and Standing Financial Instructions on a 'Once for Scotland' approach, which individual Boards will be expected to implement and adapt locally as part of implementing the Blueprint. Additionally, standard Terms of Reference for 'mandatory' Board committees (i.e. Audit, Clinical Governance and Staff Governance) are presently being prepared, again to be adopted locally when finalised by the national group. A further update to the Committee on this will therefore follow in due course.

While the Code applies to the Endowment Fund, except where it relates solely to core Exchequer funded business, or any matters for which the Trustees have determined separate governance, a review of the governance of the Fund will be undertaken in due course and submitted to Trustees for consideration.

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 financial accounting processes 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 and takes account of any initial comments thus received.

The Model Standing Orders included therein were approved by the Board at its meeting of 8 April 2020. Each Board Committee reviewed their respective remits and agreed any changes thereto at the cycle of meetings held in March 2020.

2.4 Recommendation

The paper is provided for:

- **Recommending approval to the Board** – subject to members' comments regarding any 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
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CODE OF CORPORATE GOVERNANCE

FIFE NHS BOARD

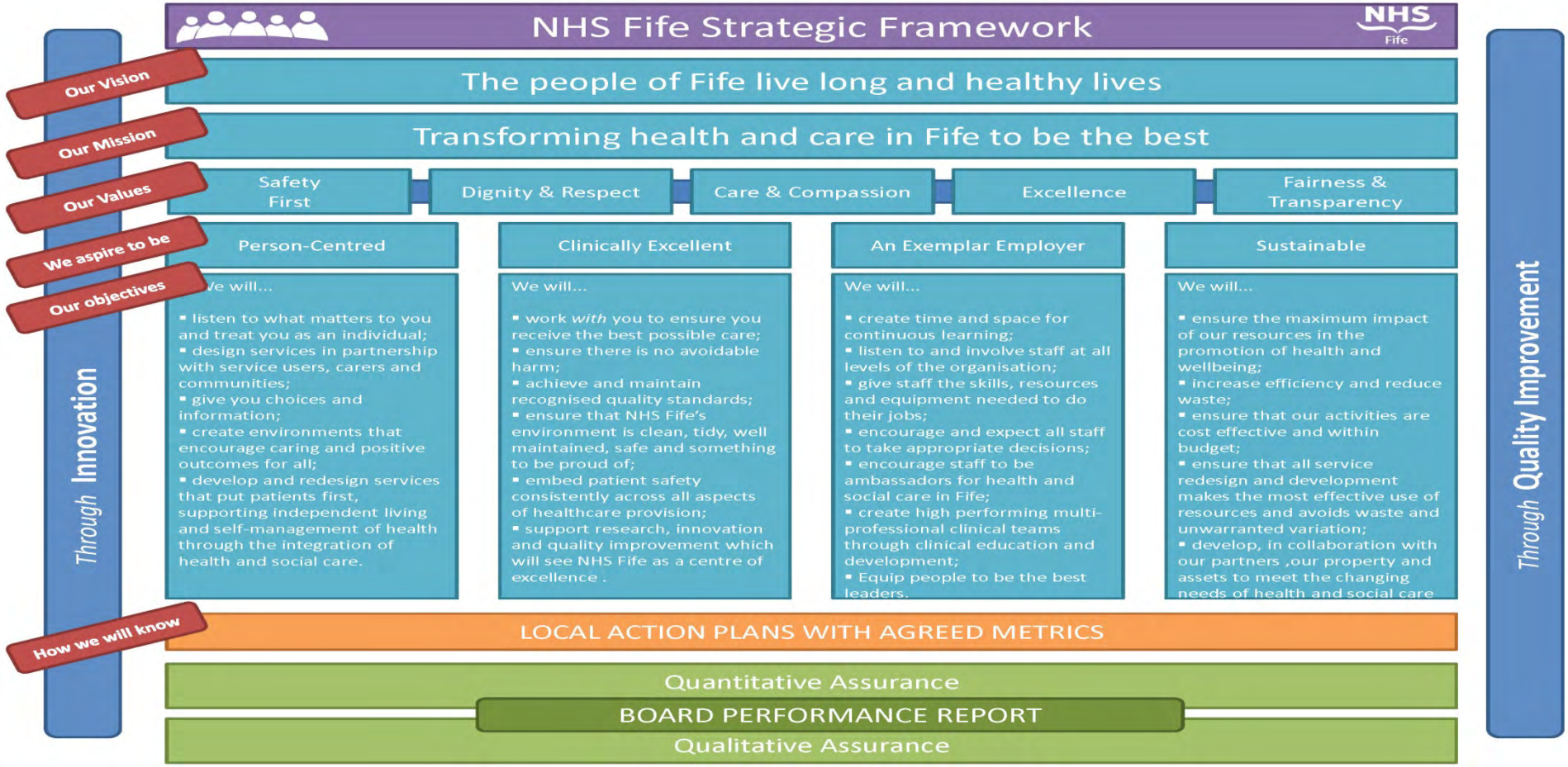
Reviewed by:	Board Secretary
Date of Board Approval:	30 September 2020
Next Review Date:	April 2021

Issue no. 16 – 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.

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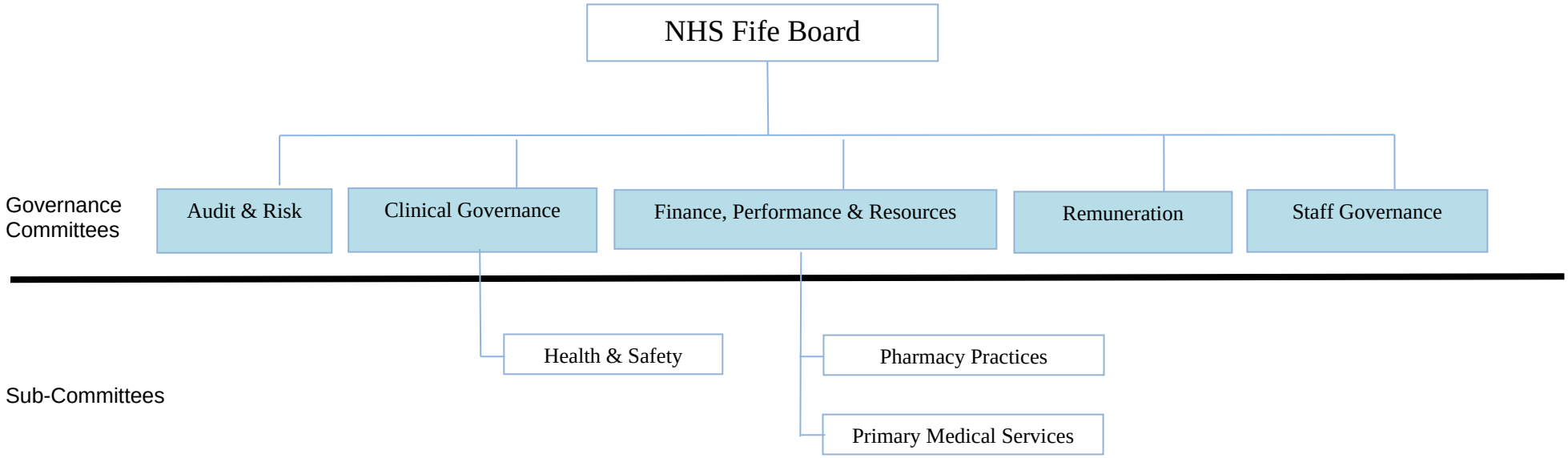
NHS Fife

NHS FIFE BOARD COMMITTEE STRUCTURE



TERMS OF REFERENCE FOR BOARD COMMITTEES

AUDIT AND RISK COMMITTEE
CONSTITUTION AND TERMS OF REFERENCE

Date of Board Approval: 27 May 2020

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
- Chief Internal Auditor or representative
- Executive Lead for Risk Management
- Statutory External Auditor
- Board Secretary

2.5 The Director of Finance shall serve as the Lead 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: 27 May 2020

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
- 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
  - eHealth 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.

FINANCE, PERFORMANCE AND RESOURCES COMMITTEE
CONSTITUTION AND TERMS OF REFERENCE

Date of Board Approval: 27 May 2020

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 Estates & Facilities
- Director of Health & Social Care
- Director of Pharmacy & Medicines
- Board Secretary

2.4 The Director of Finance 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 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;
- 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

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 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.

REMUNERATION COMMITTEE
CONSTITUTION AND TERMS OF REFERENCE

Date of Board Approval: 27 May 2020

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 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: 27 May 2020

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

2.2 Each of the Staff Side Chairs of the Local Partnership Forums shall, annually, notify the Lead Officer to the Committee of a specific nominated deputy who will attend meetings in their absence. 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

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. In addition, in order to be quorate, each meeting will require one of the staff side Chairs of the Local Partnership Forums or their nominated deputy to be 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. This 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 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;
- 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 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 unless following successful grading appeals.

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-Eexpenses, ~~and~~ 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~~6 All employees shall be paid by bank credit transfer unless otherwise agreed by the Director of Finance.

8.~~9~~7 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 ~~circumstances~~ 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 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".

2.5 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

3. Matters Delegated to Individuals

3.1 Matters Delegated to the Chief Executive	
	General Provisions
	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".

	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 sub-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.

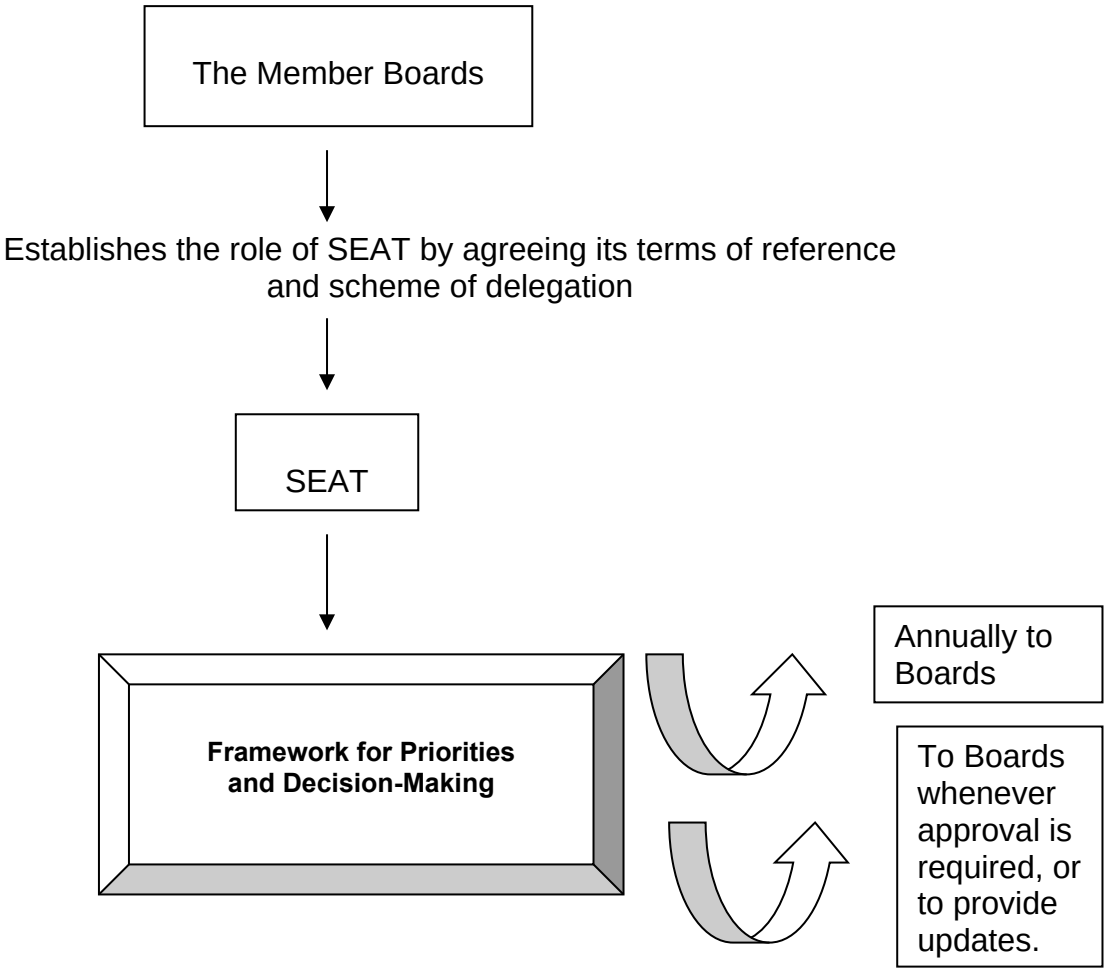
2. A **Terms of Reference**, describing the remit of the group, how it will make decisions, and how the different control elements of regional planning comes together to form the system of governance for SEAT.

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

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

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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~~5~~ 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

[1] SSI - The Ethical Standards in Public Life etc. (Scotland) Act 2000 (Register of Interests) Regulations 2003 Number 135, as amended.

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 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.

AUDIT & RISK COMMITTEE

DATES FOR FUTURE MEETINGS

Date
December 2020 (TBC)
January 2020 (TBC)
18 March 2021
13 May 2021
17 June 2021 (note, 10.30am start)
16 September 2021
9 December 2021
17 March 2022

Please note that all meetings take place via **MS Teams** / in the **Staff Club** (TBC) and start at **9.30am**

A pre-meeting of Committee Members only is routinely held, beginning at **9am**

* * * * *

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**17 September 2020**
Title:	**Post Transaction Monitoring**
Responsible Executive:	**Tony Gaskin, Chief Internal Auditor**
Report Author:	**Barry Hudson, Regional Audit Manager**

1 Purpose

This is presented to the Audit and Risk Committee for:

- Assurance

This report relates to a:

Government Directive

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

- Safe
- Effective
- Efficient

2 Report summary

2.1 Situation

In return for operational independence in respect of property transactions that NHS Boards are allowed, Scottish Government Health and Social Care Directorate (SGHSCD) now Scottish Government Finance, Corporate Governance and Value Directorate (SGFCGVD) require the procedures laid out in the NHS Scotland Property Transactions Handbook (PTH) to be followed.

2.2 Background

The purpose of this report is to advise the Audit and Risk Committee of the internal audit of the property transactions completed in 2019/20, which provides assurance that the required procedures have been followed.

2.3 Assessment

Under the PTH regulations, the Audit and Risk Committee is charged with oversight of the monitoring of the process of property transactions. The monitoring process is a cyclical exercise and Internal Audit were requested to review all three transactions completed in 2019/20 to ensure the requirements of the PTH were followed.

The audit report assessed each transaction at grade A, i.e. transaction is properly completed, with three recommendations all risk assessed as 'merits attention' which management have accepted and two of which have now been addressed.

A clean property transaction return in respect of 2019/20 can therefore be submitted to the SGHSCD by the 30 October 2020 deadline.

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.

2.3.3 Financial

The PTH is intended to ensure that NHS property is bought, sold and leased at a price and on other conditions which are the best obtainable for the public interest at that time. This post transaction monitoring process considers compliance with the PTH including the requirements associated with finance.

2.3.4 Risk Assessment/Management

The post transaction monitoring process considers the control objectives and processes in place to mitigate against the risk of non compliance with the PTH.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment has not been completed because it is not applicable for this report.

2.3.6 Other impact

Not applicable

2.3.7 Communication, involvement, engagement and consultation

The content of the report was discussed with the Chief Internal Auditor, Director of Finance and Director of Estates, Facilities, and Capital Planning ahead of submission to the Audit and Risk Committee.

2.3.8 Route to the Meeting

Not applicable

2.4 Recommendation

The Audit and Risk Committee is requested to note that:

1. The requirements of the PTH have been complied with;
2. The internal audit report is attached at Appendix 1, and
3. Arrangements are in place to issue the Board's Annual Property Transactions Return to SGHSCD by the deadline of 30 October 2020, and that the return be submitted with no significant issues identified.

3 List of appendices

The following appendices are included with this report:

- Appendix 1 – Internal Audit Report B25/21 – Post Transaction Monitoring

Report Contact

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

FTF Internal Audit Service

Post Transaction Monitoring

Report No. B25/21

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

A Fairgrieve, Director of Estates, Facilities & Capital Services
N Swan, Projects & Property Administration Manager

G MacIntosh, Head of Corporate Governance/Board Secretary

Audit and Risk Committee
External Audit

Contents

Draft Report Issued	26 August 2020
Management Responses Received	27 August 2020
Target Audit & Risk Committee Date	17 September 2020
Final Report Issued	**3 September 2020**

CONTEXT AND SCOPE

1. NHS Boards have operational independence in relation to property transactions. In return for this independence the Scottish Government Health & Social Care Directorates (SGHSCD) require that Boards follow procedures laid out in the Property Transactions Handbook (the Handbook). The NHS Scotland Property Transactions Handbook provides guidance on the responsibility and procedures to be followed by Holding Bodies, i.e. Fife NHS Board, to ensure that property is bought, sold and leased at a price, and on other conditions, which are the best obtainable for the public interest at that time.

2. It is a requirement of Part A Section 6.3 of the Handbook that: '*Post-transaction monitoring must be an integral part of the internal audit programme. The Audit Committees of the Boards of Holding Bodies are responsible for the oversight of the programme. The Internal Auditor reports his/her findings to the Audit Committee. The Audit Committee's oversight of the work of the Internal Auditor includes reporting to the Board.'*

3. The following transactions meet the criteria set out in the NHS Property Transaction Handbook for 2019/20.

Sales	**Sale Proceeds**
Fair Isle Clinic, Kirkcaldy	£200,000
ADC, Unit 7, Midfield Road, Mitchelston Industrial Estate, Kirkcaldy	£350,000
Forth Park Hospital, Kirkcaldy	£540,000

4. The Audit and Risk Committee meeting on 13 July 2020 agreed the Internal Audit Annual Plan for 2020/21 which included Post Transaction Monitoring. We agreed with client management that all three property transactions would be included in our audit.

5. Transaction files were examined to ensure that:

   ◊ Property needs are appropriately identified and suitable action taken

   ◊ Transactions are properly managed

   ◊ Certificates are completed as required.

AUDIT OPINION

6. As the audit opinions categories for post transaction monitoring are pre-defined within the Handbook we have not stated an overall opinion on the system but have provided an opinion on each sale using the Handbook categories. A description of the assessment of risks associated with weaknesses identified is provided Section 3 of this report.

7. Part A, Section 6.3 of the Handbook states that '*Post-transaction monitoring must be an integral part of the internal audit programme. The Audit Committees of the Boards of Holding Bodies are responsible for the oversight of the programme. The Internal Auditor reports his/her findings to the Audit Committee. The Audit Committee's oversight of the work of the Internal Auditor includes reporting to the Board'.*

8. Furthermore Section 6.4 states *'The Board is responsible for submitting monitoring reports (including nil returns) to the Scottish Government Health & Social Care Directorates (SGHSCD) now no later than 30 October annually. Such monitoring reports should be submitted with appropriate supporting information and explanations for all transactions not classed as Category A*'.

9. In accordance with the requirements of Part A Section 6.9 of the Handbook each transaction must be categorised as:

   A Transaction has been properly conducted, or

   B There are reservations on how the transaction was conducted, or

   C A serious error of judgment has occurred in the handling of the transaction.

10. The audit opinions for the transactions concluded in 2019/20 are:

Transaction	Sale Proceeds	Category
Sale of Fair Isle Clinic, Kirkcaldy	£200,000	**A**
Sale of ADC, Unit 7, Midfield Road, Mitchelston Industrial Estate, Kirkcaldy	£350,000	**A**
Sale of Forth Park Hospital, Kirkcaldy	£540,000	**A**

11. A review of the procedures followed for the 2019/20 transactions, confirmed that they were concluded in accordance with the Handbook. We examined evidence which confirms that appropriate advice and guidance was sought and received from the Central Legal Office (CLO) and the appointed external Property Advisers during all three transactions.

12. We noted that the Chief Executive Officer (CEO) was signing Annex III documentation as both the Director of Finance (DoF) and CEO. This was an exception due to the change in CEO/DoF, however in future years we expect the CEO and the DoF to sign these off separately in line with the requirements set within the Handbook.

13. As required by the Handbook, the relevant trawl procedures were carried out as part of the consideration process for the disposal of the three properties. The properties were advertised via trawl notice circulation by the Scottish Government to the Scottish public sector. There was no interest from any other public body for any of the three properties.

14. The Mandatory Requirements section of the Handbook requires a Monitoring Proforma to be completed to provide sufficient documentation for audit purposes. This form has been completed for the three property transactions. We did note that 'Yes' was recorded, on the Proforma related to the sale of Forth Park Hospital, in response to the question '*Was property sold/leased on Open Market to Highest Bidder?*' when this was not the case as the highest bidder was discounted due to the caveats their bid included. The answer should therefore have been recorded as 'No' and an explanation provided.

15. We were able to confirm that a decommissioning exercise was completed for all three properties. However it was noted that the paperwork for Fair Isle Clinic decommissioning exercise had not been signed off.

16. Internal Audit Review B27/19 Post Transaction Monitoring previously recommended that, in line with Section C1.18 of the Handbook, certification is required to be signed at the point where an offer for property is to be submitted or accepted. For all three

transactions, certification was signed off following final settlement but not at the point where offers were accepted.

17. Section C2.37 of the Handbook also requires Certification to be signed by the Chief Executive at the date of settlement. The Certifications for all 3 transactions were signed off by the Director of Finance, on behalf of the Chief Executive, on dates after the date of settlement. However, we noted that a significant improvement had been made in relation signing dates being closer to the date of settlement than in previous years (4 days for the Sale of Fair Isle Clinic, Kirkcaldy, 18 days for the Sale of ADC, Unit 7, Midfield Road, Mitchelston Industrial Estate, Kirkcaldy and 7 days for Forth Park Hospital).

18. The Director of Estates, Facilities & Capital Services advised that he had contacted Health Facilities Scotland requesting changes to the handbook regarding both of these sections (C1.18 & C2.37) but the changes have not been made on the latest version published.

ACTION

19. The action plan at Section 2 of this report 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

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

Barry Hudson BAcc CA
Regional Audit Manager

Action Point Reference 1	
Finding:	
A review of the decommissioning paper work for Fair Isle Clinic found that these had not been signed off at the conclusion of decommissioning by the staff undertaking the exercise. However we did note that the names of those undertaking the exercise were noted on the forms.	
Audit Recommendation:	
A reminder should be sent to staff to ensure that in future all relevant decommissioning paper work is appropriately signed as completed at the conclusion of decommissioning.	
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 decommissioning documentation has now been signed off as complete.	
Action by:	**Date of expected completion:**
Andrew Fairgrieve, Director of Estates, Facilities and Capital Planning	**Completed**

Action Point Reference 2

Finding:

We have previously reported in B27/19 and B26/20 issues around the following requirements of the Handbook:

- Section C - 1.18 of the Handbook states that '*Certification should be signed at the point where an offer is to be accepted or submitted*'.
- Section C - 2.37 of the Handbook states that '*Final certification must be completed by the Chief Executive of the Holding Body when the proceeds are received (i.e. date of settlement of transaction)*'.

All three transactions examined for 2019/20 had been signed off following final settlement, but not at the point where offers were accepted, and all were signed off by the Director of Finance rather than the Chief Executive on dates after the final settlements (4 days for the Sale of Fair Isle Clinic, 18 days for the Sale of ADC, Unit 7, Midfield Road and 7 days for Forth Park Hospital).

The Director of Estates, Facilities & Capital Services advised that he had contacted Health Facilities Scotland requesting changes to the handbook regarding both of these sections (Section C - 1.18 & 2.37) but changes to these sections have not been made on the latest version published.

Audit Recommendation:

a. Health Facilities Scotland should be requested to provide an update on the revision of these sections of the handbook.
b. Until the handbook is updated we will endeavour to comply with these sections by seeking the DoF and/or the CEO's signatures on the day of the acceptance and the date of settlement, dependant on availability.

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. **Health Facilities Scotland will be requested to provide an update on the revision of these sections of the handbook.**
b. **Until the handbook is updated we will endeavour to comply with these sections by seeking DoF and/or CEO's signatures on the day of the acceptance and the date of settlement, dependant on availability.**

Action by:	Date of expected completion:
Andrew Fairgrieve, Director of Estates, Facilities and Capital Planning	**a. 28 February 2021** **b. For future property transactions (will be followed up as part of the 2020/21 Post Transaction Monitoring Internal Audit)**

Action Point Reference 3	
Finding:	
'Yes' was recorded in response to the question '*Was property sold/leased on Open Market to Highest Bidder?*' on the Monitoring Proforma associated with the sale of Forth Park Hospital when this was not the case as the highest bidder was discounted due to the caveats their bid included. The answer should have been recorded as 'No' and an explanation provided.	
Audit Recommendation:	
A revised Monitoring Proforma for the sale of Forth Park Hospital, with the answer to question 23 corrected, should be completed and submitted to the Scottish Government.	
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 revised monitoring Proforma has now been submitted to the Scottish Government.	
Action by:	**Date of expected completion:**
Projects & Property Administration Manager	**Completed.**

Section 3 Definition of Assurance and Recommendation Priorities

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.**	None
Merits attention		There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**	Three (1, 2 & 3)

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**17 September 2020**
Title:	**Internal Audit Annual Report**
Responsible Executive/Non-Executive:	**M McGurk, Director of Finance**
Report Author:	**T Gaskin, Chief Internal Auditor**

1 Purpose

This is presented to the Audit and Risk Committee for:

- Assurance

This report relates to a:

- Government policy/directive
- Legal requirement

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

- Effective

2 Report summary

2.1 Situation

The purpose of this report is to present the **DRAFT** 2019/20 Annual Internal Audit Report to the NHS Fife Audit and Risk Committee. This report is for the Committee to consider as part of the wider portfolio of year end governance assurances. As the Annual Accounts process has experienced delays this report is still in draft and is with the Committee for discussion purposes. A final version will be presented to the next Audit and Risk Committee meeting.

2.2 Background

The Audit & Risk Committee is asked to consider this report as part of the portfolio of evidence provided in support of its evaluation of the internal control environment and the Governance Statement.

This annual report provides details on the outcomes of the 2019/20 internal audit and the Chief Internal Auditor's opinion on the Board's internal control framework for the financial year 2019/20.

Throughout the year, work has been ongoing on assignment reviews agreed in the Annual Internal Audit Plan and their contents have been incorporated into this report, most notably the Internal Control Evaluation (ICE), which was our most significant piece of assurance work for 2019/20.

This Annual Internal Audit Report presented to the Audit & Risk Committee highlights key themes, developments and exceptions. In addition to our follow-up of ICE recommendations, we have tested to ensure that there were no material changes to the control environment in the period from the issue of the ICE to the year-end. We have reflected on the impact of Covid and the special governance arrangements put in place at the end of the year.

Our detailed findings have been reflected in the NHS Fife 2019/20 Governance Statement and will inform our planning for individual 2020/21 audits.

The Internal Control Evaluation (ICE), issued on 6 January 2020, was informed by detailed review of formal evidence sources including Board, Standing Committee, Executive Directors Group (EDG) and other papers. The ICE noted many actions taken by NHS Fife to enhance governance and achieve transformation and whilst it concluded that NHS Fife assurance structures were adequate and effective, there were 15 recommendations for improvement by the end of June 2020, eight of which were classified as significant. Four recommendations have been implemented, with two partially completed and nine are still outstanding. Further details are included within each governance section.

In this annual report we have provided an update on progress to date and, where appropriate, built on and consolidated recommendations to allow revised completion dates to be agreed. The completion dates for seven actions have been extended, with the latest completion date now February 2021. Four remaining actions have previously been extended and remain outstanding. The following key findings from our ICE remain extant:

- Sustainable financial balance will not be achieved without greater progress on transformation and the revision of the IJB risk share agreement
- Information Governance assurances are insufficient
- Although progress has been made, Integration Governance arrangements have still not been concluded
- Actions to address the recommendations within Internal Audit Report B15/17 & B18/18 - Clinical and Care Governance Strategy and Assurance have not progressed as expected.

2.3 Assessment

Based on work undertaken throughout the year we have concluded that:

- The Board has adequate and effective internal controls in place;
- The 2019/20 internal audit plan has been delivered in line with Public Sector Internal Audit Standards.

In addition, we have not advised management of any concerns around the following:

- Consistency of the Governance Statement with information that we are aware of from our work;
- The description of the processes adopted in reviewing the effectiveness of the system of internal control and how these are reflected;

- The format and content of the Governance Statement in relation to the relevant guidance;
- The disclosure of all relevant issues.

Therefore, **it is my opinion** that:

- The Board has adequate and effective internal controls in place
- The Accountable Officer has implemented a governance framework in line with required guidance sufficient to discharge the responsibilities of this role.

We noted the following key themes:

- The opportunity to ensure that staffing reflects organisational priorities and the need for Board level assurance that capacity and capability are sufficient to update and drive strategy, achieve transformation and deliver required savings
- Different ways of working due to Covid19 and the opportunities and challenges these present;
- The requirement to review and potentially revise the Board's overall Strategy and all supporting strategies and ensure they are widely known and understood;
- Ongoing developments in risk management;
- The requirement to finalise governance aspects of integration;
- Recognition of eHealth as an essential enabler for change and the implementation of governance arrangements for eHealth and Information Governance;
- Improvement required around implementation of internal audit recommendations.

The importance of Remobilisation to the transformation process is vital moving forward. Internal Audit have developed a set of remobilisation principles and will be reviewing the adequacy of actions taken by the Board against these principles, with a report to be considered at the December 2020 Audit and Risk Committee meeting.

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.

The need for constant review of the Internal Audit plan has already been considered and agreed by the Audit and Risk Committee. At this stage it is still too early fully to understand the impact of Covid on NHS Fife's risk profile and the consequent changes required to the Internal Audit Plan. However, this report does have implications for the content and focus on the 2020-21 plan and in particular:

- B16/21 – Strategic Planning will focus on the adequacy of the Board's remobilisation plans and processes with later audits in the year focusing on implementation
- B28/21 - Information Assurance/Information Security Framework will focus on the extent to which the recent governance review has addressed concerns raised by ourselves, External Audit and NIS
- The plan will be amended to allow Internal Audit to review Clinical Governance arrangements and provide advice and input as required

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 the Associate Director of Finance.

2.3.8 Route to the Meeting

This paper has been produced by the Regional Audit Managers, reviewed by the Chief Internal Auditor and agreed by the Director of Finance.

2.4 Recommendation

The Audit and Risk Committee is asked to:

- **DISCUSS** this report as part of the portfolio of evidence provided in support of its evaluation of the internal control environment and the Governance Statement. The committee is asked to make a decision for the internal audit annual report 2019/20 to be distributed to Standing Committees for consideration.
- **NOTE** a final version will be reported to the next Audit and Risk Committee meeting, with a completed action plan.
- **NOTE** that a revised Internal Audit plan will be presented to the December Audit and Risk Committee.

3 List of appendices

The following appendices are included with this report:

- Annual Internal Audit Report 2019/20

FTF Internal Audit Service

Annual Internal Audit Report 2019/20

Report No. B06/21

Issued To: C Potter, Chief Executive
M McGurk, Director of Finance

C McKenna, Medical Director
L Douglas, Director of Workforce
H Buchanan, Director of Nursing
G MacIntosh, Head of Corporate Governance & Board Secretary

[Audit and Risk Committee]
[External Audit]

Contents

Draft Report Issued	4 September 2020
Management Responses Received	
Target Audit and Risk Committee Date	
Final Report Issued	

INTRODUCTION AND CONCLUSION

1. This annual report to the Audit and Risk Committee provides details on the outcomes of the 2019/20 internal audit and my opinion on the Board's internal control framework for the financial year 2019/20.

2. Based on work undertaken throughout the year we have concluded that:

- The Board has adequate and effective internal controls in place;
- The 2019/20 internal audit plan has been delivered in line with Public Sector Internal Audit Standards.

3. In addition, we have not advised management of any concerns around the following:

- Consistency of the Governance Statement with information that we are aware of from our work;
- The description of the processes adopted in reviewing the effectiveness of the system of internal control and how these are reflected;
- The format and content of the Governance Statement in relation to the relevant guidance;
- The disclosure of all relevant issues.

ACTION

4. The Audit and Risk Committee is asked to **note** this report in evaluating the internal control environment and **report** accordingly to the Board.

AUDIT SCOPE & OBJECTIVES

5. The Strategic and Annual Internal Audit Plans for 2019/20 incorporated the requirements of the NHSScotland Governance Statement and were based on a joint risk assessment by Internal Audit and the previous Director of Finance. The resultant audits range from risk based reviews of individual systems and controls through to reviews of strategic governance and the control environment.

6. The authority, role and objectives for Internal Audit are set out in Section 3 of the Board's Standing Financial Instructions and are consistent with Public Sector Internal Audit Standards.

7. Internal Audit is also required to provide the Audit and Risk Committee with an annual assurance statement on the adequacy and effectiveness of internal controls. The Audit & Assurance Committee Handbook states:

The Audit Committee should support the Accountable Officer and the Board by reviewing the comprehensiveness and reliability of assurances on governance, risk management, the control environment and the integrity of the financial statements and the annual report. The scope of the Committee's work should encompass all the assurance needs of the Accountable Officer and the Board. Within this the Committee should have particular engagement with the work of Internal Audit, risk management, the External Auditor, and financial management and reporting issues.

INTERNAL CONTROL

8. The Internal Control Evaluation (ICE), issued on 6 January 2020, was informed by detailed review of formal evidence sources including Board, Standing Committee, Executive Directors Group (EDG) and other papers. The ICE noted many actions taken by NHS Fife to enhance governance and achieve transformation and whilst it concluded that NHS Fife assurance structures were adequate and effective, there were 15 recommendations for improvement by the end of June 2020, eight of which were classified as significant. Four recommendations have been implemented, with two partially completed and nine still outstanding. Further details are included within each governance section.

9. In this annual report we have provided an update on progress to date and, where appropriate, built on and consolidated recommendations to allow revised completion dates to be agreed. The completion dates for seven actions have been extended, with the latest completion date now February 2021. Four remaining actions have previously been extended and remain outstanding. The following key findings from our ICE remain extant:

    - Sustainable financial balance will not be achieved without greater progress on transformation and the revision of the IJB risk share agreement
    - Information Governance assurances are insufficient
    - Although progress has been made, Integration Governance arrangements have still not been concluded
    - Actions to address the recommendations within Internal Audit Report B15/17 & B18/18 - Clinical and Care Governance Strategy and Assurance have not progressed as expected.

10. Covid 19 has clearly had a substantial impact on the organisation's priorities and ability to complete all of the agreed actions. However, it is our view that many of the original recommendations would not have been completed on time had the pandemic not occurred. The EDG should revisit these outstanding actions together with further required actions identified in this Annual Report to ensure the timescales for completion are appropriate, achievable and are afforded the requisite priority.

11. The ICE was our main piece of assurance work for 2019/20 and this Annual Internal Audit Report is therefore less detailed than in previous years. In addition to our ICE follow-up we have tested to ensure that there were no material changes to the control environment in the period from the issue of the ICE to the year-end. We have reflected on the impact of Covid 19 and the special governance arrangements put in place at the end of the year. Some areas for further development were identified and will be followed up in the 2020/21 ICE and, where applicable, our detailed findings have been included in the NHS Fife 2019/20 Governance Statement.

12. For 2019/20, the Governance Statement format and guidance included within the NHSScotland Annual Accounts Manual has been updated to include reference to the March 2018 SPFM Audit Committee Handbook and the Blueprint for Good Governance, issued in January 2019, albeit without specific reference to the associated Treasury Guidance on assurance mapping in the Audit Committee Handbook. Whilst Health and Social Care Integration is not specifically referenced, the guidance does make it clear that the Governance Statement applies to the consolidated financial statements as a whole, which would therefore include activities under the direction of IJBs. We are pleased to note that the NHS Fife Governance Statement does include reference to the key areas omitted from SGHSCD guidance.

13. The Board has produced a Governance Statement which states that:

    - *For 2019-20, 2595 individuals have exceeded the Treatment Time Guarantee to have their treatment provided within 12 weeks. A letter of apology was sent to each patient and every effort was made to treat patients in as short a time as possible. A Waiting Times Improvement Plan is being implemented and progress and improvement actions continue to be monitored through monthly performance reviews within the Acute Services Division.*
    - *An unannounced Healthcare Environment Inspection (HEI) was conducted at Glenrothes Hospital in March 2019, the Hospital having been last inspected in April 2014. The inspection reported on areas where NHS Fife was performing well and areas for improvement, identifying two areas of good practice and three requirements for improvement. During the visit the Board received positive feedback about the standards of cleanliness and staff knowledge of standard infection control precautions. It was, however, noted that not all staff were aware of and completed mandatory requirements for infection prevention and control education and that all patient equipment was safe and clean. An action plan was prepared in response to the areas for improvement identified, with all actions since completed. A further unannounced inspection of Glenrothes Hospital, by Healthcare Improvement Scotland, was conducted in July 2020, focused on Safety and Cleanliness and Care of Older People in Hospital; publication of the report is expected in September 2020.*
    - *There were 13 potential personal data-related incidents or data protection breaches reported to the Information Commissioner's Office (ICO) during the financial year ended 31 March 2020. Six related to personal data breaches, of which one report was rejected by the ICO as it pertained to a deceased person and one was subsequently withdrawn on investigation. Three breaches related to the unavailability of data (unplanned system outage) and four related to personal data breaches within GP Practices (NHS Fife is now joint data controller of data held within GP practices and provides Data Protection serves to GPs). None resulted in any patient harm or financial penalties being imposed. For ten of the reports submitted, the ICO took no further action, though made a series of recommendations. One report remains outstanding at the time of writing of this report.*
    - *During the 2019-20 financial year, no other significant control weaknesses or issues have arisen, in the expected standards for good governance, risk management and control.*

14. Whilst we are content that these disclosures are sufficient, members should be aware that the issues we have raised in relation to Information Governance could well lead to a disclosure in 2021-22 unless remedial action is taken as a matter of priority.

However, management have recently reviewed eHealth and Information Governance and are confident that the implementation of new governance arrangements will raise the profile of Information Governance at the Clinical Governance Committee and should address these issues.

15. Our audit has provided evidence of compliance with the requirements of the Accountable Officer Memorandum, and this combined with a sound corporate governance framework in place within the Board throughout 2019/20, provides assurance for the Chief Executive as Accountable Officer.

16. Therefore, **it is my opinion** that:

- The Board has adequate and effective internal controls in place;
- The Accountable Officer has implemented a governance framework in line with required guidance sufficient to discharge the responsibilities of this role.

17. Assurances have been received from all Executive Directors and Senior Managers that adequate and effective internal controls and risk management have been in place across their areas of responsibility and that there are no known control issues, nor breaches of Standing Orders / Standing Financial Instructions.

Covid 19

18. On 17 March 2020 NHS Scotland was placed on an emergency footing under section 1 and section 78 of the National Health Service (Scotland) Act 1978, for at least three months. Boards were given instructions *'to do all that is necessary to be ready to face a substantial and sustained increase in cases of COVID 19'*. A subsequent Directive from Scottish Government to Health Boards made clear that where directions are issued on behalf of the Cabinet Secretary there was to be no local interpretation and that these must be implemented in full and without delay in order to maintain the resilience of the NHS.

19. In recognition of the challenges caused by the rapid mobilisation of services to address Covid 19, a letter was issued by the Scottish Government Director of Health Finance to Board Chairs dated 25 March 2020, providing approval to revise governance arrangements. Individual Health Boards were invited to submit their specific proposals for governance during the pandemic period to the Office of the Chief Executive and NHS Fife submitted it on 30 March 2020. On 8 April 2020 NHS Fife Board considered a paper outlining the Board's planned approach to governance while NHS Fife continued to deal with the Covid 19 pandemic, based on the principles contained in the submission made to the Scottish Government. The paper outlined aims: to ensure the Board could effectively respond to Covid 19 as well as appropriately discharge its governance responsibilities, maximise time available for management and operational staff to deal with the significant challenges of addressing Covid 19 demand within clinical services and minimise the need for people to physically attend meetings.

20. In addition, meetings between the Chair and Vice-Chair and members of the EDG have taken place on a weekly basis and the minutes have been circulated to Board members. The Chief Executive has issued a weekly Covid update to all staff.

21. To ensure good governance around the restart of clinical services, the Remobilisation Oversight Group (ROG) was established with a wide representation of clinical leaders, to oversee the restarting of health and care services in Fife. As reported to the July 2020 Board, the purpose of this group is to take forward the reintroduction of clinical services in a safe, measured and Covid 19 sensitive way. The ROG aims to oversee the

whole system restart to improve integrated pathways from primary care, community, social care and secondary care, adhering to governance arrangements with learning from the Covid-19 response. The latest iteration of the Remobilisation plan, to March 2021, was submitted to the Scottish Government on 31 July in line with the requirements of the Scottish Government.

22. The draft NHS Fife Governance Statement recognises that *"In light of the ongoing impact of Covid 19 on NHS Fife, it is anticipated that the Board's strategic framework will require to be reviewed, in tandem with reassessment of the transformation programme and its relationship to the remobilisation / redesign of key services. As part of that work, the strategies of the IJB will also need to be considered and it is expected that all of the Board's supporting strategies will require review, to appropriately reflect a post-Covid environment."*

23. It is clear that recovery and reconfiguration will be key throughout the remainder of 2020-21. Remobilisation activity and transformation will need to be considered together in parallel with the fundamental review and, if required, revision of the Board's overall Strategy and supporting strategies. Additional responsibilities have been placed on Boards in relation to care homes and these will need to be considered in the context of the recognised need to formalise and enhance clinical and care assurance processes.

24. NHS Fife has contributed to the national response to the pandemic by piloting the Scottish Test and Protect software and the testing of the effectiveness of a Covid 19 treatment.

Key Themes

25. During 2019/20 the Chief Executive's departure resulted in changes to the NHS Fife Executive and senior leadership team structure, including appointment of the then Director of Finance as Interim Chief Executive and the subsequent appointment of an experienced Director of Finance from another Health Board on an interim basis. Other appointments during the year included a new Director of Workforce, Chief Operating Officer, Director of Health and Social Care, although the Director of Strategic Planning post remains vacant. The necessary prioritising of Covid 19 duties had emphasised the urgency to to put in place effective controls and in particular the need for the Board to seek assurance from the EDG to assure itself that it had sufficient capacity and capability to deliver long-term strategic change and develop sustainable models of care whilst delivering significant short-terms savings and continuing to deliver business as usual.

26. Over recent years the challenges facing all boards have increased significantly and NHS Fife has been no exception. Controls within the Board have not kept pace with changes to the environment in which the Board operates and may not be sufficient fully to mitigate the risks facing the Board in the coming years. Systems of control continued to have challenges to adequately resolve long-standing information governance, IJB governance and transformation issues. Capacity issues, specifically the loss of a number of key finance staff, have contributed to a delay in submission of the annual accounts, in line with the agreed timetable. Covid 19 and the consequent need to revisit the Board's overall and supporting strategies will create additional pressures going forward. The Board must assure itself that it has sufficient capacity and capability to review and, where necessary revise its strategies, deliver transformation and reconfiguration, and achieve significant short-term savings whilst continuing to deliver

business in extremely challenging circumstances at a time when staff have been under significant pressure over a long period.

27. Other key themes emerging from our ICE and other audit work during the year include:

- The Board's overall Strategy and all supporting strategies will require fundamental review and potentially significant revision to take account of the impact of Covid on population need, resource availability and the impact on modes of delivery as well as embedding potential for more rapid change. This will require considerable work to understand the impact of the pandemic and greater focus by Committees on the formation of supporting strategies and the monitoring their delivery as well as the delivery of transformation which will need both to accelerate and be genuinely transformative.
- Covid 19 will have a considerable impact on the Board's risk profile and, given the improvements still required, as reported in B13/20, there is an opportunity fundamentally to embed Risk Management processes, incorporating assurance mapping principles to ensure coherence between Governance Structures, Performance Management, Risk Management and Assurance. The revision of the Board's overall strategies provides an opportunity for fundamental review of the Corporate Risk Register to ensure it links risk to strategic objective, and to allow Board members to participate fully.
- Implementation of Internal Audit recommendations requires improvement with the vital support of EDG to ensure completion of actions. In particular, the completion of actions agreed within the ICE has been poor. Whilst some of this has undoubtedly been affected by Covid 19, we would anticipate that progress with actions will improve as staff return to their substantive duties. There is a need for more robust monitoring of ICE recommendations by officers and via the appropriate governance committees, who should reflect on any significant non-compliance in their year-end assurances.
- Digital and Information (eHealth) will be an essential enabler for transformation and remobilisation. Whilst there have been enhancements in the Digital and Information function, the overall governance arrangements and assurance reporting for Digital and Information, particularly for Information Governance, require substantial improvement to reflect their increasing importance and substantially increased risk profile.
- Following Covid, NHS Fife should establish clear and comprehensive Remobilisation principles which cover:
    - Learning lessons and identifying what did and did not go well, and thereby what changes and improvements can be instigated (noting that lessons learnt exercises have been undertaken with reporting to the Gold Command).
    - Where processes revised as a result of Covid are proving more effective and efficient, these should be incorporated into Business as Usual and there should be no assumption of a reversion to prior models; the past should have no special place
    - Data to evidence success and failure should be identified at the outset for both formal transformation projects and changes introduced as a result of the Covid 19 pandemic.

- It was already clear that services were not sustainable without substantial change and Covid 19 has increased the requirement for rapid transformation. Our Transformation Programme Governance Follow-up review (B15A/20) found that only one of the six recommendations from our report B10/18 had been fully implemented. Transformation work must be fully aligned with remobilisation activity and the organisation must seize the opportunity for rapid, sustainable change, in accordance with the actions agreed with Internal and External Audit over the last two years. This should be a central priority for both for the NHS Fife Board and particularly the Clinical and Care Governance Committee which has been delegated with responsibility for monitoring progress.

28. As a result of the Covid 19 pandemic, the Scottish Government delayed the requirement for comprehensive review of Integration Schemes. Whilst there has been progress, two key areas still need to be agreed including Clinical and Care Governance, which will now require particular attention. There is a commitment by management to reach agreement by 31 December 2020 in readiness for an approved Integration Scheme for the start of 2021-22.

29. The Board has been working in different ways as a result of the pandemic. Again, this provides an opportunity to reflect on its governance structures to ensure that they focus on the delivery of key organisational objectives, the mitigation of risk and effective assurance. This would also be a good time to refresh the understanding of the Board and Standing Committees on governance, culture and principles, ensuring that they are evident in all aspects of business. Whilst national initiatives such 'active governance' are expected to be introduced in 2020-21, we would expect the Board and Standing Committees to demonstrate:

    - Clear expectations of acceptable progress and delivery, tempered with an understanding of risks and acknowledgement that risks may crystallise
    - An expectation that officers will notify and address poor performance in a timely way
    - A collective understanding from members that NHS Fife must deliver on realistic targets which requires the Board and its Committees to ensure that targets are meaningful and realistic and then to ensure that all possible actions have been taken to meet them
    - Clear focus on priority areas including transformation, integration and information governance.

AUDIT PRODUCTS AND OPINIONS

30. During 2019/20 we delivered 34 audit products, including 9 from 2018/19. These audits reviewed the systems of financial and management control operating within the Board. Our reviews assisted the Board by examining a wide range of controls in place across the organisation.

31. Our 2019/20 audits of the various financial and business systems provided opinions on the adequacy of controls in these areas. Summarised findings or the full report for each review were presented to the Audit and Risk Committee throughout the year.

32. A number of our reports, including reviews of areas such as eHealth Strategic Planning & Governance, Transport of Medicines, and Attendance Management (Workforce Planning) have been wide ranging and complex audits which have relevance to a wide range of areas within NHS Fife.

33. Board staff had previously maintained a system for the follow up of internal audit recommendations and reporting of results to Audit & Risk Committee. To improve the effectiveness of the Audit Follow Up system, a revised approach was adopted from October 2019 with Internal Audit conducting an exercise to identify all outstanding actions back to 2017/18.

34. Although the Audit & Risk Committee has acknowledged improvements in the quality of Audit Follow Up (AFU) reports since January, the AFU management response rate and the quality of responses still requires enhancement. Of the 177 recommendations made in the years 2017/18, 2018/19 and 2019/20, 74 have been reported as complete, 61 of which have been verified by internal audit (as at 22 June 2020). While progress with some of these actions has undoubtedly been affected by Covid 19, we would expect that as staff return to their substantive duties, there should be clear and significant evidence of progress.

ADDED VALUE

35. The Internal Audit Service has been responsive to the needs of the Board and has added value by:

- Providing opinion on and evidence in support of the Governance Statement at year-end and conducting an extensive Internal Control Evaluation which recommended remedial action to be taken in-year. This review made recommendations focussed on enhancements to ensure NHS Fife has in place appropriate and proportionate governance, which supports and monitors the delivery of objectives and is commensurate with the challenging environment within which it is operating.
- Continuing to liaise with management and providing ad-hoc advice on a wide range of governance and control issues.
- Progressing the ongoing assurance mapping exercise to identify, assess, structure and develop assurances relating to key risks as well as those required from Directors. Internal Audit facilitated a joint approach across its four mainland clients as well as linking with national developments. In NHS Fife the Board Assurance Framework risk chosen for review was '*eHealth – Delivering Digital and Information Governance & Security*' which is described as '*There is a risk that due to failure of Technical Infrastructure, Internal & External Security, Organisational Digital Readiness, ability to reduce skills dilution within eHealth and ability to derive Maximum benefit from digital provision NHS Fife may be unable to provide safe, effective, person centred care*'. Work was progressing well, with very strong input from the Board Secretary, but was paused due to impact of Covid 19 and will continue as part of the 2020/21 Annual Internal Audit Plan.
- Continued participation in the development of information governance arrangements through attendance at Information Governance and Security Group and eHealth Board meetings and provision of support and advice on governance and assurance reporting.
- Detailed commentary on the developing Risk Management Framework.
- The B21/20 Medicines Management review contributed to the broader Medicines Assurance Audit Programme by considering compliance with the controls included in the Safe and Secure Use of Medicines Policy and Procedures (SSUMPP) regarding the movement and transportation of medicines to Community Hospitals. The audit found a number of lapses in expected controls and these were communicated at the

Safe and Secure Use of Medicines Group and the Medicines Transport Project Group.

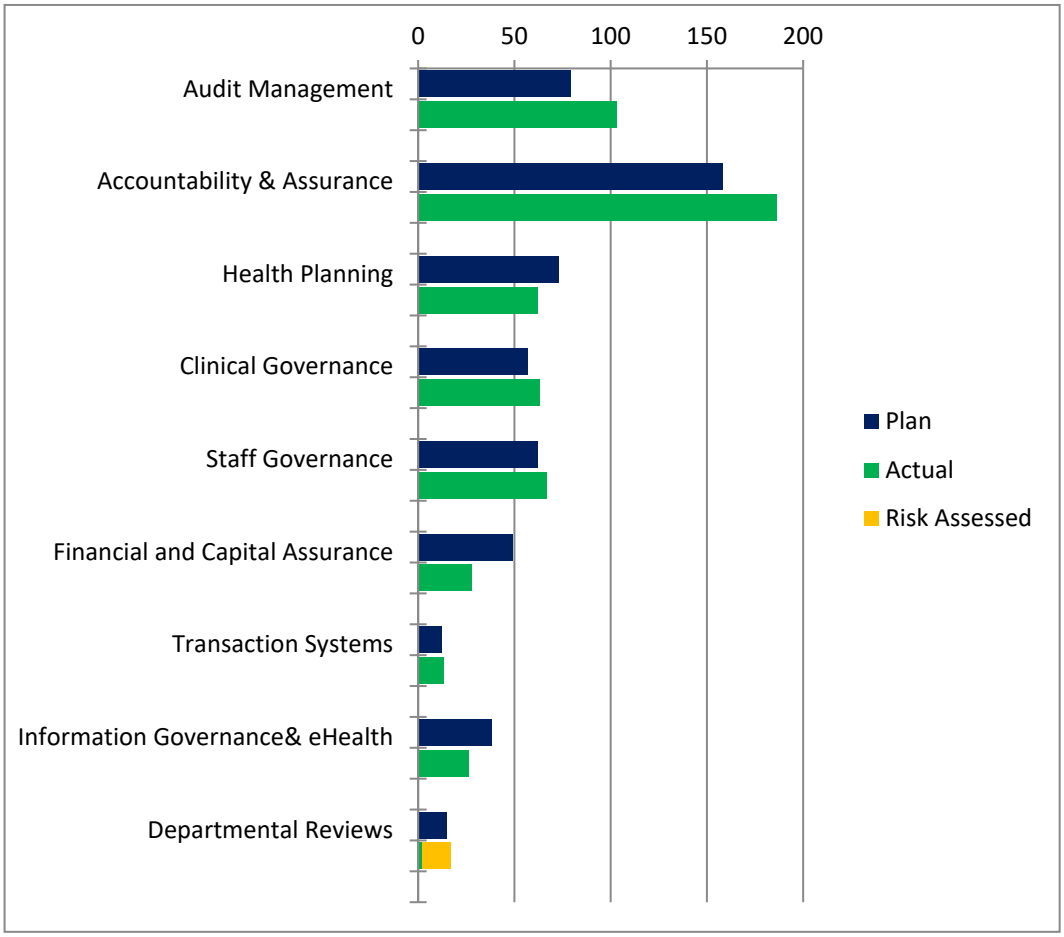
- The B23A/20 Attendance Management review provided assurance over the implementation of the attendance management policies and procedures and provided positive feedback that the training and awareness sessions were having a positive impact.

36. Internal Audit developed a governance checklist tool to capture evidence and provide assurance on areas of good governance and identify any gaps in arrangements to support the work of the NHS Boards during the pandemic. An abbreviated checklist was considered by the NHS Fife Standing Committees between June and July 2020 and Internal Audit will provide a review of these completed checklists early in the autumn. Internal Audit has also developed reconfiguration and remobilisation principles to assist management and to inform the 2020-21 audit process.

37. Internal Audit has continued to highlight governance and assurance aspects of integration and the need for clear lines of accountability and ownership of risk and to advise on specific issues, as well as maintaining an awareness of the impact of the IJB control environment on NHS Fife and providing updated assurance principles for consideration by management.

INTERNAL AUDIT COVER

38. Figure 1: Internal Audit Cover 2019/20



39. Figure 1 summarises the 2019/20 outturn position against the planned internal audit cover. The Annual Internal Audit Plan was approved by the Audit and Risk Committee at its meeting on 20 June 2019. To date, we have delivered 550 days against the planned 543 days. Work is ongoing to ensure that the two remaining products from 2019/20 are completed by the September 2020 Audit and Risk Committee. All audit products required for External Audit and for year-end assurance have been delivered.

40. Following a recommendation from the External Quality Assessment carried out on Internal Audit in 2018/19, we continue with the agreed process of risk assessing outstanding 2019/20 audits for inclusion in the 2020/21 plan. Only one review, Recruitment and Retention, required risk assessment and has been included within the audit plan for 2020/21.

41. A summary of 2019/20 performance is shown in Section 4.

PERFORMANCE AGAINST THE SERVICE SPECIFICATION AND PUBLIC SECTOR INTERNAL AUDIT STANDARDS (PSIAS)

42. The FTF Partnership Board has produced as annual summary of activity for the year:

FTF Partnership Board
Annual Summary 2019/20

1. Introduction

This report sets out a summary of Partnership Board meetings held in 2019/20.

2. FTF Partnership Board Meetings

Meetings were held on the following dates:

- 12 April 2019
- 13 November 2019

3. Attendance

The following individuals attended meetings in person or via teleconference:

Members:

- Scott Urquhart, Director of Finance, NHS Forth Valley (Chair)
- Carol Potter, Director of Finance & Performance, NHS Fife (now Chief Executive, NHS Fife)
- Frances Gibson, Head of Finance – Governance & Assurance, NHS Tayside / Robert MacKinnon, Associate Director of Finance

In Attendance:

- Tony Gaskin, Chief Internal Auditor FTF
- Jocelyn Lyall Regional Audit Manager FTF
- Barry Hudson Regional Audit Manager FTF
- Angela McEwan NHS Forth Valley (Minutes)

4. Business

The committee considered both routine and specific work areas during the year:

Key items discussed and outputs included the following:

- Review of External Quality Assessment (EQA) of FTF Internal Audit Service
- Health & Social Care Integration issues
- Internal Audit Shared Service Agreement 2018-2023 - update and review
- Internal Audit Service Specification – update and review
- Governance Issues including Governance Statement Guidance, Assurance Mapping and SGHSCD Assurance letters
- Review of budget performance 2018/19
- Approval of budget proposals 2019/20
- Review of Performance including KPIs and Balanced Scorecard
- Recruitment

5. Conclusion

As Chair of the Partnership Board I can confirm that the breadth of the business undertaken, and the range of attendees at meetings of the Partnership Board has allowed us to fulfil our remit.

Scott Urquhart
Chairperson, FTF Partnership Board

43. We have designed protocols for the proper conduct of the audit work at the Board to ensure compliance with the specification and the Public Sector Internal Audit Standards (PSIAS).

44. Internal Audit is compliant with PSIAS, and has organisational independence as defined by PSIAS, except that, in common with many NHSScotland bodies, the Chief Internal Auditor reports through the Director of Finance rather than the Accountable Officer. There are no impairments to independence or objectivity.

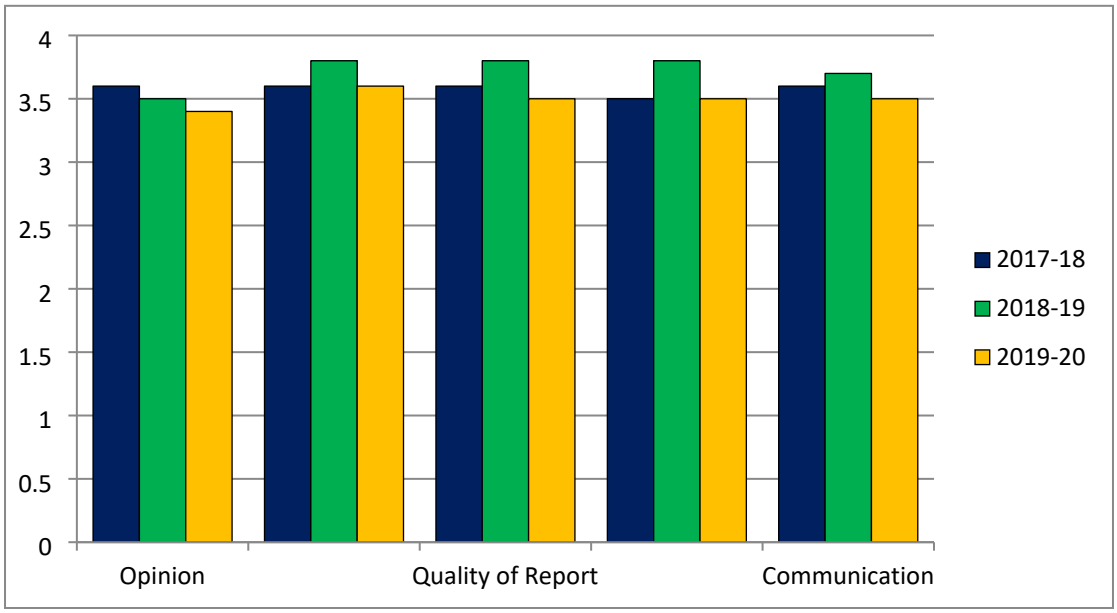
45. Internal and External Audit liaise closely to ensure that the audit work undertaken in the Board fulfils both regulatory and legislative requirements. Both sets of auditors are committed to avoiding duplication and securing the maximum value from the Board's investment in audit.

46. Public Sector Internal Audit Standards (PSIAS) require an independent external assessment of internal audit functions once every five years. The most recent external assessment of the Internal Audit Service was presented to the Audit Committee on 9 June 2019 and concluded that *'following completion of the comprehensive External Quality Assessment (EQA) Checklist and, based on the work undertaken, it is my opinion that the FTF Internal Audit service for Fife and Forth Valley generally conforms with the PSIAS.'* All actions are now complete and we are in the process of updating our self assessment of the EQA requirements. The outcomes will be reported to the FTF Partnership Board.

47. A key measure of the quality and effectiveness of the audits is the Board responses to our client satisfaction surveys, which are sent to line managers following the issue of each audit report. Figure 2 shows that, overall, our audits have been perceived as good or very good by the report recipients.

48. Figure 2: Summary of Client Satisfaction Surveys

Scoring: 1 = poor, 2 = fair, 3= good, 4 = very good.



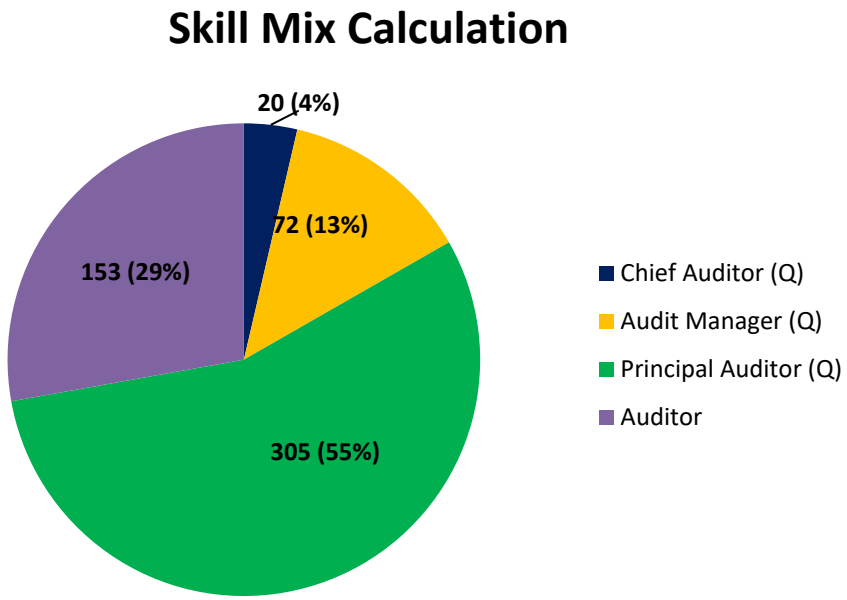
49. Other detailed performance statistics are shown in Section 4.

STAFFING AND SKILL *MIX*

50. Figure 3 below provides an analysis, by staff grade and qualification, of our time. In 2019/20 the audit was delivered with a skill mix of **72%**, which substantially exceeds the minimum service specification requirement of 50% and reflects the complexities of the work undertaken during the year.

51. **Figure 3: Audit Staff Skill Mix 2019/20**

Audit Staff Inputs in 2019/20 [days] Q= qualified input.



ACKNOWLEDGEMENT

52. On behalf of the Internal Audit Service I would like to take this opportunity to thank all members of staff within the Board for the help and co-operation extended to Internal Audit.

53. My team and I have greatly appreciated the positive support of the Chief Executive, Director of Finance, the Head of Corporate Governance & Board Secretary, and the Audit and Risk Committee.

A Gaskin, BSc. ACA
Chief Internal Auditor

Corporate Governance

Summary

The overall NHS Fife senior leadership structure and supporting sub structure should be reviewed and presented to the Board with clear assurance on capability, including Business as Usual arrangements, Strategy production, transformation and remobilisation. Assurance on the essential question of whether NHS Fife has the capacity and capability to deliver its operational and strategic objectives should be provided to the Board from the EDG.

Statements of Assurance

Assurance statements from Standing Committees include a Best Value Framework, which links to performance, governance and accountability as well as a separate section on risk management. However not all relevant key matters relating to governance, internal control and risk management were properly highlighted, including areas of significant concern which had already been identified by Internal and External Audit.

While we commend the more detailed and reflective style of the Standing Committee Annual Statements of Assurance, disclosures included in the Board's Governance Statement were not highlighted as such within either the Annual Statements of Assurance or Executive Directors' Assurance letters. For example, while the HIS inspection reports of Glenrothes and Victoria Hospitals were not referred to in the Clinical Governance Committee Annual Statement of Assurance, nor in the relevant Executive Director's letter, these required disclosure within the Board's Governance Statement.

Integration Arrangements

The 'Review of Progress with Integration of Health and Social Care', published by the Ministerial Strategic Group for Health and Community Care (MSG) in February 2019, outlined 25 practical proposals for NHS Boards, Local Authorities and Integration Authorities, working with key partners including the third and independent sectors, to increase the pace and effectiveness of integration by February 2020. The Director of Delivery, Health & Social Care Integration has met with Fife IJB and HSCI to support the governance and integration arrangements.

Internal audit report B08/20 - Evaluation of Internal Control Framework (ICE) recommended that updates on HSCI should be provided to the Board. The integration scheme review, including the financial risk share, is being undertaken by NHS Fife in conjunction with Fife Council, and was due to be completed by April 2020 but has been delayed due to Covid 19.As a consequence the 'Integration Joint Board' BAF has still not been revised.

Audit Scotland issued a Section 102 report for Fife IJB on financial management and sustainability. Internal Audit had previously highlighted delays in progressing joint governance arrangements, transformation and best value. There has been improvement in financial management with a medium to long term Financial Strategy developed. However, the financial strategy will require further development to reflect the more challenging financial environment created by Covid.

Governance Arrangements

The Scottish Government issued a Director's Letter DL(2019)24 – Model Standing Orders -in December 2019, these were adopted by the Board for implementation effective from 1 April 2020. Internal Audit report B10/20 reviewed the Board's progress on the *'Blueprint for Good Governance*' issued by the Scottish Government on 1 February 2019, with one

recommendation to address issues to enhance future reiterations of the action plan by 31 October 2020.

An Internal Audit Governance Checklist regarding preserving governance during the pandemic was considered helpful by all standing committees and will be used to inform the development of agendas moving forward so that no element of risk is missed. Internal Audit have now also developed Remobilisation/ reconfiguration principles which it is hoped will be similarly helpful.

Transformation and Remobilisation

The response by clinical services to Covid has presented an opportunity to enhance the scale and pace of delivery of transformation. Audit Report B15A/20 Transformation Governance Follow Up reported limited progress has been made and Covid 19 has now provided the opportunity for transformation work to be fully aligned with remobilisation activity, along with a fundamental review of strategies. As above we would recommend the adoption and monitoring of a clear set of principles for remobilisation which ensure that services are transformed wherever possible and that the past has no special place.

In response to the emerging situation of Covid 19, NHS Fife submitted versions of the mobilisation plans to the Scottish Government, in line with SGHSCD requirements. A Gold, Silver and Bronze emergency planning command structure was implemented by the Board at the start of the pandemic and a Remobilisation Oversight Group (ROG) has now been established to oversee the remobilisation and reconfiguration of clinical services.

During 2019/20, the Chief Executive and the Director of Finance commenced a series of formal executive, general management and Board discussions on the medium term financial position of NHS Fife. This focused on delivering transformation and securing a recurring balanced financial position. The importance of delivering “value” based health and social care services through effective resource allocation across the organisation was a key underpinning principle in this work. We also note that the use of Digital Technologies has the potential to transform how people access services and how health and care is delivered moving foward. A range of strategic areas to support evaluation and measurement of impact have been identified, with a proposed suite of key performance indicators.

Performance

The Chief Executive provided an overview of performance reporting to the 27 May 2020 Board meeting, where it was highlighted that Elective activity was paused due to Covid 19, with the exception of areas of highest clinical priority including cancer. This has impacted on normal performance metrics, where the 12 Week Outpatient Wait, Access to Psychological Therapies and 18 week referral to treatment had been improving up to end February 2020. Considerable challenges remain in continuing to improve performance against the key national targets as business returns to normal.

Operational Planning

The Board received confirmation from the Scottish Government that the approval process for the draft Operational Plan 2020/21 – 2022/23 is presently on hold. The document submitted in mid March was considered by the Board’s governance committees and will be used to establish a recovery plan in relation to Treatment Time Guarantee and other routine performance targets.

Risk Management

Sections of the Board Assurance Framework (BAF) were reported to relevant standing committees throughout 2019/20, however we noted that many scores for target and current risk have not changed during the year, which may indicate insufficient consideration of the risk profile possibly connected to the capacity and capability issues highlighted earlier. For example, the scores or recorded information within the Integration BAF have not changed despite specific action being agreed in response to Internal Audit concerns. Integration continues to be reported as a moderate risk despite significant known issues and the s102 report. We understand that it was decided that the risk would be reviewed once the integration scheme was updated.

Internal Audit Report B13/20 - Risk Management Framework, presented to Audit & Risk Committee in July 2020, noted the following :

- A risk management appetite has been agreed by the Board and key performance indicators agreed by the EDG, although the KPIs have not yet been reported formally.
- Delegation of functions to the IJB and the implications for risk management, governance and assurance and the treatment of residual risk, have not yet been clarified
- The Risk Management Policy was due to be presented to the Audit and Risk Committee and the Board in January 2020 but was delayed again. We have now been assured by the Risk Manager that this will definitely be presented to the September 2020 Audit and Risk Committee.

A process has been developed for identification, reporting, review and management of Covid 19 related risks. The format of the annual Risk management report requires further enhancement and whilst Covid 19 has impacted on timing, it will need to be produced by June next year.

Clinical Governance

Clinical and Care Governance Strategy

The Clinical and Care Governance Strategy had a review date of April 2020 but should have been updated before that in line with actions agreed in two previous Internal Audit reports (Clinical Governance Strategy and Assurance B15/17 & B18/18). Despite this and the Strategy review date of April 2020, the NHS Fife Clinical Governance Committee (CGC) has not been updated regarding the status of the strategy review or provided with a revised date for its production and approval.

A Fife multi-agency Care Home Oversight Group has been formed following the Scottish Government decision to increase responsibilities for Health Boards in relation to assurance around care homes. A Fife Care Home Action Plan has been produced by the Health and Social Care Partnership. These increased responsibilities may exacerbate existing weaknesses in the Clinical and Care Governance Framework previously highlighted by Internal Audit.

We are aware of ongoing discussions regarding revising the Integration Scheme for Fife. Management have advised that these discussions have considered Clinical and Care Governance arrangements in Fife and that any changes would need to be reflected in a revised Clinical and Care Governance strategy. We therefore propose to amend the Annual Internal Audit Plan for 2020/21 specifically to consider Clinical and Care Governance arrangements and revisiting weaknesses highlighted previously, thereby superseding our previous reports.

Clinical Governance Committee Annual Statement of Assurance

Our B08/20 Internal Control Evaluation (ICE) included 2 action plan findings (ref 3 & 4) related to Clinical Governance neither of which have been addressed. The implementation dates for actions to address these findings have been extended due to Covid 19. There was no reference within the CGC Annual Statement of Assurance to non-completion of audit recommendations and the impact this had on the control environment.

The CGC acknowledged that there will be ongoing implications for the Board's clinical governance oversight processes and structures due to the pandemic, and that new responsibilities placed on the Health Board regarding public health testing and care home support would need to be incorporated in these new arrangements. The CGC assurance statement did not highlight the failure to implement key internal audit recommendations, that the Strategy had not been updated by its due date, or major issues in relation to transformation. Most importantly, the assurance statement conclusion did not specifically refer to known Information Governance issues despite an agreed Internal Audit action and the acknowledged major improvement required.

In May 2019 Healthcare Improvement Scotland (HIS) published their Unannounced Inspection Report – Safety and Cleanliness of Hospitals report regarding their visit to Glenrothes Hospital on 19 & 20 March 2019. The CGC has not received an update on actions to address the report findings since it was informed at its 4 September 2019 meeting that '*The HIS report included errors which the Director of Nursing is working with HIS to resolve*'. The report is included as a disclosure in the Board's Governance Statement along with further HIS unannounced inspection reports for Glenrothes and Victoria Hospitals.

Transformation and Remobilisation

Our Transformation Programme Governance Follow-up review (B15A-20) found that only 1 of the six recommendations from our report B10/18 had been fully implemented. The subsequent impact of the Covid 19 pandemic on all aspects of NHS Fife's operational and strategic planning will mean that the planning of transformational work will be even more complex and the need for proper oversight and control becomes more urgent and more important. We would recommend that the CGC gives this area an appropriate level of oversight as well as ensuring that there is appropriate coordination and integration with remobilisation and reconfiguration activity. Consideration of Internal Audit's draft remobilisation/reconfiguration principles may be helpful to the CGC in assessing the Board's arrangements.

The Remobilisation Oversight Group is considering the balance between remobilisation of services and redesign/transformation. The role of the Integrated Transformation Board will be reconsidered to learn lessons from Covid 19 and is intended to evolve into a Strategic Planning Group with links with both the H&SCP and Local Authority and spans all business including financial planning, workforce planning, clinical strategy and eHealth. The Winter Plan will be included in the next version of the Joint Mobilisation plan.

NHS Scotland Resilience

The CGC considered the NHS Fife self assessment against the NHS Scotland Health Resilience Unit standards NHS Fife self assessment which were submitted the SGHSCD, updated to include reference to Covid 19, on the due date. We will be undertaking an audit of Compliance with NHS Scotland Resilience: Preparing for Emergencies Guidance and Covid 19 impact in 2020/21 (B15/21).

Staff Governance

Staff Governance Action Plan

A mid-year review of the Staff Governance Action Plan (SGAP) was reported to the SGC in November 2019. No year-end review of the SGAP has been undertaken but the SGC have been informed that it will be updated to reflect the impact of Covid 19 and brought back to SGC in November 2020. Each SGC meeting during 2019/20 reviewed a particular strand of the Staff Governance Standard.

Workforce Planning

Revised Integrated Health and Social Care Workforce Planning for Scotland: Guidance published in December 2019 requires a revisit of NHS Fife's Workforce Plan and publication of a revised plan covering the period from 2021 to 2024 (with a deadline of 31 March 2021). The Workforce Planning Group has been reconvened and will review all required actions. The SGC were advised that 'normal' working arrangements for Workforce Planning have been paused and that the Strategy will require significant edits to take account of changes in service delivery, as a result of Covid 19, although we would highlight that it will also need to reflect changes to the Board's overall strategy. The annual Workforce Projections exercise was formally suspended by the Scottish Government due to Covid 19. Services are being supported to consider the workforce implications of changes arising from mobilisation.

Whistleblowing

Draft National Whistleblowing standards were issued by the Independent National Whistleblowing Officer to Boards in anticipation of these receiving parliamentary approval in summer 2020. The SGC was advised on 6 March 2020 that an implementation plan is to be developed to ensure full compliance with the standards, although a date for its completion is not yet noted. A new NHS Fife Whistleblowing Champion took up their position in April 2020. No Whistleblowing Report for 2019/20 has been presented to SGC.

TURAS - Staff Appraisal System

No year-end update on TURAS compliance in 2019/20 was provided to the SGC. TURAS compliance was 43% at 31 May 2020 (compared to 42% at 30 April 2019).

Attendance Management

The Sickness absence rolling 12-month average remains above the 4% target at 4.95% in 12 months to 30 April 2020).

Internal Control Evaluation

There were four recommendations in our B08/20 ICE audit relating to staff governance, one of which remains outstanding in that there has been no update to the SGC on action taken to address Audit Scotland's 'NHS workforce planning (part 2) – The clinical workforce in general practice' report. The related Primary Care Improvement Plan has not been provided to SGC to date.

Covid 19

The SGC was updated at its 18 June 2020 meeting on the current position regarding the pandemic and the planned arrangements for the remobilisation of NHS Fife's workforce.

Financial Governance

Structure of Finance Department

There have been a number of recent changes within senior management in the Finance Department including the previous Director of Finance moving to cover the Chief Executive role from February 2020, the interim appointment of a new Director of Finance from April 2020 (with some part-time cover during February and March, the secondment of the Assistant Director of Finance (Financial Services) to NHS Orkney and the departure of some senior financial and management accounting staff during January 2020.

The Director of Finance is currently progressing a restructure of the directorate, in line with the direction of travel identified for the department, with the intention of ensuring a focus on key priorities as well as ensuring consistent senior leadership for each of the critical functions and allowing for succession planning.

The restructure process was paused, partly due to Covid and the need for HR support and will be consulted on with all parties (including Internal Audit) in the coming months, after which the FP&RC will be provided with assurances that capacity and capability are sufficient to provide appropriate financial support for strategy, transformation and business as usual.

The Director of Finance arranged for interim senior support from NHS Tayside from April 2020 to September 2020 for the Financial Services and Endowment areas however this arrangement changed at short notice in July 2020 which impacted on capacity at that key time. Consequently, and also due to the impact on availability of staff working remotely during the pandemic, financial accounts were submitted to Audit Scotland beyond the financial accounts timetable deadline with the potential to delay the year-end timetable beyond the statutory deadline. The Director of Finance is working with Audit Scotland and Scottish Government to ensure the accounts are laid within the statutory deadline of 31 December 2020.

Anticipated Year-end Financial Position

As reported to the 27 May 2020 Board, the draft financial outturn position to 31 March 2020, subject to external audit review, was:

- Revenue Resource Limit (RRL) - £779.851 million - target met with £0.063m under spend
- Capital Resource Limit (CRL) - £9.286 million - a resource budget for net capital investment - target met.

For 2019/20 the financial year end position for NHS Fife includes costs incurred for Covid 19 of £3.711m split £2.090m NHS Fife and £1.621m IJB which the Director of Finance stated is expected to be funded in full.

Efficiency Savings

For 2019/20 NHS Fife was required to make £17.333m of cash efficiency savings. Reported savings at year end totalled £10.154m of which £5,397m (53%) was non recurring. Therefore, there was £7m of unidentified savings and 73% of the overall savings target has not been met on a recurring basis. Internal and External Audit have previously reported the reliance on non recurring savings to achieve financial balance in previous years. For 2019/20 the delivery of savings in Acute Care was significantly short of the planned amount and this area should be a focus of attention for the Finance, Performance and Resources Committee for 2020/21.

Financial Reporting

Financial reporting throughout the year was consistent, with a visible financial improvement at year end and the position was clearly presented via the Integrated Performance & Quality Report to the Finance and Performance and Resources Committee.

The Director of Finance advised at the weekly meeting between the Chair and Vice Chair on 26 June 2020 that the revenue and capital plans drawn up originally in January/ February 2020 required full reassessment to reflect changed priorities as part of the remobilisation process. Updates will be provided to the EDG with further detail on the position, covering core spend and additional Covid 19 related costs.

The January 2020 FP&RC considered its self assessment and agreed that it was operating as per its Terms of Reference with positive assessments from its members and attendees and no areas of major concern identified.

Risk Management

The narrative within the Financial Sustainability BAF (FSBAF) recognises the ongoing financial challenges facing Acute Services as well as the pressures within the Health and Social Care Partnership in relation to social care budgets and the impact of potential amendment to the risk share arrangement. The report to the July 2020 meeting of the FP&RC highlighted concern over the financial position for the 2020/21 year and the planned savings for Acute Services where much more work is required. The FSBAF states that the impact of the Social Care overspend has been highlighted to Scottish Government within the monthly reporting template.

Internal Control Evaluation

The challenging financial position was highlighted within B08/20 Evaluation of Internal Control Framework (ICE). We strongly reiterate that financial balance during 2020/21 and beyond will be challenging unless the pace of transformation accelerates significantly; the savings within Acute Services are significantly improved and the resolution of the IJB risk share agreement.

The sole ICE recommendation relating to Value for Money has been partly implemented in that Management have started a process of utilising Audit Scotland Best value toolkits and other benchmarking tools (e.g. Discovery) but this has not been reported to the FP&RC which is therefore not in a position to be able to provide assurance on this area as required.

Information Governance

Year-end Assurances

Assurances provided to the NHS Fife CGC in 2019/20 were not sufficient to allow it to conclude accurately on the adequacy and effectiveness of Information Governance arrangements. Such assurances that were provided were delivered via minutes and annual statements of assurance from the Information Governance and Security Group (IG&SG), eHealth Board and the eHealth Performance Report. However, these did not provide assurance regarding compliance with Data Protection Act 18/GDPR, NIS Regulations, NHS Scotland's Information Security Policy Framework and the Cyber Resilience Public Sector Action Plan, all of which have significant gaps in control.

The IG&SG and eHealth Board Annual Statements of Assurance did not highlight significant matters of concern and were not considered and agreed by members prior to being presented to the CGC. Similarly, the relevant Director's annual assurance letter did not highlight these major concerns.

The conclusion at section 8.1 of the CGC Annual Statement of Assurance regarding adequate and effective governance arrangements being in place for the year does not specifically refer to Information Governance and we would have expected any conclusion on this area to contain significant caveats.

Competent Authority Audit – NIS Regulations

The outcome of the NIS Regulations/ISPF audit undertaken by the Competent Authority for Health, issued on 30 March 2020, has not been reported to a Standing Committee of the Board or considered for inclusion in the Board's Governance Statement. NHS Fife was assessed as being compliant with 53% of the controls. The report included 58 recommendations to address areas of non-compliance 18 of which were in the 'Red-Urgent' category. A draft remediation plan grouping the recommendations and proposed action by related topics has been prepared but needs to be finalised and approved. The CGC Annual Statement of Assurance also makes no reference to this important piece of assurance to the Committee.

Cyber Resilience

The IG&SG have been informed that '*the timeframe (31 October 2018) for gaining Cyber Essentials as required by PSAP has already passed and it should be noted that the scale and complexity of the IT estate and reliance in places upon legacy systems, remains a significant challenge' and the plan provided IG&SG with the key dates towards achieving 'alignment with ISPF/NIS whilst completing the requirements of the Public Sector Action Plan for Cyber Resilience*'. This information has not been explicitly conveyed to the CGC.

eHealth and Information Governance Arrangements

We raised a number of significant concerns over Information Governance and have been assured by management that changes to governance arrangements to be implemented following a very recent review of eHealth and Information Governance arrangements, reported to the CGC in July 2020, will raise the profile of Information Governance at the CGC and will address our concerns.

However, the July paper only provided a direction of travel and did not explicitly and overtly address a number of concerns raised by Internal and External Audit. We will review both the adequacy of the final agreed arrangements and their implementation in 2020-21.

Internal Control Evaluation

The following fundamental recommendations, some of which had also been highlighted previously, from the ICE report B08/20 are still outstanding:

- Information Governance arrangements currently operating in NHS Fife do not provide Fife NHS Board with sufficient assurance regarding compliance with its legislative requirements
- The management of information governance risks needs to be addressed so that Fife NHS Board is assured that all significant risks have been identified and that the mitigating actions in place or planned will be sufficient to reduce the risk to a level acceptable to the Board within an acceptable timescale
- Reporting to the Board and NHS Fife CGC on ISPF/GDPR/DPA 2018 and Cyber Resilience Public Sector Action plan has been minimal
- Reporting on the eHealth Delivery Plan to a standing committee only occurred once in 2019/20 and did not overtly link projects to relevant national and local strategies

As part of our ICE work we followed up on recommendations made in Internal Audit report B31&B32/19 and concluded that nine issues regarding assurances provided to the IG&SG had still not been addressed. At year-end, two issues had been partly addressed and seven were still unresolved. Overall it is not clear that these issues are being progressed with sufficient urgency; NHS Fife must prioritise these issues and actively monitor progress in much greater detail than previously.

eHealth Strategic Planning

We are aware that the reaction to the pandemic (Covid 19) included accelerating and bringing forward elements of the NHS Fife Digital and Information Strategy Delivery Plan for example to allow clinicians to consult with patients remotely.

Action Point Reference 1 – Corporate Governance

Finding:

Over recent years the challenges facing all boards have increased significantly and NHS Fife has been no exception. Controls within the Board have not kept pace with changes to the environment in which the Board operates and be sufficient fully to mitigate the risks facing the Board in the coming years. Systems of control continued to have challenges to adequately resolve long-standing information governance, IJB governance and transformation issues. Capacity issues, specifically the loss of a number of key finance, have contributed to a delay in submission of the annual accounts, in line with the agreed timetable. Covid 19 and the consequent need to revisit the Board's overall and supporting strategies will create additional pressures going forward. The Board must assure itself that it has sufficient capacity and capability to review and, where necessary revise its strategies, deliver transformation and reconfiguration, and achieve significant short-term savings whilst continuing to deliver business in extremely challenging circumstances at a time when staff have been under significant pressure over a long period.

Audit Recommendation:

The EDG should consider the specific issues highlighted in this report and other known issues and reflect on its structures and priorities and the resources required to deliver activity in a post Covid environment while updating strategies, implementing savings and designing and delivering remobilisation whilst seizing the very limited opportunity for radical transformational change to ensure long-term sustainability of services. It should then provide overt assurance to the Board which should specifically comment on whether NHS Fife has the capacity and capability to deliver its operational and strategic objectives in the current circumstances and outline any changes required and how they will be subject to appropriate governance monitoring.

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:

To be completed by Client

Action by:	Date of expected completion:
Responsible person designation	**Enter the date the action is to be completed by.**

Action Point Reference 2 – Corporate Governance	
Finding:	
Our Internal Control Evaluation report (B08/20) issued in December 2019 included 15 Action Plan points, many of which were significant and all of which should have been completed by year-end. However, progress to date has been limited.	
Audit Recommendation:	
Our Internal Control Evaluation report is undertaken part way through the financial year in order to allow management time to address the findings prior to year-end. Whilst we recognise that the pandemic has been a disruptive factor it is not clear that this is the sole or even the main factor in their non-delivery. The EDG should consider why these recommendations have not been delivered, why this was not recognised earlier and produce an action plan for monitoring by the Audit and Risk Committee. Any such plan should take into account the issues relating to capacity and capability raised in recommendation 1.	
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:	
To be completed by Client	
Action by:	**Date of expected completion:**
Responsible person designation	**Enter the date the action is to be completed by.**

Action Point Reference 3 – Corporate Governance

Finding:

Whilst the introduction of standard templates for standing committee assurances and Directors assurances has improved the assurance process, not all relevant key matters relating to governance, internal control and risk management were properly highlighted, including areas of significant concern which had already been identified by Internal and External Audit.

Audit Recommendation:

All potential areas for inclusion in the Governance Statement should be clearly identified in both Executive Director and Senior Manager assurances and in Standing Committee annual assurance reports. The information within these sources of assurance should be triangulated to ensure all issues to be considered within the Governance Statement are clearly and consistently identified.

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:

To be completed by Client

Action by:	Date of expected completion:
Responsible person designation	**Enter the date the action is to be completed by.**

Action Point Reference 4 – Corporate Governance	
Finding:	
The IJB is undergoing a governance review which is supported by the Director of Delivery, Health & Social Care Integration from Scottish Government. However, whilst progress has been made, the review has not yet been fully completed due to Covid 19. There is a revised timescale for implementation which appears appropriate We noted that the BAF for the IJB reported to the July 2020 NHS Fife Board and throughout 2019/20 has remained at a Moderate Risk and does not reflect the current risk profile.	
Audit Recommendation:	
Monitoring and consideration of the arrangements for HSCI including the recommendations of the MSG report, should reflect the strategic importance of the activities directed by the IJB. Whilst we understand that the risk cannot be fully articulated until the Integration Scheme is updated, the BAF for the IJB should be reviewed and updated urgently to at least reflect the known key issues.	
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:	
To be completed by Client	
Action by:	**Date of expected completion:**
Responsible person designation	**Enter the date the action is to be completed by.**

Action Point Reference 5 – Clinical Governance

Finding:

The Clinical and Care Governance Strategy should have been updated in line with actions agreed in two previous Internal Audit reports (Clinical Governance Strategy and Assurance B15/17 & B18/18). The agreed dates were not met, nor was the official Strategy review date of April 2020. The NHS Fife Clinical Governance Committee (CGC) has not been updated regarding the status of the strategy review or provided with a revised date for its production and approval.

We are aware of ongoing discussions regarding revising the Integration Scheme for Fife. Management have advised that these discussions have considered Clinical and Care Governance arrangements in Fife and that any changes would need to be reflected in a revised Clinical and Care Governance strategy. We therefore propose to amend the Annual Internal Audit Plan for 2020/21 specifically to consider Clinical and Care Governance arrangements and revisiting weaknesses highlighted previously, thereby superseding our previous reports.

Audit Recommendation:

The CGC should take ownership of this issue and ensure that the Clinical and Care Governance Strategy is reviewed and presented to Fife NHS Board for approval in an appropriate timescale.

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:

To be completed by Client

Action by:	Date of expected completion:
Responsible person designation	**Enter the date the action is to be completed by.**

Action Point Reference 6 – Clinical Governance	
Finding:	
Healthcare Improvement Scotland (HIS) published their Unannounced Inspection Report – Safety and Cleanliness of Hospitals report regarding their visit to Glenrothes Hospital on 19 & 20 March 2019 in May 2019. The CGC has not received an update on this report since it was informed at its 4 September 2019 meeting that '*The HIS report included errors which the Director of Nursing is working with HIS to resolve*'. The report is included as a disclosure in the Board's Governance statement along with further HIS unannounced inspection reports for Glenrothes and Victoria Hospitals.	
Audit Recommendation:	
The CGC should be actively monitor actions arising from all HIS and other external inspections and reflect on them appropriately in the preparation of their annual assurance statement.	
Assessment of Risk:	
Merits attention 	There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**
Management Response/Action:	
To be completed by Client	
Action by:	**Date of expected completion:**
Responsible person designation	**Enter the date the action is to be completed by.**

Action Point Reference 7 – Financial Governance

Finding:

For 2019/20 NHS Fife were required to make £17.333m of cash efficiency savings. Only £10,154m was delivered, over half of which was non-recurrent. In essence only 27% of the savings target was delivered recurrently and 40% was not delivered at all. In particular, the delivery of savings in Acute Services was significantly short of that planned. Internal and External Audit have repeatedly highlighted the reliance on non recurring savings to achieve financial balance, as well as the failure to deliver the transformational change required to deliver financial sustainability.

Audit Recommendation:

The Finance, Performance and Resources Committee workplan should include a series of focused deep-dives to understand the root cause of these issues, particularly within Acute Services and there should be congruence with the work of the CGC in assessing progress with Transformation.

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:

To be completed by Client

Action by:	Date of expected completion:
Responsible person designation	**Enter the date the action is to be completed by.**

Action Point Reference 8 – Information Governance

Finding:

Action has not yet been taken to address the findings and recommendations included in internal audit report B08/20 Evaluation of Internal Control. A review of eHealth and Information Governance arrangements was reported to the CGC in July. We were advised by management that the implementation of new governance arrangements is expected to raise the profile of Information Governance at the Clinical Governance Committee and will address the issues raised by Internal Audit, although not all details of how this would be achieved were fully apparent in the July paper.

Audit Recommendation:

The CGC should monitor implementation of new governance arrangements for eHealth and Information Governance to determine whether they have addressed the issues in the narrative of this and the following reports:

- B31&32/19 Information Governance and eHealth – Action Plan Points 1, 2 & 3
- B06/20 Annual Internal Audit report – Action Plan Point 7
- B08/20 Evaluation of Internal Control – Action Plan Points 10, 12 & 15
- Competent Authority Report on Compliance with NIS Regulations – Recommendations 1.1.1 & 1.1.2

Revised governance arrangements should include providing the Clinical Governance Committee with explicit assurance regarding compliance with DPA 18/GDPR, NIS Regulations, NHS Scotland's Information Security Policy Framework and the Cyber Resilience Public Sector Action Plan and should result in more robust scrutiny of both Information and eHealth governance by the CGC.

Revised governance arrangements should be implemented at pace so that the CGC receives the required assurances regarding this critical area of governance in 2020/21.

Assessment of Risk:

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.**

Management Response/Action:

To be completed by Client

Action by:	Date of expected completion:
Responsible person designation	**Enter the date the action is to be completed by.**

Section 4 Key Performance Indicators

Key Performance Indicators – Performance against Service Specification

	Planning	Target	2019/20	2018/19
1	Strategic/Annual Plan presented to Audit and Risk Committee by April 30th	Yes	No (June 20)	May 2019
2	Annual Internal Audit Report presented to Audit and Risk Committee by June	Yes	Yes	Yes
3	Audit assignment plans for planned audits issued to the responsible Director at least 2 weeks before commencement of audit	75%	95%	78%
4	Draft reports issued by target date	75%	76%	65%
5	Responses received from client within timescale defined in reporting protocol	75%	57%	65%
6	Final reports presented to target Audit and Risk Committee	75%	76%	75%
7	Number of days delivered against plan	100% at year-end	101% at year-end	90%
8	Number of audits delivered to planned number of days (within 10%)	75%	76%	70%
9	Skill mix	50%	72%	74%
10	Staff provision by category	As per SSA/Spec	Pie chart	
	Effectiveness			
11	Client satisfaction surveys	Average score of 3	Bar chart	

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.**	1 (9)
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.**	6 (1, 2, 3, 4, 5 & 7)
Merits attention		There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**	2 (6 & 8)

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**17 September 2020**
Title:	**Risk Management Annual Report**
Responsible Executive:	**Helen Buchanan, Director of Nursing**
Report Author:	**Pauline Cumming, Risk Manager**

1 Purpose

This is presented to the group for:

- Awareness

This report relates to a:

- Local framework and policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This report provides the Committee with detail of the risk management activities undertaken during the period 2019 - 2020 and progress against the Risk Management work plan.

2.2 Background

The report forms a component of the governance reporting arrangements for risk management as set out within the NHS Fife Risk Management Framework and in accordance with the risk management component of the NHS Fife Code of Corporate Governance.

2.3 Assessment

The report describes the range of work carried out in the past year which has contributed to the Board's management of risk including developments in the following areas:

- NHS Fife Risk Management Framework updated including risk appetite and tolerance
- Assurance Mapping
- Board Assurance Framework
- Key Performance Indicators
- Adverse events management and duty of candour
- Datix system

2.3.1 Quality/ Patient Care

NHS Fife's risk management system should minimise risk and support safe, effective, person centred delivery. The report refers to activities that support that ambition.

2.3.2 Workforce

Risk management requires all staff to manage risk as part of their daily work.

2.3.3 Financial

No issues identified.

2.3.4 Risk Assessment / Management

The report describes risk management activities that support the Board objectives.

2.3.5 Equality and Diversity, including health inequalities

Report describes risk management activity and raises no equality and diversity issues.

2.3.6 Other impact

None identified.

2.3.7 Communication, involvement, engagement and consultation

NHS Fife Risk Management Team
Helen Woodburn, Head of Quality & Clinical Governance, NHS Fife
Helen Buchanan, Director of Nursing
Internal Audit

2.3.8 Route to the Meeting Helen Buchanan

2.4 Recommendation

Discussion – Examine and consider the implications of a matter.

3 List of appendices

Report Contact
Author Name: Pauline Cumming
Author's Job Title: Risk Manager, NHS Fife
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NHS Fife Risk Management Annual Report

2019-2020

1. PURPOSE OF REPORT

NHS Fife supports the view that risk management is key to ensuring informed decision making, delivering safe, effective, quality patient care and supporting the efficient and effective use of resources in delivering health care to the people of Fife.

This report provides an overview of the risk management activity carried out during 2019 – 2020 and seeks to provide assurance that risk management processes are in place to support the delivery of NHS Fife's strategic objectives.

The report also outlines the focus of activity in the coming year.

The Board is asked to note and take assurance from the information provided.

2. RISK MANAGEMENT GOVERNANCE

The Audit & Risk Committee is responsible for assessing the effectiveness of the corporate governance framework and systems of internal control operating across NHS Fife.

Assurance on key strategic risks - quality and safety, strategic planning, eHealth, environmental, financial and workforce sustainability is provided through the governance committees to which these are aligned. Each Committee will provide an assurance statement in relation to risk within their annual reports.

3. NHS FIFE RISK MANAGEMENT FRAMEWORK

The Framework, including the NHS Fife Risk Register/ Risk Assessment Policy GP/R7, was due for review and update. Draft updates of the Framework and Policy have been consulted upon and are now being finalised. The updated versions will be submitted to the Audit and Risk Committee and Fife NHS Board for approval in September 2020.

4. RISK REGISTERS

4.1 Board Assurance Framework

To enable the Board to focus on the risks which may compromise the achievement of its strategic objectives, in 2017, NHS Fife implemented a Board Assurance Framework (BAF). The BAF integrates information including controls, mitigating actions, assurances, gaps in any of these, as well as linked operational risks and an assessment of current performance.

Over the past year, the BAF has continued to be reported bi monthly to the governance committees to which its components are aligned. These reflect the Director's review and risk assessment, and highlight key issues and questions for the committees' attention and scrutiny.

The BAF has evolved to reflect the changing risk landscape and since November 2019, has included eHealth - Delivering Digital and Information Governance & Security. Table 1 details the components of the current BAF and the aligned committees.

Table 1	
BAF component	**Governance Committee**
Financial Sustainability	Finance, Performance & Resources Committee (F,P&R)
Workforce Sustainability	Staff Governance Committee (SG)
Environmental Sustainability	F,P&R
Quality & Safety	Clinical Governance Committee (CGC)
Strategic Planning	CGC and F, P&R
Integration Joint Board (IJB)	IJB
eHealth	CGC

In the period under review, all BAFs have been reported to their respective governance committee (s) in line with reporting requirements. BAF updates have been reported throughout the year to the Audit & Risk Committee and the Board in accordance with requirements.

4.2 Corporate Risk Register

As previously reported, in recent years, the BAF has largely superseded the corporate risk register as the key document subject to scrutiny at committee and Board level. For the period 2019-20, identified high level risks were reported bi monthly as to the governance committees as part of the BAF.

.The processes relating to the corporate risk register have been reviewed and will be clarified in September 2020 as part of the updated Risk Management Framework. The Code of Corporate Governance will be updated to reflect the revised arrangements.

4.3 Operational Risk Registers

All of the key areas within the organisation continue to maintain risk registers in Datix. Risks are reported and monitored at local and organisational levels, including through performance reviews and via clinical and clinical and care governance structures.

To support compliance on the timely review of risks in Datix, a log in message 'To Do' list was added to the system earlier this year to prompt users to review any actions allocated to them.

An email alert is also sent each week to all risk handlers prior to a risk being due for review.

Appendix 1 provides a breakdown of active risks by current risk level and risk type.

4.4 Assurance

Assurance is at the heart of any organisation's work and is a key component of risk management. It can be defined as: "an evaluated opinion, based on evidence gained from review, on the organisation's governance, risk management and internal control framework" and the extent to which these are functioning effectively and, just as importantly, the aspects which need to improve.

During 2019 - 20, the Board has been considering how it can further develop its assurance processes in accordance with the requirements in the revised Scottish Public Finance Manual (SPFM) Audit Committee Handbook; these include requiring organisations to define their assurance needs and map their sources of assurance. To take this work forward, a small working group was set up comprising representatives from the four Boards covered by the FTF Internal Audit Service (Fife, Forth Valley, Lanarkshire and Tayside. The group is chaired by the Chief Internal Auditor.

The group's intention is to agree a proposed process for assurance mapping, together with relevant documentation, and timescales. Topics discussed have included guidance on risk mapping; the principles behind mapping approaches; and the design of a template that could be used to test an exemplar risk from each Board based on the 'three lines of assurance e' model.

It was agreed that in Fife, the exemplar risk for review would be the eHealth BAF and that the review would be facilitated by Internal Audit. An assurance mapping exercise commenced on the eHealth BAF in early 2020. This work has been delayed due to COVID-19 but it is intended it will restart as soon as possible. The Chief Internal Auditor will provide a timetable indicating how long it will take to apply this process to the other BAFs. The work will inform the future development of the BAF and efforts to strengthen the Board's overall approach to assurance and risk management.

4.5 COVID-19 - Risk Management Processes in response to the pandemic

A process for identifying, reviewing and monitoring COVID-19 related risks was established within the organisation's Pandemic Command structure. This required the Bronze and Silver Commands to record the risks in Datix and regularly review and update. To date, the risks have fallen mainly into the categories of Estates, Facilities & Medical Physics, Pharmacy, Procurement including Infection Control, Workforce, Mental Health Services and Public Health; this is a dynamic process which captures new risks as they emerge. Initially, the Risk Management team provided Gold Command with a fortnightly report on the high level risks which converted to a monthly report in August 2020. Many of these risks are not Board-specific, but relate to national risks common across the health sector.

It is recognised that in light of COVID-19, in parallel with the remobilisation and reconfiguration of services, and the associated review of strategic planning and priorities, the BAF and associated risks must be re- evaluated to ensure these capture the activity and experiences of the last six months, and where necessary, rearticulated to reflect potential future challenges and disruptors. The risks identified will be mainstreamed into the overall Board Assurance Framework structure.

5. RISK APPETITE AND TOLERANCE

Last year's annual report outlined the Board's approach to setting its risk appetite and provided an example of the preliminary work carried out with the Staff Governance Committee in May 2019. This work was further developed over 2019 with the Clinical Governance Committee and the Finance, Performance & Resources Committee.

Committee members were provided with information on the definition and classification of risk appetite, and the strategic objectives relating to their respective BAF risks. A facilitated discussion took place, during which members worked through the risks and proposed risk appetite classifications. The decisions were recorded and the outputs were shared with and confirmed by members.

A dedicated Board Development Session was held on 23 October 2019 to provide an opportunity for members to consider the totality of the work carried out by the governance committees and collectively set the Board's risk appetite. The Board approved the proposed risk appetites and tolerances on 27 November 2019.

The processes and responsibilities required to support further development and implementation of the Board' s approach to risk appetite and tolerance will be described in the updated Risk Management Framework.

6. THE MANAGEMENT OF ADVERSE EVENTS

As in other NHS Boards, the management of adverse events is a key organisational priority. Appendix 2 provides a summary of the events reported in Datix for the period 1 April 2019 - 31 March 2020. Reporting levels have been broadly consistent over the last few years @ 16.000 events per annum. Similarly, the events most commonly reported are consistent with reporting in previous years.

6.1 Governance

The NHS Fife Adverse Events / Duty of Candour (Dock) Group provide oversight of local adverse events management. The group is chaired by the Board Medical Director. Its purpose is to:

- Coordinate and monitor the implementation of the HIS national framework for Scotland
- Oversee the development and implementation of local policy and guidance relating to the management of adverse events and
- Monitor performance in relation to significant adverse events against agreed measures

6.2 Systems and Processes

NHS Fife promotes adverse event reporting and requires that all events, regardless of the severity of harm and who or what is affected, are reviewed in accordance with the NHS Fife Adverse Events Policy GP/I9. Each adverse event is reviewed to understand what happened and the actions we can take to improve the care provided in the future. The level of review depends on the severity of the event, as well as the potential for learning. Recommendations are made as part of the review, and local management teams develop action plans to meet these recommendations.

Adverse events graded major or extreme require local management to complete a standardised SBAR summary, and submit for executive consideration and a decision on the type of review required. Currently, the options for review are Significant Adverse Event Review (SAER) or Local Adverse Event Review (LAER).

The Risk Management Team plays a key role in this area of activity, in particular, supporting the administration of major and extreme adverse events. Additionally, the Risk Manager and s the Head of Quality and Clinical Governance, provide senior managerial input to Significant Adverse Event Reviews (SAER).

- Where the decision is for SAER, the Risk Management team coordinate the review through to its conclusion; this includes convening an oversight group which is chaired by the Board Nurse or Medical Director or an Associate Medical or Nurse Director. Every review generates a SAER report and Learning Summary.

- The management team of the area in which the event occurred, is responsible for sharing the report and the learning summary as appropriate throughout their areas of responsibility.

- Where the decision is for LAER, the service must organise the review. As with SAER, a LAER report and Learning Summary are produced which must be shared as appropriate.

6.3 Internal Audit Report B19/20 - Adverse Event Management

During the period under review, the above audit was carried out. This review evaluated the design and operation of the controls relating to implementation of actions to address issues identified from Adverse Event Reviews - Significant Adverse Event Reviews (SAER) and Local Adverse Event Reviews (LAER). Specifically, this audit looked at process and procedures in place to manage actions to full implementation, as well as the ongoing monitoring of actions to confirm they remain operational and effective.

The review identified several weaknesses. In summary, these related to the need to provide assurance that actions identified from reviews are implemented within set timescales; that there are adequate systems of governance in place to ensure management oversight of and action on backlogs at operational and strategic levels; and that there is documentary evidence in the system of the steps taken to achieve implementation, rather than just an affirmation that an action is complete.

Actions to address the identified weaknesses include:

- A log in message - ‘To Do’ list was added to Datix earlier this year. This is the default page when logging in. It prompts action owners to review and update any actions allocated to them. This allows users when logged in to see every action they require to do, e.g. to review and update the status of an incident.

- A report on the overall status of overdue actions will continue to be reported to each meeting of the NHS Fife Adverse Events / Duty of Candour Group.

- Adverse event Key Performance Indicators (KPI) see Appendix 3, will be reported from August 2020 to EDG, the NHS Fife Adverse Events and Duty of Candour Group, the NHS Fife Clinical Governance Committee and the NHS Fife Audit and Risk Committee.

- The Risk Management team will provide further support to senior managers in Divisions and Directorates to maximise their use of adverse events data and the existing reporting functionality in Datix, ‘My Reports’, for their areas of responsibility.

- Consideration is to be given to reinstating outstanding / overdue actions into Performance Review packs.

- The recommendation to mandate entry in Datix of the evidence of actions being implemented requires to be more widely discussed, in the first instance at the Adverse Events / DoC group, particularly in terms of minimum requirements and feasibility. A field in Datix already exists into which such evidence can be added.

- The process for strengthening local governance around adverse events management, particularly oversight of actions from adverse event reviews, including action status and overdue actions needs to be incorporated into local clinical governance groups. This also requires further discussion.

6.4 COVID 19 - Information Support

Since March 2020, and partly in order to provide information to services focussed on the pandemic response that might ordinarily have generated their own reports, a monthly report has been provided to the Associate Medical Directors and Associate Directors of Nursing in the Acute Services Division (ASD) and the Health and Social Care Partnership (HSCP). This report contains detailed information on reporting numbers and types of events, outstanding documentation i.e. SBARs for major or extreme events and reports, organisational Duty of Candour and the status of actions from 2017 to date.

Additionally, as part of the response to COVID -19, an incident reporting process for Silver & Gold Commands was introduced to work in parallel with the NHS Fife Adverse Events Policy GP/I9.The Risk Management team initially provided a report, initially daily, moving to weekly and now monthly, detailing COVID -19 related incidents for the Corporate Directorates, the ASD and the HSCP Silver Commands. This allowed them to have oversight of such events and take action as necessary, including escalation to Gold Command. As the Command structure has been stood down, the reports are now being submitted to ASD and HSCP Associate Medical and Nurse Directors.

6.5 Miscellaneous risk management input to adverse events activity

Local

Mental Health Unexpected Deaths including Drug related Deaths: The grading and process for reviewing these events has been revised. The events will be subject to cluster review in order to better identify themes, maximise learning and make best use of staff time. Each review will have external scrutiny from Public Health and/or the Head of Nursing. Where necessary, the cluster review may escalate a case for e.g. SAER.

Criteria for Commissioning a SAER: Criteria to support the decision making process have been drafted and will be considered at the August 2020 NHS Fife Adverse Events and Duty of Candour Group.

Cardiac Arrest Review Process: A Fife- wide approach is being developed in collaboration with clinicians and senior managers.

Integrated Performance & Quality Report (IPQR): High level adverse events data previously reported in the Quality Report is now included in the IPQR.

National

National Notification System

In September 2019, Healthcare Improvement Scotland (HIS) published the Adverse Event Management: NHS Boards self-evaluation report. This highlighted areas of good practice in adverse event management across the country but it also identified variations and inconsistencies between these organisations.

In response to the report, the Cabinet Secretary for Health and Sport instructed HIS to work with all NHS Boards to ensure that they notify HIS when a Significant Adverse Event Review (SAER) is commissioned*, with a view to moving towards standardising terminology and definitions, including national implementation of the the term 'Significant Adverse Event Review'.

This process* is referred to as the National Notification System. The primary objective of this work is to support improvement, the aim of safe, effective and person-centred healthcare services, and a culture of openness and learning.

The system took effect from 1 January 2020 and NHS Fife has reported the minimum data set to HIS on a monthly basis as required (paused due to COVID -19 but now reinstated).

6.6 Organisational Duty of Candour

Organisational Duty of Candour (DoC) for health and social care organisations in Scotland came into effect on 1 April 2018. The purpose of the duty is to ensure that organisations are open, honest and supportive when there is an unexpected or unintended adverse event resulting in death or harm, as defined in the Act.

The Risk Management team were instrumental in supporting implementation of DoC in Year 1 including contributing to the production of an Annual Report and this has continued in Year 2. In the last year this work has included the following:

- further refinement of the required minimum data set
- revision of DoC fields in Datix
- development of documentation to support implementation
- more focussed discussion as part of SAER process

As in Year 1, during Year 2, NHS Fife has identified events activating organisational DoC mainly through its adverse event management processes. A key element of this work involves assessing the extent to which cases which activated 'the duty', have complied with the DoC procedure. This is determined by indicators including:

- the people affected being informed
- timely provision of an apology
- a full case review

Decisions on whether an event activates the DoC procedure have been taken by the Board Medical Director, the Board Director of Nursing, the Director of Pharmacy, the Associate Medical and Nurse Directors, the Associate Director of Allied Health Professionals, Clinical Directors and Heads of Nursing. The final decision rests with the Board Medical Director.

The NHS Fife Organisational Duty of Candour Year 2 Annual Report has been prepared and will be reported to EDG week beginning 17 August 2020, CGC on 7 September 2020 and Fife NHS Board on 30 September 2020.

To support DoC implementation, staff have been encouraged to complete the NHS Education Scotland on line learning module which is available to staff through the intranet. The Medical Director had organised a DoC workshop for key stakeholders; this was postponed due to COVID-19 but will be rearranged.

7. DATIX RISK MANAGEMENT SYSTEM

Datix is the risk management software system used in the Acute Services Division and the East, West and Fife wide Divisions of the HSCP. It is the repository for risks, incidents (adverse events), safety alerts and complaints and claims.

The system has more than 900 registered users. As well as risks, around 16000 adverse events continue to be reported annually via DatixWeb and over 3000 complaints, suggestions, queries, concerns and compliments are logged via the Complaints module.

To facilitate operational ownership and oversight of risk management information, the Risk Management team has invested considerable effort in developing the reporting functionality in Datix; specifically setting up pre configured 'My Reports'. These allow users to extract real time data from various Datix modules at the 'touch of a button,' and use this to inform and direct activity and priorities within their areas of responsibility. The team provide training and support to enable staff to derive maximum benefit from this and other reporting functions available within Datix.

7.1 User Permissions

To improve Datix system efficiency and effectiveness, the team has carried out a review of users to enable a more streamlined design of security groups and user notifications to be embedded. This included a major review and restructure of Pharmacy user permissions.

7.2 Datix System Change Process

To strengthen the governance around changes to the Datix system and in particular, changes to the Incidents module, a DatixWeb System Change Request Form has been instigated. This requires the requestor to provide specific details of a change, the reason for same, the priority level and staff who have been party to related discussions. The request must be authorised by a manager. It must also outline any communications required if is approved.

The Risk Management team will appraise the request, consider if it is technically possible and assess the implications of making this change. The team will then submit the request with a recommendation to the Adverse Events and Duty of Candour Group to approve or otherwise.

7.3 Communications

The DatixWeb Feedback Newsletter, which reports on system changes and improvements was produced weekly and issued via email and the Intranet until it was paused due to COVID-19. It has now been reinstated. Where necessary, information has been issued via the Daily Coronavirus Update and latterly Staff Link. The team regularly receives feedback on articles and features in the newsletter. There have been 279 issues to date. Consideration is being given to the future development of the newsletter.

7.4 Staff Engagement

The Risk Management team takes every opportunity to respond to feedback about Datix and to improve system functionality and user satisfaction. All developments involve high levels of staff engagement to ensure they are fit for purpose.

The feature in the Incidents module that enables automated email feedback to be sent from Datix to every incident reporter following incident review and closure, continues to be well received. The system issues approx 30 feedback emails per day to reporters.

In the past year, a significant amount of work has been carried out on the Datix modules and is summarised below.

7.5 Risk Register Module

Currently there are 543 active risks recorded in Datix. Appendix 2 provides a breakdown of the risks by current risk level and risk type.

To improve the governance and quality of risk registers, preliminary redesign work has been carried out in Datix test to further develop the risk register templates therein.

Improvements include the addition of a ‘pre-requisite’ section which users must complete before adding a risk to the system. Users will be required to confirm with whom the risk has been discussed, and risk ownership, description, grading and rationale agreed.

Prompts will be provided to assist users to improve the definition of risks.

The templates will also be redesigned to include fields in which to capture assurances.

KPIs relating to risk registers (Appendix 3) will be reported to EDG from August 2020 and thereafter to the NHS Fife Audit and Risk Committee.

7.6 Incidents Module

Reporting Options

The Risk Management team has worked with colleagues across the organisation to improve options for incidents including:

- Violence and aggression
- Information governance & security
- Catheter related trauma
- Fluid and nutrition
- Adult protection
- Fire and security incidents

Equipment including medical devices

Changes have been made in Datix to enhance the reporting of equipment related events including consumables. These changes were carried out in conjunction with the NHS Fife Capital Equipment Management Group and the NHS Fife Equipment Coordinator. This work required a redesign of the equipment section and will ensure the organisation can comply with reporting requirements flowing from new legislation Medical Devices Regulations (MDR) and In Vitro Medical Devices Regulations (IVDR) due later in 2020.

Information Governance & Security

Exploratory discussions have taken place regarding facilitating General Practice to adopt Datix to report and investigate information governance incidents in line with national legislative requirements.

7.7 Complaints Module

NHS Fife continues to work closely with the Patient Relations team to ensure the system remains fit for purpose and allows complaints to be recorded and analysed in accordance with national requirements.

Work is underway to further utilise a function which enables the merging of information within a record with a pre-designed template. The basis of this is already in use, however with additional fields, information to be contained within the body of letters can be drafted within the record, merged into a template and then saved as a document; each version of the document can be uploaded to the record which will provide a clear audit trail on letter versions and amendments.

As reported last year, the adaptation of this module to provide an option for users wishing to report Learning from Excellence examples, remains in place in the Orthopaedic and Renal inpatient areas. Further roll out of this function requires to be considered by the organisation. 112 reports have so far been submitted, an increase of 27 reports since last year.

7.8 Clinical Effectiveness Register

As previously reported, this above register is now hosted in Datix. It enables staff to register local and national audits and service evaluations electronically in one place. Data on registered projects can be extracted and used to inform directorates and divisions of the work that is being carried out in their areas and so influence departmental and organisational priorities and improvement work. It can also provide clinical governance groups and committees with oversight of the scope of audit activity across the organisation. The register currently contains 158 audit projects.

7.9 Safety Alerts Module

As previously reported, the Datix Safety Alerts module is now used across NHS Fife for the distribution and management of safety alerts including medical device alerts, hazard notices and product recalls. To date 323 alerts have been added to Datix and distributed for action.

The system was subject to an Internal Audit review in 2019 and was deemed fit for purpose. A revised policy GP/E5 Processing External Hazard and Safety has been published which incorporates the Datix process.

It is intended that going forward, Corporate Services will submit a quarterly report to EDG detailing compliance on responding to safety alerts issued through Datix.

7.10 Miscellaneous Activity

Internal Audit: - The team developed a process and report design in Datix for the Fife Internal Audit (IA) team to use to create and manage actions from IA reports. This allows the IA administrator or identified others to:

- generate email to managers with actions, at the point of creation, update and closure
- use Progress Notes or Actions Update section to track progress
- extract a list of outstanding actions relating to IA reports and follow up on completed actions as required.

Acute Services Division Site Optimisation project - multiple changes implemented in Datix to account for changes of location and purpose.

Women, Children & Clinical Services – component of Datix restructured to support changes in the service.

7.11 Future Developments

Datix will not further develop the web versions, and only offer fixes to problems. Datix Cloud IQ is the upgrade path from Datix. To inform future decisions, in October 2019, Datix demonstrated Cloud IQ to the Director of Nursing, the Medical Director and staff and senior managers from risk management, clinical governance and eHealth & IMT. The Board is currently considering its options.

8. RISK MANAGEMENT TRAINING

The Risk Management team continue to provide a range of training and support through generic or customised training for individuals, specialities and teams. During 2019 - 20, training and facilitated sessions were delivered on the following topics:

- Incident Reviewer/Approver
- Risk Registers
- Managing Safety Alerts
- Reporting from Datix
- In House Core
- Customised sessions for a range of services including Theatres staff, Estates managers, Addictions Teams, Adult Mental Health, District Nursing teams, Primary Care Emergency Services (PCES), Specialist Nursing Teams, Infection Prevention and Control, Consultant Surgeons, Psychiatry Medical staff, Pharmacists and Obstetrics/Gynae medical staff and the Finance Directorate.

The Risk Management team took the opportunity to adapt some training into bite size sessions, typically 1 hour slots, to make these more accessible and practical for staff to attend. Bite size sessions have been developed and delivered on 'How to Report an Incident in Datix' since June 2019 & How to Review an Incident in Datix' since July 2019. Sessions will be developed for other risk management topics.

Risk management Learnpro modules and user guides are available on the NHS Fife intranet. The following user guides were updated during 2019 - 2020:

- DatixWeb Risks - Risk Register Guide
- DatixWeb Incidents - Quick Reference Card Reporter
- DatixWeb Actions - Using the Actions Module in Datix
- DatixWeb All Modules - Using the Email function
- Using the Print function in Datix

In response to COVID -19 and the need to work differently, the team have used the Microsoft Teams application to support remote training and coaching in the use of Datix and other risk management topics. The advantages are that sessions can be set up quickly and there is no need to travel. Uptake has been very good with more than 30 sessions delivered.

The team will continue to evaluate and further develop training using this application and any others that become available.

9. LEARNING AND SHARING

Sharing lessons learned and improvements is facilitated through the use of learning summaries, newsletters, departmental and divisional clinical and clinical and care governance meetings, and Interspecialty Clinical Governance events.

In the past year, closer collaboration with medical staff, particularly in Adult Psychiatry has led to the establishment of a regular feedback event for these staff which is supported by medical education and the Deanery.

10. RISK MANAGEMENT INPUT TO GROUPS AND COMMITTEES

In 2019 - 2020, the Risk Management team provided risk information and / or representation to the following:

- Divisional Performance Reviews
- EDG Major and Extreme Adverse Event Status Report
- Integrated Performance & Quality Report
- Local Partnership Forum
- Point of Care Testing
- Safe Use of Medicines

Local

- NHS Fife Adverse Events and Duty of Candour Group
- NHS Audit & Risk Committee
- NHs Fife Capital Equipment Management Group
- NHS Fife Clinical Governance Committee
- NHS Fife Clinical Governance Oversight Group
- NHS Fife Datix Users' Group
- NHS Fife Decontamination Group
- Fife Health & Social Care Partnership Health & Safety Forum
- NHS Fife Hospital Transfusion Committee
- NHS Fife Infection Control Committee
- NHS Fife Information Governance & Security Group
- NHS Fife Medical Gas Committee
- NHS Fife Tissue Viability Working Group
- NHS Fife Violence & Aggression Management Forum

National

- **Datix Scottish User Group -** chaired by NHS Fife Risk Management Coordinator

- **HIS Adverse Events Network**

- **National Whistle blowing Standards -** The NHS Fife Risk Management team has been extensively involved, through its links with the national Datix Scottish User Group (DSUG), in discussions to potentially modify the Datix system to be able to record and manage concerns raised by staff in preparation for the impending launch of national whistleblowing concerns standards. A series of short life working groups has been convened nationally involving Scottish Government Workforce, Scottish Public Service Ombudsman, Directors of Workforce from several Boards and members of the DSUG to design a system In Datix that might be used to support this initiative.

- **Standardisation of Violence and Aggression Reporting -** The NHS Fife Risk Management team has additionally been involved in a working group, led by Scottish Government Workforce Unit in response to a request from the Cabinet Secretary for Health and Sport, to identify a more standardised way of reporting incidents involving violence, aggression and other unwanted behaviours across Scotland, and to consider how Datix might be used to capture and report such incidents. Ultimately, a national approach will be agreed which Chief Executives will be mandated to implement.

11. OTHER ACTIVITY

In 2019 - 20, the Risk Management team contributed to other key pieces of work including:

Internal Audits

- B10/19 Policies and Procedures - Safety Alerts - see above.

- B22/19 Losses & Compensations - One audit finding was there was no prompt within Datix regarding financial losses and the need to follow Financial Operating Procedure (FOP) 16a and report these to Finance. In response to the audit recommendation, an alert message was added to Datix to prompt the incident reporter to inform finance regarding the loss so that it is dealt with appropriately, in accordance with FOP16a, and potentially recorded in the losses register.

- B19/20 Adverse Event Management - see above

Freedom of Information (Scotland) Act (FOI) - Provision of data to support FOI responses

12. HEALTH AND SOCIAL CARE INTEGRATION

The Risk Management team has continued to work with HSCP colleagues to support the management of risk across the organisation.

13. RISK MANAGEMENT OBJECTIVES 2020/21

Activity in the year ahead will centre on actions to support implementation of the updated Risk Management Framework and to develop capacity and capability in risk management practice.

- Maintain good practice in current systems.
- Review the governance structures, systems and processes to support effective and integrated risk management across the organisation.
- Clarify governance committee responsibilities in relation to risk management.
- Identify ‘risk leads’ within directorates and services.
- Identify risk learning and development needs within directorates and services.
- Deliver targeted training and support for ‘risk leads’ and senior managers.
- Improve risk register quality including assurance mapping & links to strategic objectives

- Embed risk appetite and tolerance.
- Support improvements in adverse events management and organisational DoC
- Transfer Legal Services Claims management activity from Datix Rich Client to DatixWeb.

Appendix 1

Chart 1

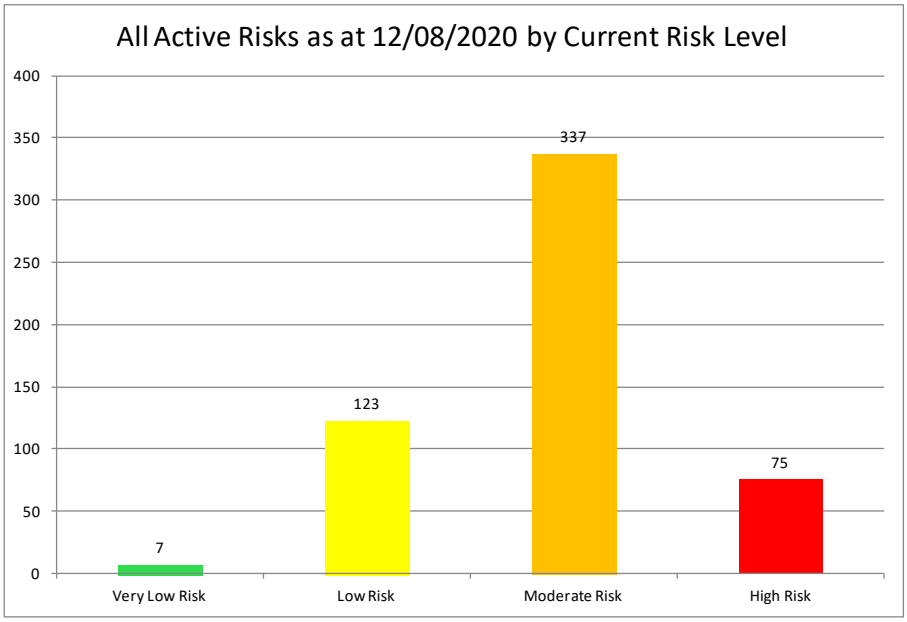
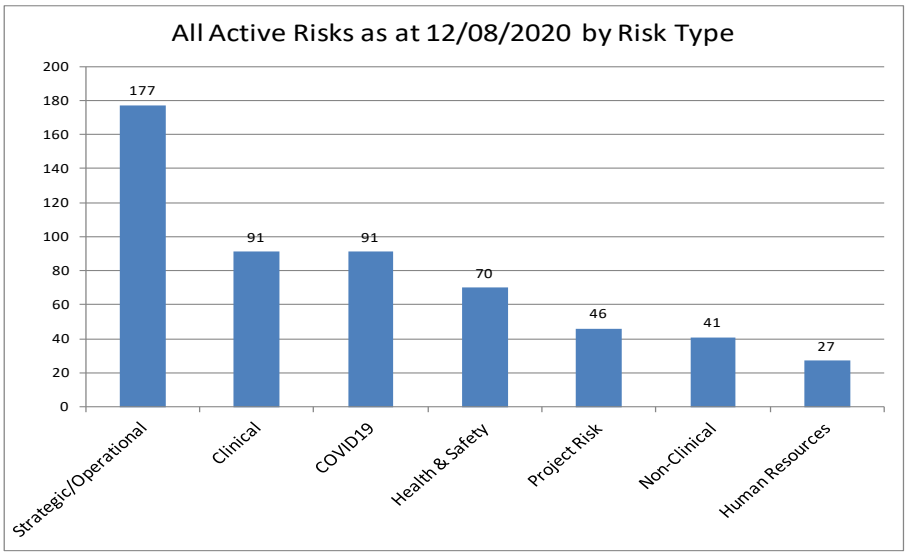
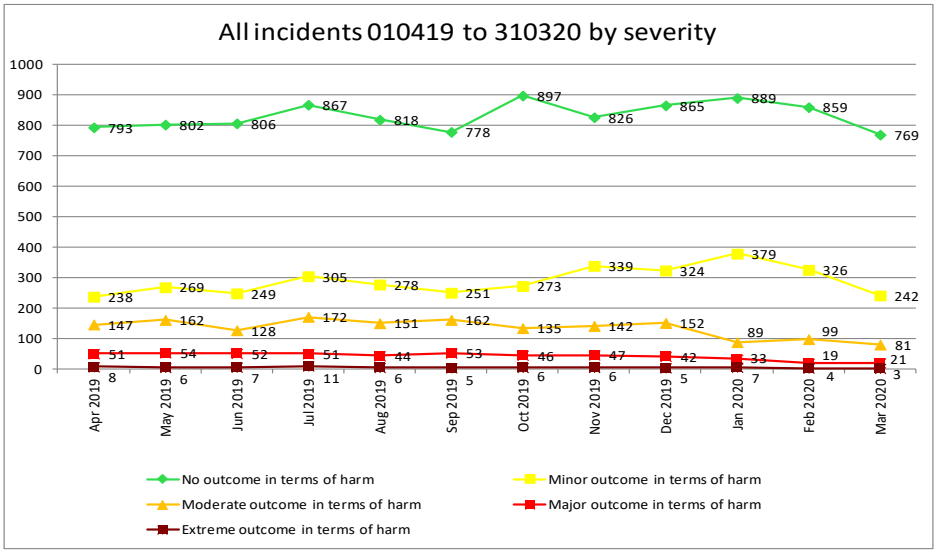
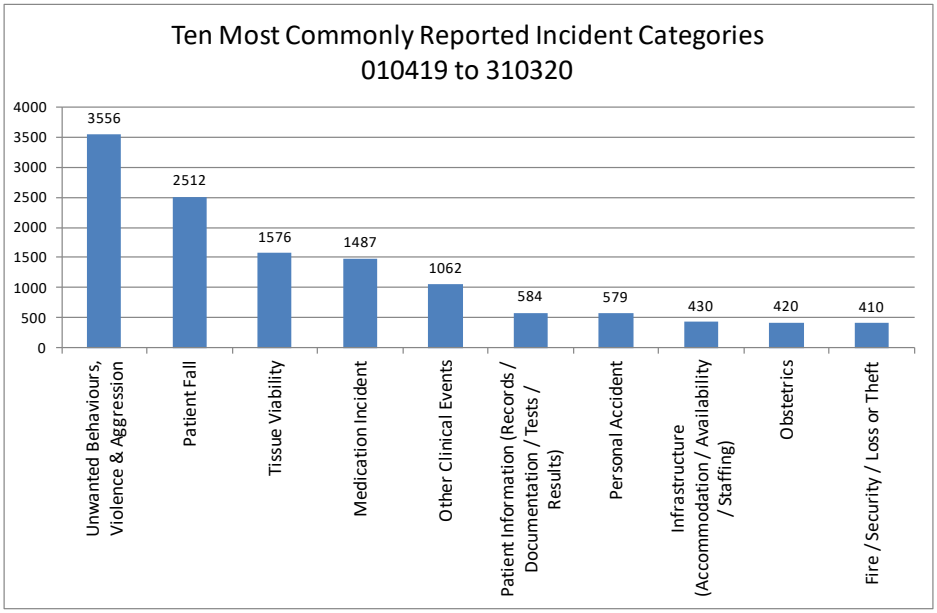


Chart 2







Other Clinical Events' contains discrete sub categories including 'Delay in Treatment', 'Failure of Diagnosis & Referral', 'Misdiagnosis'.

Appendix 3

Risk Management Key Performance Indicators (KPI)

KPI		Reported to	Frequency
1. All risks are reviewed by the review date and no later than 10 working days of the scheduled review date. • % compliance on 1st of month • % compliance at 10 working days		EDG NHS Fife Audit & Risk Committee	Bi- monthly Quarterly
2. All risks must have a review date scheduled commensurate with the assessed risk level.		EDG NHS Fife Audit & Risk Committee	Bi- monthly Quarterly
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		
3. Length of time 'high' and 'very high' level risks have been at that level		EDG NHS Fife Audit & Risk Committee	Bi- monthly Quarterly
4. Designated standing committees receive a report aligned to the Board Assurance Framework at every meeting.		EDG NHS Fife Governance Committees NHS Fife Audit & Risk Committee	Bi monthly Bi monthly Quarterly
5. % of Decision Making SBAR for Major and Extreme Adverse Events submitted in line with Adverse Events Policy GP/I9 (i.e. to fife adverse events within 5 working days of being reported)		EDG NHS Fife Adverse Events & Duty of Candour Group NHS Fife Clinical Governance Committee Group as part of IPQR	Bi monthly Bi monthly Bi monthly
6. • % no harm adverse events closed within 10 days of being reported • % minor and moderate adverse events closed within 60 days of being reported • % major or extreme adverse events closed within 90 days of being reported		EDG NHS Fife Adverse Events & Duty of Candour Group NHS Fife Clinical Governance Committee as part of IPQR	Bi monthly Bi monthly Bi monthly
7.% of LAER and SAER actions completed by target date		EDG NHS Fife Adverse Events & Duty of Candour Group NHS Fife Clinical Governance Committee as part of IPQR	Bi monthly Bi monthly Bi monthly

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**17 September 2020**
Title:	**Update on Risk Management Framework**
Responsible Executive:	**Helen Buchanan, Director of Nursing**
Report Author:	**Pauline Cumming, Risk Manager**

1 Purpose

This is presented to the Committee for:

- Awareness

This report relates to a:

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

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this paper is to set the review of the NHS Fife Risk Management Framework in context and seek the Audit & Risk Committee's approval of the latest iteration.

2.2 Background

The Risk Management Framework developed in 2014, contained the following pillars:

- Risk Philosophy
- Approach to Risk Management
- Board Assurance Framework
- Risk Policy & Procedures
- Audit & Risk Committee Terms of Reference
- Reporting Framework
- Risk Appetite & Tolerance

- Tools to assess ourselves against

Content relating to the (i) Board Assurance Framework, and (ii) Risk Appetite & Tolerance components was, at that time, reserved, pending the sign off of the Strategic Clinical Framework. These components were ultimately developed in 2017 and 2019 respectively.

2.3 Assessment

The updated Framework reflects updates made in light of the time lapse between the original document and the latest iteration, and changes made in response to feedback obtained from the stakeholder consultation process. Key changes are as follows:

Philosophy: The component which previously stated the Board's commitment to risk management and its related beliefs, is now contained within an introductory section.

Approach to risk management: Content has been updated and for clarity, some of it has been re - organised into stand - alone sections.

Board Assurance Framework (BAF): Content reflects that the BAF is now established, and explains its relationship to our overall risk management arrangements. Additionally, the Framework outlines how, based on best practice guidance, we will further develop the governance and internal control processes through which the Board receives its assurance that these are operating effectively. Key areas of focus will include the accuracy of BAF content, alignment with the strategic objectives and evidence that the BAF is regularly subjected to effective scrutiny and challenge.

Risk Policy & Procedures: The Risk Register/ Risk Assessment Policy GP/R7 remains in place. Consultation feedback confirmed there is considerable duplication between the Framework and Policy. There is now an opportunity to consider streamlining the content to make it less unwieldy, more accessible and meaningful for the organisation and so achieve better performance. It is felt this could be accomplished by retaining an overarching framework aligned to a suite of simpler procedures. This could facilitate implementation and make it easier to assess how successfully the Framework translates into practice. As this recommendation requires further consideration and discussion, the policy component is not provided with this submission.

Audit & Risk Committee Terms of Reference: These are included in full along with those of the other governance committees.

Reporting Framework: This section has been renamed Reporting and Review, and has been expanded to reflect the required arrangements and reporting cycle.

Risk Appetite & Tolerance: Content has been added to reflect the current position and the approach that is recommended to implement in full. The risk appetite statement requires to be updated by the end of November 2020.

It is recommended that the update process:

- takes cognisance of the updated strategic objectives
- includes a review of the Board's categorisation of risk
- agrees and apply risk tolerances for specific types of risk

Tools to assess ourselves against: The extant Framework includes the Risk And Control Evaluations (RACEs) tool, developed by Internal Audit to be a guide to support the assessment of controls which mitigate to an acceptable level, key risks and control weaknesses that result in risk exposure. The tool is based heavily on Public Sector Internal Audit Standards (2013), section 2010 - Risk Management. It is a key part of the internal audit fieldwork process. It is recommended that we consider if there is value in retaining this tool, or if we should rely wholly on the Annex F, Key Lines of Enquiry in the Scottish Government Audit & Assurance Committee Handboook, 2019.

Health and Social Care Integration: It is desirable that the updated Framework accurately describes the delegation of functions to the Integration Joint Board (IJB), and the implications for risk management, governance and assurance, in particular, the treatment of residual risk. This detail is not yet available pending the Integration Scheme review. In the interim, the Director of Health and Social Care has provided a form of words for the Framework, that reflect the current position under the terms of the Integration Scheme, 2018, and the Health and Social Care Partnership / Integration Joint Board Risk Management Strategy and Policy 2019.

In summary

The updated Framework reaffirms the Board's belief that the successful management of risk is fundamental to meeting its strategic objectives, and restates our commitment to ensuring that risks to the quality, safety, effectiveness and sustainability of our services are identified, managed and reduced to an acceptable level or eliminated as far as reasonably practicable.

It offers the vision and direction for the further development of risk management in NHS Fife. This is at a time when it is vital to build on existing good practice, and refresh and reinvigorate our approach, not least given the significant challenges and uncertainty facing our health and care systems, such as those generated by the COVID -19 pandemic, and EU withdrawal. These crystallise the need for clarity of purpose around a shared endeavour; to deliver high quality, integrated services in a financially sustainable manner.

Successful delivery will depend on first principles: clear understanding about our objectives, the associated challenges, and a compelling case for change where this is necessary or desirable. To better understand what is required, several actions are recommended including:

- an organisational review of the governance infrastructure and processes, including the accountability arrangements that currently support risk management functions

- an assessment of risk management capacity and capability
- a wholesale review of the organisation's risk registers and current risk profile
- a review of the Datix Risk Register module set up

Outputs from the above will inform the activities for successful implementation and will include the following:

- risk awareness sessions to launch the updated Framework
- roll out of risk appetite and tolerance as part of the planning and decision making framework
- implementation of risk management KPI reporting
- progression of assurance work, based on best practice guidance
- production of a risk management 'toolkit' i.e. training, materials and support to enable staff to develop the risk management capability necessary for their job
- resetting the governance of risk management activity across the organisation

The actions above will form part of the risk management work plan for the year ahead.

2.3.1 Quality/ Patient Care

NHS Fife's risk management systems and processes should support the delivery of safe, effective, high quality, person centred care. The updated Risk Management Framework embraces that ambition.

2.3.2 Workforce

The arrangements for risk management are contained within current resource. Good risk management should empower staff to make decisions and improvements to ensure risks are identified and addressed, enhance the working environment, protect health and wellbeing and reduce staff exposure to risk.

2.3.3 Financial

Proportionate management of risk should assist in the efficient and effective use of scarce resources.

2.3.4 Risk Assessment/Management

The extant Framework including the Policy remains in place.

2.3.5 Equality and Diversity, including health inequalities

This paper does not relate to any decisions that would significantly affect groups of people and EQIA is therefore not required.

2.3.6 Other impact

Not applicable.

2.3.7 Communication, involvement, engagement and consultation

In addition to the consultation process, there have been communications with the Director of Nursing, the Head of Quality and Clinical Governance, the NHS Fife Risk Management Team, and through the Manager, Risk Compliance, Health and Social Care, with the Director of Health and Social Care.

2.3.8 Route to the Meeting

This paper has not been considered by any group.

2.4 Recommendation

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

3 List of appendices

Not applicable

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Risk Management Framework

Approval Record	Date
Strategic Management Team	17 February 2014
NHS Fife Audit and Risk Committee	2 April 2014
Fife NHS Board	26 August 2014
	17 September 2020
	29 September 2020

Contents

RISK MANAGEMENT FRAMEWORK

1. Introduction

NHS Fife endorses the view that, “In successful organisations, risk management enhances strategic planning and prioritisation, assists in achieving objectives and strengthens the ability to be agile to respond to the challenges faced. If we are serious about meeting objectives successfully, improving service delivery and achieving value for money, risk management must be an essential and integral part of planning and decision-making.” HM Treasury, Orange Book,2020.

Implementation of this Framework will support the Board to identify, assess and mitigate the risks that could undermine our ability to meet the local, regional and national objectives and priorities within the NHS Fife Clinical Strategy, NHS Fife Annual Operational Plan 2020/21-2022/23, and the Health and Social Care Strategic Plan, In this way it will help us to achieve our ambition to be a strongly performing board providing quality, person - centred and clinically excellent care, delivered by a well trained workforce, within a safe environment, using our resources in the most cost effective and sustainable manner.

The Board is committed to an approach that is forward looking and comprehensive; that makes the management of risk integral to everyday practice, that supports a culture which encourages continuous improvement and development and a focus on proactive rather than reactive risk management, and importantly. to ensuring that responsibility for implementation is accepted at all levels of the organisation.

The Board also recognises the importance of involving local stakeholders in its risk management processes and of working in partnership to identify, prioritise and control shared risks.

This Framework sets out our approach to risk management and outlines the key objectives and responsibilities for the management of risk throughout our organisation.

2. Approach to Risk Management

Risk is a part of everything we do; we all manage risk every day - often without realising it. It can be defined as ‘uncertainty of outcome, whether positive opportunity or negative threat of actions and events. It is the combination of the likelihood of something happening and the consequence materialising’.

To manage this uncertainty, the Board will implement a systematic and proactive approach to risk management in which the culture, processes and structures are directed towards realising potential opportunities whilst managing adverse effects, and which is applied across all of its activities,

Risk Management is a process consisting of steps which, taken in sequence, support better decision making by contributing to a greater insight into risks and their impacts.

The key steps are:

- identification of risks;
- assessment of the likelihood and potential consequence of risks;
- elimination of those risks that can be reasonably and practicably eliminated;
- control of those risks that cannot be eliminated by reducing their effects to acceptable level through appropriate actions;
- monitoring and review of progress to establish if further action is necessary;
- reporting and assurance

Good risk management is about identifying what might go wrong, what the consequences might be if that happens and then deciding what we can do to reduce the likelihood and / or the impact of something going wrong.

It has the potential to:

- identify and mitigate threats to the achievement of key strategic objectives;
- improve service quality;
- minimise harm to patients, staff and visitors;
- enhance risk awareness and consistent risk management practice;
- protect assets and make best use of resources;
- support the Board's activities by using valid risk information to underpin strategy, decision-making and resource allocation;
- enable compliance with legislative and regulatory requirements;
- strengthen assurances on the adequacy and effectiveness of our systems;
- enhance reputation;
- ensure we act with integrity and within the Code of Corporate Governance

Our approach, will, through internal and external intelligence and horizon scanning, help us to better identify, and anticipate risks before they materialise. This will ensure we are not surprised by risks which could, and should have been foreseen.

The Board and its senior management will, through exemplary behaviours, foster a culture which encourages and empowers all staff to identify and reduce risk effectively, as part of daily business, to learn from experience and build upon existing good practice to avoid re- work and 'fire fighting'.

3. Purpose

The purpose of the framework is to:

- identify responsibilities for managing risk
- define the processes for consistent risk management practice
- describe the Board's approach to risk appetite and tolerance
- ensure appropriate structures are in place to manage risks
- describe the reporting arrangements to governance committees and groups

This will allow NHS Fife to:

- establish systems, processes and structures throughout the Board which support effective risk management;
- increase devolution of decision making and accountability for management of risk throughout the organisation from 'Board to Ward' ;

- embed a risk culture of monitoring and improvement, which ensures risks to the delivery of Board's strategic ambitions are identified and addressed;
- support patients, service users, carers and stakeholders through reduction of risks to service delivery and improved service provision;
- enable the Board to receive and provide assurance that it is compliant with legislative and statutory requirements;
- provide assurance that adequate and effective risk management systems are in place to enable the Annual Governance Statement to be signed.

4. Scope

Risk management is the responsibility of all staff. It is integral to the delivery of safe, effective, person centred care and services. Every member of staff within the Board is therefore responsible for identifying and managing risk in the course of their work.

- This framework applies to the management of risk across all areas and to all employees of NHS Fife working in the NHS Fife Corporate Directorates, the Acute Services Division (ASD), and, the NHS Fife services delegated to the Integration Joint Board (IJB) and delivered through the Fife Health and Social Care Partnership (HSCP). systems.

- It also applies to permanent and temporary contractors, students, honorary contract holders, bank, agency and volunteer staff working in NHS Fife and the health related functions of the HSCP and by agreement, independent GP, Dental, Pharmacy and Optometry contractors working within, or on behalf of NHS Fife.

5. Risk Management System

The risk management system is an integral part of the Board's framework for assurance and corporate governance. It will enable the Board to identify and monitor risks to its strategic objectives, support the appropriate management and escalation of these risks and inform the Board whether the systems and process in place are providing effective controls and assurances. Risks will be recorded in the Risk Register module of Datix. The Board will achieve the above by:

- **Assessing** risk - standardised system of identification, assessment & control of risks using the NHS Fife risk assessment matrix.
- **Building** risk management capability - engaging with and & training staff
- **Communicating** risk information - using data for learning and improvement. Datix provides the repository in which to record, report and learn from risks, adverse events, complaints, claims and safety alerts; this data supports the performance management process.
- **Data analytics -** informing decision making - risk data is used to provide all levels of the Board with information on its risk profile, provide assurances and enable decisions to be made on prioritisation of resources.
- **Effectiveness of control -** a self assessment of the risk management system will be carried out using the Key Lines of Enquiry to provide evidence and assurance for the Chief Executive's Annual Governance Statement.

The key components of the risk management system are the Risk Appetite Statement, the Board Assurance Framework, and the Corporate and Operational risk

registers. The production of these components is supported by the Board's risk management processes.

6. Risk Appetite and Tolerance

Risk Appetite

The Board acknowledges that a certain amount of risk is unavoidable and it will be necessary to take risks if it is to achieve its objectives; this must be done in a controlled and considered way. Risk appetite is the type and level of risk that NHS Fife is prepared to accept, tolerate or be exposed to in pursuit of its strategic objectives at a point in time.

Exposure to risks will be kept to a level of impact deemed acceptable to the Board. Risk appetite is not static, so the acceptable level may vary at different times according to the amount of risk the Board is prepared to accept in the context in which the appetite is being considered.

Risk Tolerance

While risk appetite relates to the pursuit of risk, risk tolerance relates to the boundaries set for specific risks. Risk tolerance is often expressed in quantifiable measures e.g.; target risk level, % targets, but can also be expressed in terms of absolutes, e.g. "the Board will not perform certain types of surgery".

Risk tolerance should assist in day to day operational decision making, guiding services as they implement risk appetite within their sphere of activity.
When agreeing the risk tolerances, the following approach should be adopted:

- Management sets objectives;
- Management with the Board consensus, articulate risk appetite that is acceptable in pursuit of these objectives;
- Management sets tolerances acceptable at corporate or operational level

The Board will have different appetites for different categories of risk. Some risks above the agreed acceptable level may be accepted because:

- the likelihood of the risk occurring is deemed to be sufficiently low;
- they have the potential to deliver considerable benefits and reward;
- they are too costly to control given other priorities;
- the cost to control is greater than cost of the impact should the risk materialise;
- there is a short period of exposure;
- assumption of the risk is essential to achievement of objectives

In such cases, further action must be taken to mitigate the risk to the lowest possible level.

The Board will set its risk appetite for categories of risk using the terminology and descriptors[1] in Table 1 below aligned to tolerances based on the NHS Fife Risk matrix. See Appendix 2.

Table 1: Risk Appetite

Appetite	Descriptor	Tolerance
Averse	Prepared to accept only the very lowest levels of risk, with the preference being for ultra-safe delivery options, while recognising that these will have little or no potential for reward/return.	1-3
Cautious	Willing to accept some low risks, while maintaining an overall preference for safe delivery options despite the probability of these having mostly restricted potential for reward/return.	4-6
Moderate	Tending always towards exposure to only modest levels of risk in order to achieve acceptable, but possibly unambitious outcomes.	8-12
Open	Prepared to consider all delivery options and select those with the highest probability of productive outcomes, even when there are elevated levels of associated risks.	15-16
Hungry	Eager to seek original/pioneering delivery options and to accept the associated substantial risk levels in order to secure successful outcomes and meaningful reward / return.	20-25

An illustration of the Board's risk appetite is provided at Appendix 3.

The Board will review its risk appetite periodically, at least annually, in line with the identification of strategic objectives. The Board will then publish its risk appetite, identifying the appetite for each risk identified to the achievement of the strategic objectives for the financial year in question.

The Board will not usually accept a current risk score 15 - 25 (high) on the risk matrix, unless the appetite for the risk is also high. In such cases, further action must be taken to mitigate the risk to the lowest possible level. A high scoring risk for which the organisation has a low risk appetite requires serious and urgent action.

Risks with a current risk matrix score of 15 or above or with a consequence score of 5 will require to be escalated to the Executive Directors' Group (EDG) for review and consideration for inclusion on the Corporate Risk Register and / or as a linked risk on the Board Assurance Framework (BAF).

When new risks or further risks to ongoing activities are identified, the Board will attempt to mitigate such risks to an acceptable level in the context of the prevailing conditions. The statement does not rule out the potential for the Board to make decisions that result in risk taking that is outside of the stated risk appetite.

[1] HM Treasury, Orange Book, 2004

Assessed level of risk	Risk Appetite & Tolerance Descriptor	Level & Frequency of Review / Assurance
Green **Very Low** **1-3**	Risk level within Board risk appetite and subject to regular local monitoring	• Executive Director Group (EDG) 6 monthly through the Corporate Risk Register • Board through Annual Report • Audit & Risk Committee through quarterly risk profile and KPI reporting and Annual Report
Yellow **Low** **4-6**	Risk level within Board risk appetite and subject to regular active monitoring measures by responsible Director and Managers	• EDG quarterly with assurance report from the risk owner • Audit & Risk Committee through quarterly risk profile & KPI reporting and Annual Report
Amber **Moderate** **8-12**	Risk level within Board risk appetite and subject to regular active monitoring measures by responsible Director and Managers	• EDG quarterly with assurance report from the risk owner • Audit & Risk Committee through quarterly risk profile reporting and Annual Report Board through Annual Report
Red **High** **15-25**	Risk level exceeds Board risk appetite and requires immediate action, monitoring at EDG, Governance Committee and Board. Individual risks can be tolerated at high, but only if EDG accept; final approval must be through the Board	• Every Board Meeting through report on the Corporate Risk Register and Board Assurance Framework for decision-making and assurance. • Every Audit & Risk Committee through reporting for assurance • Monthly EDG for discussion and review of mitigation controls, triggers and assessment Audit & Risk Committee and/or EDG can escalate any individual high graded risk to the Board as required

The risk appetite informs the risk tolerance levels, which are considered for individual risks. Based on this, a target (acceptable) risk score is set for individual risks; this is the level to which the risk is to be managed and takes into account the Board's risk appetite and practicality of reducing the risk

The benefits of this approach include:

- Management focus on risks that can be managed / reduced;
- Identification of targeted actions to reduce risks to target;
- Timely reduction of risks;
- Identification of static risks / ineffective actions;
- Management focus on risks that cannot be reduced

Board Assurance Framework (BAF)

The Board Assurance Framework (BAF) provides a high- level view of risk, which sits above the risk register system. Appendix 4 provides an illustration of the NHS Fife BAF structure and scope. The BAF describes the overarching risks to the organisation's strategic objectives and priorities.

It is designed to enable the Board to:

- identify and understand the principal risks to achieving its strategic objectives;
- receive assurance that suitable controls are in place to manage these risks;

- identify where improvements are needed;
- receive assurance that action plans are in place and are being delivered;
- make an assessment of the risk to achieving the objectives based on the strength of controls and assurances in place;
- address the issues identified in order to deliver its strategic objectives and determine how to best use resources

The strategic risks contained in the BAF are reviewed and updated by Executive Directors and reported bi-monthly to the aligned Board governance committee.

To inform the content of the BAF, the EDG will review and monitor on a monthly basis, all risks with a current risk score of 15 and / or above outside the tolerance threshold and agree the course of action to be taken. In addition, EDG will also review on a monthly basis any and all risks rating of 10 with a Likelihood rating of unlikely (2) and a consequence rating of Extreme (5).

The Board will evaluate the quality and robustness of the BAF process and content on a regular basis and ensure arrangements are in place to:

- update the BAF in the light of evidence from e.g. relevant reports, internal and external reviews and organisational developments;
- assure the Audit & Risk Committee to enable an evaluated opinion to be made and support the Chief Executive in the completion of the annual Governance Statement

NHS Fife will achieve this through monitoring and review which will include:

- Annual review of the risks identified within the BAF, and supporting controls and assurance sources following review of and agreement on the strategic objectives;
- Annual review as part of the Internal Audit planning process;
- Annual review of the governance arrangements supporting the BAF to ensure it continues to be fit for purpose and is subject to effective scrutiny and challenge;
- Review in response to best practice governance and assurance guidance;
- Horizon scanning

Horizon scanning

Horizon scanning is about identifying, evaluating and managing changes in the risk environment, preferably before they manifest as a risk or become a threat to the organisation. Horizon scanning can also identify development opportunities.

Through horizon scanning, the Board will be better able to respond to changes or emerging issues in a co- ordinated manner. Issues identified through horizon scanning should link into and inform business planning, the development of our strategic priorities and objectives.

Operational Risk Register - risks are recorded on risk registers in services and directorates, managed by lead directors, with reporting and scrutiny through the local governance structures e.g. risks within e.g. directorate, team or service which have the potential to affect the ability to deliver a service because of e.g. failed or inadequate systems, processes, resources or infrastructure.

Corporate Risk Register (CRR) - contains the highest scoring risks from across the organisation e.g. risks that have the potential to affect the whole organisation, or operational risks which have been escalated e.g. can no longer be managed by a service or require senior ownership and support to mitigate. The register will be routinely reviewed and monitored by Executive Directors.

A process will be established to review the organisation's risk registers to ensure consistency in the identification, assessment and rating of risks and to ensure effective management action is being taken to mitigate and control risks.

7. Assurance

Assurance is a key component of the risk management system. It is defined as: "an evaluated opinion, based on evidence gained from review, on the organisation's governance, risk management and internal control framework" and the extent to which these are functioning effectively and, just as importantly, the aspects which need to improve in order to achieve best value. In summary[2]:

Assurance	
Provides:	Evidence/Certainty/Confidence
To:	Management/Directors/Organisation/ External reviewer
That:	What we are currently doing is making an impact on risks

The process for gaining assurance involves bringing together all of the relevant evidence and arriving at informed conclusions on the value of assurance provided.

In accordance with the Scottish Government directive, and best practice principles, NHS Fife will further develop its approach to assurance mapping, rating and reporting, to strengthen quality of assurance provided. To do this, the Board will use the 'three lines of assurance' model.

First line:	management assurance from "front line " or operational areas that own the risks and are responsible for controlling them day-to-day and for taking corrective actions to address deficiencies.
Second line:	functional oversight, separate from those responsible for delivery, but not independent of the organisation's management chain e.g. compliance assessments / reviews to determine if standards/ policy/ regulatory considerations are being met in line with expectations.
Third line:	independent oversight to provide objective assurance including the quality of assurance derived from the first and second lines e.g. internal & external audit, accreditation bodies, inspection reviews.

[2] Northumberland, Tyne and Wear NHS Foundation Trust, Risk Management Strategy 2017-2022

8. Governance and Accountability

The governance and accountability arrangements for risk management are based on the principles that the information provided to groups and committees for assurance:

- is accurate, meaningful and well presented;
- makes clear where the responsibilities lie and;
- provides assurance on the effectiveness of arrangements in place

Appendix 5 outlines the risk management reporting arrangements.

Fife NHS Board

The Board is responsible for ensuring that there is in place a sound system of internal control which is effective in managing risks to the quality, delivery and sustainability of services accordance with the NHS Fife Code of Corporate Governance and informed by the NHS Scotland Blueprint for Good Governance.

The Board shall:

- set the risk appetite and associated risk tolerance levels;
- approve the Risk Management Framework and associated procedures;
- inform and approve the BAF by periodically considering the content and determining if it accurately reflects the scope of risks to which the organisation is exposed, and if the risks are accurately described;
- use horizon scanning and scenario planning collectively and collaboratively with those setting strategy and policy, to identify and consider the nature of emerging risks, threats and trends;
- provide assurance to the IJB through the process of Direction from the IJB and in line with the Fife HSCP Risk Management Policy and Strategy.1

Governance Committees

The governance committees are responsible for the oversight of all strategic and high level risks associated with their remits. They must be assured on the adequacy and effectiveness of related risk management arrangements.

Each Committee will scrutinise:

- relevant risks on the Corporate Risk Register on a bi monthly basis;
- the Board Assurance Framework risk(s) aligned to it on a bi-monthly basis

Members will:

- comment on the accuracy of the content, risk scores, and the adequacy and effectiveness of the controls to manage the risk within appetite;
- take cognisance of any relevant information including internal and / or external audit reviews of the risk management system;
- through its annual statement of assurance to the Audit and Risk Committee, describe how it has addressed risk management within the context of the BAF;
- each committee will demonstrate leadership behaviours and actions that support a positive safety culture and a commitment to openness

Audit and Risk Committee

The purpose of this Committee is to provide the Board with the assurance that its activities 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 and the NHS Fife Code of Corporate Governance.

With regards to risk management this includes:

- 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

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.

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

Clinical Governance Committee

The purpose of the Committee is 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. This includes overseeing the clinical governance and risk management activities in relation to the development and delivery of the Clinical Strategy. The committee is specifically responsible for oversight of risks in relation to the quality and safety of patient care, eHealth, information governance and security, and, with the Financial, Performance and Resources Committee, risks relating to strategic planning. planning. effectively.

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.

Finance, Performance and Resources Committee

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. The committee is responsible for oversight of risks relating to the Board's business arrangements, particularly finance, operational performance and resource utilisation, risks associated with environmental sustainability including the Board's estate, its facilities and capital services, and to compliance with related legislation. The committee is also responsible, with the Clinical Governance Committee, for oversight of risks related to strategic planning.

Staff Governance Committee

The purpose of the Staff Governance Committee is to support the development of a culture within Board where the highest standard possible of staff management is delivered within the direction provided by the Staff Governance Standard and to ensure the workforce has the right composition of staff, with the right skills and competencies deployed in the right place at the right time to provide services and patient care as set out in the Clinical Strategy. The committee is therefore responsible for oversight of risks to workforce sustainability including health and wellbeing and staff training.

Integration Joint Board (IJB)

Members of the Integration Joint Board are responsible for:
- oversight of the IJB's risk management arrangements;
- receipt and scrutiny of reports on strategic and corporate risks and any key;
- operational risks that require to be brought to the IJB's attention;
- ensuring they are aware of any risks linked to recommendations from the Director

of Health and Social Care concerning e.g new priorities/policies;
- providing assurance to NHS Fife and Fife Council on the key risks relating to the planning, development and provision of health and social care services in Fife

In line with the Fife Health and Social Care Integration Scheme, 2018, NHS Fife will report relevant risks that relate to the delivery of delegated services in line with the process of Direction from the IJB and the Health & Social Care Partnership / Integration Joint Board Risk Management Policy and Strategy, 2019[3].

Executive Directors' Group (EDG)

The EDG chaired by the Chief Executive, has collective responsibility to deliver effective risk management arrangements throughout NHS Fife. This includes identifying risks and opportunities in relation to the strategic objectives, 'horizon scanning', the analysis of those risks and the development of action plans to eliminate or minimise impact.

The EDG will receive and scrutinise strategic, corporate, newly identified high risks, risks with a consequence score of 5 and any escalated risks on a monthly basis. Directors will highlight risk management issues to the appropriate governance committees and provide assurance to the Audit and Risk Committee and by extension to the Board, that these matters are being adequately managed. For risks relating to delegated services, connection to the IJB and its committees will be picked up under the role of the NHS Fife Board.

9. Delegated Authority

The following describes the detail and extent of the delegated authority with regard to risk management in NHS Fife.

Chief Executive

The Chief Executive as the Accountable Officer for NHS Fife, is legally responsible for ensuring that there is a sound system of internal control that supports achievement of the Board's strategic objectives. This means that risks must be identified, their significance assessed and appropriate systems must be in place to manage the risks. As the Accountable Officer, the Chief Executive shall require assurance from the executive directors that risks are being managed. The Chief Executive shall also take independent assurance from the Audit and Risk Committee as to the robustness of the Board's risk management arrangements.

Director of Nursing

The Director of Nursing is by delegation from the Chief Executive, the executive lead for risk management, systems and processes. This includes preparation of an annual report on risk management and periodic reporting to the Board, the Audit and Risk Committee and others as required.

[3] Health & Social Care Partnership / Integration Joint Board Risk Management Policy and Strategy, 2019

Executive Directors and Chief Operating Officer

While the Chief Executive has overall accountability for risk management, each Director is accountable for managing risk in their areas of responsibility and risks associated with their assigned corporate objectives. They are responsible for ensuring effective systems for risk management, compatible with this framework, are in place within their directorate. They must provide leadership and set the tone for risk management and a positive risk culture within their areas of responsibility. Specifically, they must ensure:

- suitably competent staff are identified to lead on risk management within the directorate
- staff understand their roles and responsibilities for risk management
- staff attend risk training appropriate to their role (including in house core)
- risks are effectively managed i.e. identified, assessed and that actions to mitigate risks are developed, documented and regularly reviewed
- the review process ensures that the current mitigating actions are effective and sufficient to reduce the risk to the target level within an acceptable timescale.
- where a risk has been scored as high and escalated, further mitigating actions are implemented reduce the score
  service developments, business cases and capital plans are formally risk assessed

Director of Estates, Facilities and Capital Services

The Director of Estates, Facilities and Capital Services is accountable to for leadership and co-ordination of the risk agenda relating to:

- environmental sustainability including property and asset management, and
- health and safety, specifically to ensure that the Board is fully compliant with Health and Safety legislation and best practice

Director of Finance

The Director of Finance is accountable for leadership and co-ordination of the risk agenda relating to financial sustainability, performance, transformation and corporate governance.

Senior Information Risk Owner (SIRO)

The Director of Finance is also the NHS Fife Senior Information Risk Owner (SIRO). The SIRO is responsible, by delegation from the Chief Executive, for ensuring compliance with the data protection regulations and the NHSS Information Governance and Security Strategic Framework and policies, and for ensuring that information risk is properly identified and managed and that appropriate assurance mechanisms exist. The SIRO:

- implements and leads the Information Asset risk assessment and management processes within the organisation and advises the EDG on the effectiveness of Information Governance and Security across the organisation;

- takes overall ownership of the NHS Fife Information Risk related policies, acts as champion for information risk on the Board and provides written advice on the content of the NHS Fife Statement of Internal Control in regard to information risk;
- has a key role with the Caldicott Guardians and the wider Information Governance team, to ensure that the Board adheres to the Caldicott principles in terms of protecting the confidentiality, privacy and fairness of patients and service-user information, and enables appropriate information-sharing.

Director of Health and Social Care

The Director of Health and Social Care is accountable for leadership and co-ordination of risks relating to the delivery of delegated services in line with the process of direction from the IJB and the shared risk management strategy.

Medical Director and Director of Nursing

The Medical Director and Director of Nursing are jointly accountable for leadership and co-ordination of the risk agenda relating to clinical quality and safety.

Medical Director

The Medical Director is accountable for leadership and co-ordination of the risk agenda relating to delivery of the eHealth, Information & Digital Strategy to support strategic transformation & performance, and strategic planning.

NHS Fife has appointed three Caldicott Guardians as follows:
- Corporate Caldicott Guardian (Medical Director)
- Acute Services Caldicott Guardian (Associate Medical Director)
- H&SC Partnership Caldicott Guardian (Associate Medical Director)

Caldicott Guardians are senior clinical managers of the Board responsible for protecting the confidentiality, privacy and fairness of patients and service-user information and enabling appropriate information-sharing. Caldicott Guardians:

- oversee that all procedures affecting access to person-identifiable health data are appropriate from the medical perspective;
- are responsible for ensuring that NHS Fife or partners using NHS Fife data, adhere to the Caldicott principles;
- acting as the "conscience" of an organisation, actively support work to facilitate and enable information sharing, advising on options for lawful and ethical processing of information as required;
- are key members of the broader Information Governance function with support staff, Caldicott or Information Governance leads including the Data Protection Officer, Freedom of Information leads, Health Records Manager and IT Security staff contributing to the work as required
- work with the SIRO and the wider Information Governance team, to ensure that information risk is properly identified and managed and that appropriate assurance mechanisms exist.

Director of Pharmacy and Medicines

The Director of Pharmacy and Medicines is accountable to for leadership and co-ordination of the risk agenda relating to the Safe & Secure Use of Medicines.

Director of Public Health

The Director of Public Health is accountable for leadership and co-ordination of the on risk agenda relating to public health priorities including the prevention and reduction of health inequalities, and for ensuring there is effective resilience capacity in NHS Fife.

Director of Workforce

The Director of Workforce is accountable for leadership and co-ordination of the risk agenda relating to staff governance and workforce sustainability including health and wellbeing and staff training.

Local Level Responsibility

Divisional Directors (Associate Medical Director (ASD) and (HSCP), Associate Nurse Directors (ASD) and HSCP, General Managers (ASD) and Divisional General Managers (HSCP),Clinical Directors (ASD) and (HSCP),Heads of Nursing (ASD) and (HSCP), or equivalent) are responsible for ensuring effective systems for risk management are in place within their divisions or directorates.

They must:

- provide leadership and set the tone for risk management
- promote a risk culture
- ensure staff have access to and attend appropriate risk management training
- ensure systems and processes are in place for the identification, assessment, recording, escalation, monitoring and review of risks
- ensure timely communication of risks and risk information
- ensure that risks are documented in the risk register
- establish local governance groups (or equivalent) which provide management oversight of risk registers
- review overall local risk management performance
- use risk information to support learning and improvement

Line Managers

Including: Service Managers, Clinical Nurse Managers, Senior Charge Nurses, other managers at Directorate, Departmental, Service level or equivalent, are responsible for ensuring effective systems for risk management are in place at ward, service or departmental level and that staff have access to and attend appropriate risk management training.

Risk Owners

Risk owners are responsible for ensuring that:

- their risks are analysed in line with the NHS Fife risk matrix
- risks are described clearly

- risk assessments are based on reliable information
- risks are reviewed in terms of context, likelihood and consequence
- management control and actions are proportionate to context and risk level and are in line with the organisation's risk appetite

Staff

All staff and contractors have a responsibility to contribute to the management of risk. They must:

- comply with risk management policies and procedures
- attend training provided appropriate to their role
- be risk aware and consider potential risks in the course of their daily work
- identify risks and take prompt, appropriate action to eliminate, control or escalate
- report adverse events to allow lessons to be learned and risk management arrangements to be improved

Risk Manager

The Risk Manager plays a key role in improving and monitoring the Board's risk management system and providing clarity around its risk profile, to enable the Board to fully understand the main risks to the organisation. The Risk Manager will:

- systematically review and update the Risk Management Framework and related procedures
- set standards for the management of risk registers oversee implementation of risk management related procedures
- provide advice and support to EDG on the BAF, the Corporate Risk Register, and reporting to the Audit & Risk Committee, and to other directors and other senior managers on risk management and risk registers
- prepare risk reports for the Board and the Audit & Risk Committee
- carry out risk reviews with risk owners
- carry out deep dive reviews as requested by e.g. non executive directors, EDG
- have regular meetings (at least quarterly) with individual EDG members / corporate risk owners
- monitor and report on risk management Key Performance Indicators (KPIs)
- carry out a self assessment using key lines of inquiry on behalf of the EDG
- prepare an annual report
- oversee the continuing development of the Datix IT risk management system
- implement a programme of risk management training for staff

10. Review and Reporting

The reporting requirements vary dependent on the type of risk. Risk will be a key focus of each governance committee and be reflected in its terms of reference. The key organisational reports relating to risk will be as follows

Risk Management Reporting Cycle

Risks	Board	Audit & Risk Committee	Other Governance Committees	Executive Directors' Group
Strategic Risks (BAF)	Quarterly	Quarterly	Bi monthly	Bi monthly
Operational High Risks (CRR) (15-25) & KPIs	Quarterly	Quarterly	Bi monthly	Bi monthly

Reporting to the Board

Risks to our strategic objectives will be reported as part of the BAF to the Board on a quarterly basis.

Reporting to the Audit & Risk Committee

Risks to our strategic objectives will be reported as part of the BAF to the Committee on a quarterly basis for review and comment. The Committee will receive an annual Risk Management report on the adequacy and effectiveness of risk management arrangements and regular reports on risk management including performance against agreed Key Performance Indicators (KPIs).

Reporting to the Governance Committees

Risks that score 15 or more which are considered to threaten the achievement of the strategic objectives will be included in the BAF and reported to the appropriate committees on a bi monthly basis.

Reporting to the IJB

In line with the Integration Scheme 13.2, NHS Fife will report relevant risks that relate to the delivery of delegated services in line with the process of Direction from the IJB and the shared risk management strategy.

Annual Report

An annual report on risk management will be provided which confirms whether or not there have been adequate and effective risk management arrangements in place throughout the year, and highlighting any material areas of risk.

Work plan

A risk management work plan will be developed and progress against this will be reported will be reported quarterly to the Audit and Risk Committee**.**

Key Performance Indicators

To provide assurance on the adequacy and effectiveness of key aspects of risk management activity in NHS Fife, key performance indicators will be reported to the EDG, NHS Fife Adverse Events & Duty of Candour Group and the governance committees as appropriate, as part of a scheduled programme of reporting.

11. Training and Support

For risk management to be effective and embedded organisation- wide, staff must understand its benefits and their responsibilities. Risk management guidance, training and support will be made available to enable staff to acquire relevant knowledge and skills necesaary for their role. This will be advertised on Staff Link and where appropriate via targeted communications to managers. This will include:

- Corporate Induction
- In House Core Training
- Board Development sessions convened at the discretion of the Board Chair
- Customised training on request

12. Risk Management in Partnership

NHS Fife is committed to ensuring there are appropriate governance arrangements in place to identify, evaluate, record and monitor and manage joint risks. Such risks will be communicated by invoking the mechanisms contained within the HSCP IJB Risk Management Strategy and in accordance with the Integration Scheme.

A Memorandum of Agreement (MoA) may be invoked when considering the appropriate ownership of risks that may impact on more than one partner; this must be discussed through the EDG. See Appendix 6.

13. Patients and the Public

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

- be open with the public about our understanding of the nature of known risks
- engage with stakeholders as appropriate in relation to risks that affect them
- provide assurance through the Annual Accountability Review and the Risk Management Annual Report that we have in place adequate and effective systems to manage risk

14. Implementation

Successful implementation will depend on communication and sharing with all stakeholders ; having in place the appropriate governance structures at all levels of the organisation through which to provide management oversight, including monitoring and review of risk management practice and progress, and risk escalation where necessary.

This Framework and its associated procedures will be circulated to Executive and Non executive Board members, Corporate Directors, Divisional General Managers, Associate Medical Directors, Associate Nurse Directors, and Heads of Services for dissemination to their staff.

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

15. Framework Review

The Board will review the Risk Management Framework at least annually, making any changes required to reflect national and regulatory standards, best practice and learning and improvement opportunities identified by the Board, including through internal or external reviews of the risk management system.

16. References

1. Health & Social Care Partnership / Integration Joint Board Risk Management Policy and Strategy, 2019

2.Northumberland, Tyne and Wear NHS Foundation Trust, Risk Management Strategy 2017-2022

3. The Orange Book: Management of Risk - Principles and Concepts, 2004

This Framework relates to and should be read in conjunction with **all** Board policies and procedures but particularly:

NHS Fife Adverse Events Policy GP/I9
NHS Fife Data Protection & Confidentiality Policy GP/I5
NHS Fife Health & Safety Policy GP/H1
NHS Fife NHS Fife's Complaints Handling Procedure

Appendix 1

Glossary of Terms

***Assurance*:** Stakeholder confidence in our service gained from evidence showing that risk is well managed.

Consequence: Most predictable consequence to the individual or organisation if the circumstances in question were to occur.

Contingency: Emergency plans/alternative arrangements that intervene should the risk become apparent.

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

***Horizon scanning*:** The systematic examination of potential threats, opportunities and likely future developments which are at the margins of current thinking and planning.

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

***Likelihood*:** Probability of an event occurring, wherever possible based upon the frequency of previous occurrences.

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

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

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

Risk Appetite: The amount and type of risk that an organisation is willing to take in order to meet their strategic objectives Risk Appetite and Risk Tolerance Guidance Paper(institute of Risk Management, 2018)

***Risk Assessment*:** An overall process to identify risk and evaluate whether acceptable or not taking into account new/ best practice.

***Risk Control Measure*:** An action undertaken to minimise risk to an acceptable level either by reducing the likelihood of an adverse event or the severity of its consequences or both.

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

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

Risk Handler: The person identified as the contact or administrator responsible for updating the risk in Datix.

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

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

***Risk Management*:** All the activities required to identify, understand and control the exposure to risk which may have an impact on the achievement of an organisation's objectives.

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

***Risk Register*:** A database of risks always changing to reflect the dynamic nature of the risk and our management of them. Its purpose is to help managers prioritise available resources to minimise risk to best effect and provide assurances that progress is being made.

Risk Tolerance: The boundaries of risk taking outside of which the organisation is not prepared to venture in the pursuit of its long term objectives Risk Appetite and Risk Tolerance Guidance Paper (institute of Risk Management, 2018)

Appendix 2

Risk Assessment Matrix

Figure 1

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

In terms of grading risks, the following grades have been assigned within the matrix.

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

Likelihood of Recurrence Ratings
Figure 2

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

Figure 3: Consequence Ratings

Descriptor	Negligible	Minor	Moderate	Major	Extreme
Objectives / Project	Barely noticeable reduction in scope / quality / schedule	Minor reduction in scope / quality / schedule	Reduction in scope or quality, project objectives or schedule	Significant project over-run	Inability to meet project objectives, reputation of the organisation seriously damaged.
Injury (Physical and psychological)	Adverse event leading to minor injury not requiring	Minor injury or illness, first aid treatment required	Agency reportable, e.g. Police (violent and aggressive	Major injuries/long term incapacity or disability (loss of	Incident leading to death or major permanent

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

Appendix 3

Illustration of Risk Appetite

Strategic Value	Strategic Aspiration	Strategic Objectives	Board Assurance Risk	Area of Risk	Risk Appetite
Safety First Dignity & Respect Care & Compassion Excellence Fairness & Transparency	Clinically Excellent	• Work with you to ensure you receive the best possible care • Ensure there is no avoidable harm • Achieve and maintain recognised quality standards • Ensure that NHS Fife's environment is clean, tidy, well maintained, safe and something to be proud of • Embed patient safety consistently across all aspects of healthcare provision • Support research, innovation and quality improvement which will see NHS Fife as a centre of excellence	**Environmental Sustainability** 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.	Patient safety Service user & carer experience Compliance with legislation Performance against national standards and targets Reputation Site optimisation/ therapeutic environments	Averse Cautious Averse Averse Averse Moderate
Safety First Dignity & Respect Care & Compassion Excellence Fairness & Transparency	Sustainable	• Ensure the maximum impact of our resources in the promotion of health and wellbeing • Increase efficiency and reduce waste • Ensure that our activities are cost effective and within budget • Ensure that all service redesign and development makes the most effective use of resources and avoids waste and unwarranted variation • Develop, in collaboration with our partners, our property and assets to meet the changing needs of health and social care provision	**Financial Sustainability** There is a risk that the funding required to deliver the current and anticipated future service models will exceed the funding available. Thereafter there is a risk that the 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.	Service sustainability Cost reduction efficiencies Board overspend IJB overspend Non recurring financial flexibility Value for money	Cautious Open Averse Averse Open Hungry
Safety First Dignity & Respect Care & Compassion Excellence Fairness & Transparency	Person Centred	• Listen to what matters to you and treat you as an individual • Design services in partnership with service users, carers and communities • Give you choices and information • Create environments that encourage caring and positive outcomes for all • Develop and redesign services that put patients first, supporting independent living and self-management of health through the integration of health and social care	**Quality & Safety** 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.	Patient Safety Service user & carer experience Stakeholder engagement Service redesign Access to treatment	Averse Cautious Moderate Moderate Averse
Safety First Dignity & Respect Care & Compassion Excellence Fairness & Transparency	Clinically Excellent	• Work with you to ensure you receive the best possible care • Ensure there is no avoidable harm • Achieve and maintain recognised quality standards • Ensure that NHS Fife's environment is clean, tidy, well maintained, safe and something to be proud of • Embed patient safety consistently across all aspects of healthcare provision • Support research, innovation and quality improvement which will see NHS Fife as a centre of excellence		Compliance with legislation Performance against national standards and targets Reputation Site optimisation / therapeutic environments	Averse Averse Averse Cautious
Safety First Dignity & Respect Care & Compassion Excellence Fairness & Transparency	Sustainable	• Ensure the maximum impact of our resources in the promotion of health and wellbeing • Increase efficiency and reduce waste • Ensure that our activities are cost effective and within budget • Ensure that all service redesign and development makes the most effective use of resources and avoids waste and unwarranted variation • Develop, in collaboration with our partners, our property and assets to meet the changing needs of health and social care provision	**Strategic Planning** There is a risk that NHS Fife will not deliver the recommendations made by the Clinical Strategy within a timeframe that supports the service transformation and redesign required to ensure service sustainability, quality and safety at lower cost.	Service sustainability Cost reduction efficiencies Board overspend IJB overspend Non recurring financial flexibility Value for money	Cautious Cautious Cautious Cautious Cautious Moderate
Safety First Dignity & Respect Care & Compassion Excellence Fairness & Transparency	An Exemplar Employer	• Create time and space for continuous learning • Listen to and involve staff at all levels of the organisation • Give staff the skills, resources and equipment needed to do their jobs • Encourage and expect all staff to take appropriate decisions • Encourage staff to be ambassadors for health and social care in Fife • Create high performing multi-professional clinical teams through clinical education and development • Equip people to be the best leaders	**Workforce Sustainability** 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.	Learning & Organisational Development Recruitment and Retention Workforce Planning Compliance with legislation Performance against national standards and targets	Open Open Open Averse Cautious

Averse	Prepared to accept only the very lowest levels of risk, with the preference being for ultra-safe delivery options, while recognising that these will have little or no potential for reward/return.
Cautious	Willing to accept some low risks, while maintaining an overall preference for safe delivery options despite the probability of these having mostly restricted potential for reward/return.
Moderate	Tending always towards exposure to only modest levels of risk in order to achieve acceptable, but possibly unambitious outcomes.
Open	Prepared to consider all delivery options and select those with the highest probability of productive outcomes, even when there are elevated levels of associated risks.
Hungry	Eager to seek original/pioneering delivery options and to accept the associated substantial risk levels in order to secure successful outcomes and meaningful reward/return.

NHS Fife Board Assurance Framework (BAF)

Scope of BAF risks

- Financial Sustainability
- Workforce Sustainability
- Environmental Sustainability
- Quality & Safety
- Strategic Planning
- Integration Joint Board
- eHealth - Delivering Digital and Information Governance & Security

BAF Template

NHS Fife Board Assurance Framework (BAF)

					Initial Score				Current Score												Target Score				
Risk ID	Strategic Framework Objective	Date last reviewed	Date of next review	Description of Risk	Likelihood (Initial)	Consequence (Initial)	Rating (Initial)	Level (Initial)	Likelihood (Current)	Consequence (Current)	Rating (Current)	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?	Responsible Person	Timescale	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	Likelihood (Target)	Consequence (Target)	Rating (Target)	Level (Target)	Rationale for Target Score

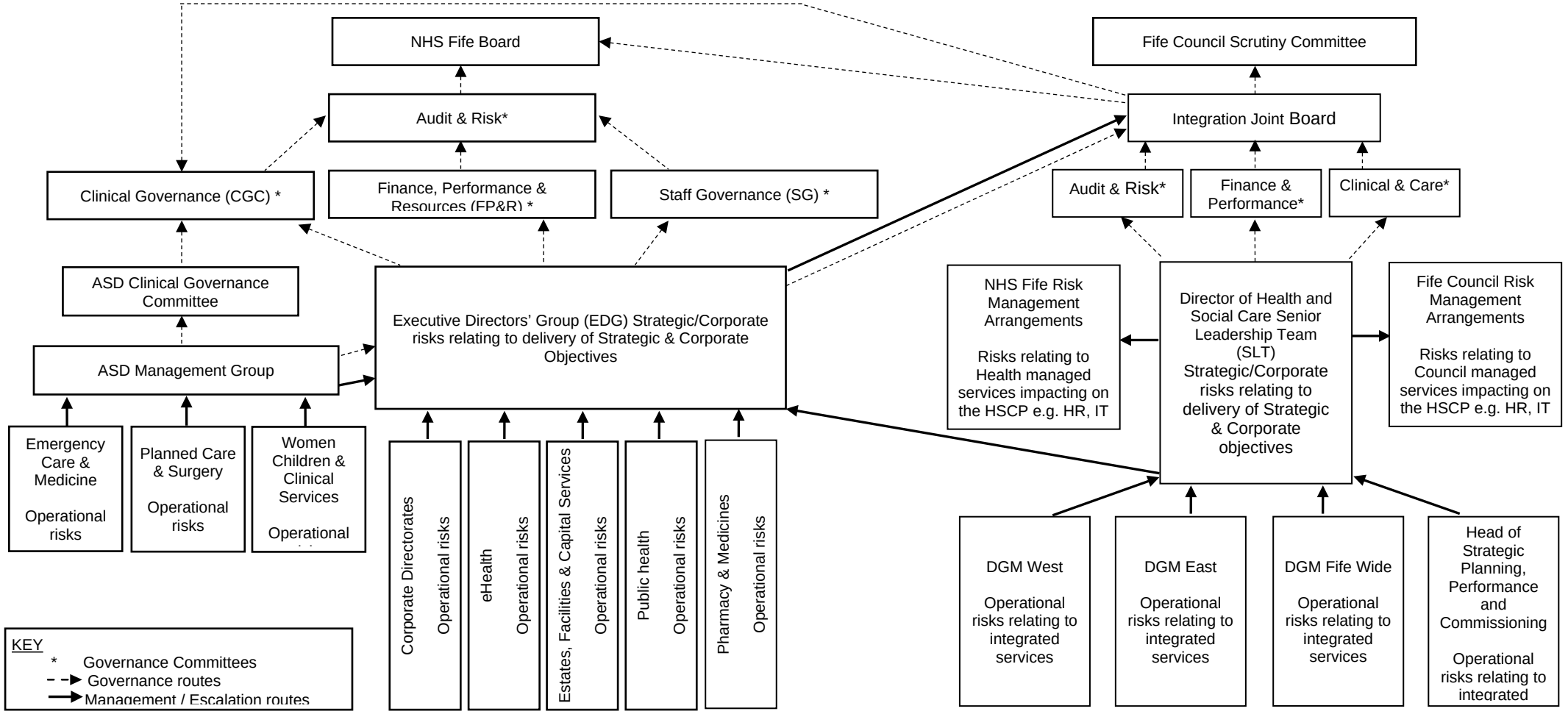
Linked Operational Risk(s)

Risk ID	Risk Title	Current Risk Rating	Risk Owner

Previously Linked Operational Risk(s)

Risk ID	Risk Title	Reason for unlinking from BAF	Current Risk Rating	Risk Owner

Risk Management Reporting Arrangements



Groups & committees with specific responsibilities that report into governance committees including:

CGC: Acute Services Division CGC |Area Clinical Forum | Area Drugs & Therapeutics | Area Radiation Protection| Clinical & Care Governance| Clinical Governance Oversight Group| e|Health Board |H&S Sub Committee| Infection Control Committee| IG&S Group |IJB|ITB| Public Health Assurance Committee | Research Governance Group| Resilience Forum

FP&R: Pharnacy Practices| Primary Care Medical Services
SG: Area Partnership Forum| Local Partnership Fora

INTEGRATED RISK MANAGEMENT

MEMORANDUM OF AGREEMENT (MOA)

With regard to the partnership risk management arrangements, it is necessary to identify those risks that may have an impact on one or more partner and agree an appropriate course of action. This Memorandum of Agreement sets out the process for discussions that will enable risks to be directed to the appropriate risk register(s) for ownership and management.

Risk identified by:

NHS Fife Board	☐	NHS Corporate Directorate	☐				
Acute Services – EC&M	☐	Acute Services – PC&S	☐	Acute Services – WC&CS	☐		
HSCP - East	☐	HSCP - West	☐	HSCP – Fife Wide	☐		

Date risk identified: dd / mm / yy

Describe the risk	**State current mitigations**

Agree ownership of the risk and mitigations, noting that these may differ for each partner with interdependency on the hosting arrangements, delivery and commissioning aspect of the risk and leads for mitigating controls.

Initial assessed level of risk i.e. likelihood x consequence = risk level

Likelihood (score 1- 5)		Consequence (score 1- 5)		Assessed Level of Risk			
Score	Risk	Score	Risk	Score	Risk	Score	Risk
1-3	Very Low	6-7	Low	8-12	Moderate	15-25	High

Who else may be affected by this risk?

NHS Fife Board	☐	NHS Corporate Directorate	☐	Fife Integration Joint Board (IJB)	☐		
Acute Services – EC&M	☐	Acute Services – PC&S	☐	Acute Services – WC&CS	☐		
HSCP - East	☐	HSCP - West	☐	HSCP – Fife Wide	☐		

Consider the following:

Does this risk affect / impact on:

Strategic commissioning intentions

Strategic planning decisions

Service delivery

Performance targets

Does the risk have governance implications?

Clinical

Financial

Staff

EDG to consider the risk and agree on whom it impacts:

Agreed outcome: Risk to be added to the following risk register(s)

Board Assurance Framework
- eHealth ☐
- Environmental Sustainability ☐
- Financial Sustainability ☐
- Integration Joint Board ☐
- Strategic Planning ☐
- Quality & Safety ☐
- Workforce Sustainability ☐

NHS Fife Corporate Risk Register ☐

Fife Integration Joint Board (IJB) ☐

NHS Fife Corporate Directorate Risk Register (specify)
- Estates, Facilities and Capital Services ☐
- Finance ☐
- Human Resources ☐
- Medical Director ☐
- Nurse Director ☐
- Pharmacy and Medicines ☐
- Planning & Performance ☐
- Public Health ☐

NHS Fife Acute Services Divisional Register
- Emergency Care Directorate Register ☐
- Planned Care Directorate Register ☐
- Women, Children and Clinical Services Directorate Register ☐

Fife Health & Social Care Partnership Register
- East Division ☐
- Fife - Wide Division ☐
- West Division ☐

Date discussed and agreed by EDG: dd /mm/yy

Adapted from NHS Lanarkshire Risk Management Strategy, May 2019

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**17 September 2020**
Title:	**Risk Management Key Performance Indicator (KPI) Report**
Responsible Executive:	**Helen Buchanan, Director of Nursing**
Report Author:	**Pauline Cumming, Risk Manager**

1 Purpose

This is presented to the group for:

- Discussion

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

Key Performance Indicators (KPIs) are recognised to have value as quantifiable measures to evaluate performance and can be a useful management tool. The Audit and Risk Committee requires assurance that specific risk management KPIs are in place and demonstrate progress over time. This is the first report on performance against the NHS Fife Risk Management KPIs. 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 being submitted to every meeting of the governance committees to which they are aligned.
- KPI s 5 - 7 relate to adverse events management and are intended to show overall organisational performance on the effectiveness of arrangements for managing

adverse events in line with national guidance[1] and local policy,[2] including the timeliness of our response following our most serious adverse events.

2.2 Background

NHS Fife has not used risk management KPIs for several years, but in 2019, partly in response to an Internal Audit recommendation, EDG approved a suite of risk management KPIs; these were also endorsed by Internal Audit. It is anticipated their introduction will strengthen the governance around key elements of risk management activity and provide an objective performance management mechanism through which to give additional assurance on the adequacy and effectiveness of the risk management systems, processes and oversight in NHS Fife.

2.3 Assessment

The KPIs require to be communicated to the organisation and if approved, this will be done as part of the roll out of the updated Risk Management Framework. Appendix 1 provides an initial assessment of compliance against the KPIs. Future reports will present performance over time.

All services currently have access to risk management information in Datix for their areas of responsibility. Staff can be provided with access and training to run reports from Datix using the “My Reports” functionality. The processes governing local risk management arrangements, including the review of risk registers and adverse events at service / directorate and divisional levels vary across the organisation and require to be clarified. While it is recognised that these will have evolved in line with their internal structures, going forward it will be important to standardise standing agenda items relating to risk management. The Risk Management Team will support this process as part of the implementation of the Risk Management Framework.

Improvement actions will be identified and where necessary, supportive targeted intervention will be offered. It is proposed that risk management reporting and accountability forms part of the Performance Review process.

2.3.1 Quality/ Patient Care

NHS Fife’s risk management system seeks to minimise risk and support safe, effective, person centred delivery. Adverse events have an impact on the quality and safety of patient care and experience. Risk management can provide opportunities for improvement, for example, by highlighting gaps in capacity, procedures or service delivery, and over time, demonstrate the impact of such improvements through the reduction or elimination of risk. The KPI data will provide assurance on the effectiveness of our systems and processes and / or identify where action is required to change or improve the services delivered and avoid, prevent and reduce risk.

[1] Learning from adverse events through reporting and review - A national framework for Scotland (Healthcare Improvement Scotland (HIS)
[2] NHS Fife Adverse Events Policy , 2018

2.3.2 Workforce

Risk management involves all staff in the process of identifying and assessing risks, taking action to mitigate or anticipate, and monitoring and reviewing progress to reduce or eliminate risk. The Risk Management team, with the support of Executive Directors, will work with the service to review and further develop effective risk management arrangements across the organisation.

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 risk. Risks must therefore, be properly managed in order 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

KPIs 1- 3 were shared with the NHS Fife Adverse Events & Duty of Candour Group on 18 August 2020. All KPI s were shared with the Director of Nursing and the Medical Director.

2.3.8 Route to the Meeting

Via approval from Helen Buchanan, Director of Nursing

2.4 Recommendation

Discussion – Examine and consider the implications of a matter.

3 List of appendices

Appendix 1, Risk Management Key Performance Indicators (KPIs) Summary
Appendix 2, Compliance with Risk KPI 4 - A BAF report is submitted to every meeting of the governance committee to which it is aligned

Report Contact
Pauline Cumming
Risk Manager, NHS Fife
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Risk Management Key Performance Indicators (KPIs) Summary
Reporting Period
Risks - KPI 1-3 - All Active Risks at report date
Risks - KPI 4 - BAF reports to Committees at report date
Adverse Events - KPI 5-6 - where event date is 01/01/2020 to 31/07/2020
Adverse Events- KPI 7 - where event date is 01/04/2018 to 31/07/2020

KPI	KPI Descriptor	Total number of active risks	Compliance: Number still within timeframe set for next review	Compliance: %		Target
1	All risks are within timescale for review	548	334	60,9		100%

COMMENT: This data shows that there is considerable room for improvement in relation to the timely review and update of risks in accordance with timescales. This performance may be attributed in part to the emergency footing invoked in response to the COVID-

KPI	KPI Descriptor	Total number of active risks	Number of risks at each level: Risk Level (Rating)	Number of risks at each level: Number	Number of risks with scheduled review date commensurate with level: Each Level: Number	Each Level: %	Overall: Number	Overall: %	Target
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	548	Very High (25)	4	1	25,0	249	45,4	100%
			High (15-20)	68	20	29,4			
			Moderate (8-12)	340	144	42,4			
			Low (4-6)	125	80	64,0			
			Very Low (1-3)	10	4	40,0			
			No value	1	N/A	#VALUE!			

COMMENT: This information reflects the current position against the review timescales. The latter will be proposed as part of the updated Risk Management Framework. If approved, expectations around review frequency will be communicated to the organisation as

KPI	KPI Descriptor	Number of risks at each level: Risk Level	Number of risks at each level: Number	Length of time risks have been open: Time period	Length of time risks have been open: Number	Length of time risks have been open: %	Initial risk level: Risk Level	Initial risk level: Number	Initial risk level: %	Target
3a	Length of time 'Very High' level risks have been at that level	Very High (25)	4	Number of risks open <= 1 year	3	75,0	Very High (25)	3	100,0	100%
							High (15-20)	0	0,0	
							Moderate (8-12)	0	0,0	
							Low (4-6)	0	0,0	
							Very Low (1-3)	0	0,0	
				Number of risks open >1 year	1	25,0	Very High (25)	1	100,0	100%
							High (15-20)	0	0,0	
							Moderate (8-12)	0	0,0	
							Low (4-6)	0	0,0	
							Very Low (1-3)	0	0,0	

COMMENT: This information shows that all but one of the very high risks have been at that level for less than 1 year. Risk management is a dynamic process with risk levels constantly changing as new risks emerge and others become less critical. It is essential to

KPI	KPI Descriptor	Number of risks at each level: Risk Level	Number of risks at each level: Number	Length of time risks have been open: Time period	Length of time risks have been open: Number	Length of time risks have been open: %	Initial risk level: Risk Level	Initial risk level: Number	Initial risk level: %	Target
3b	Length of time 'High' level risks have been at that level	High (15-20)	68	Number of risks open <= 1 year	31	45,6	Very High (25)	2	6,5	100%
							High (15-20)	25	80,6	
							Moderate (8-12)	4	12,9	
							Low (4-6)	0	0,0	
							Very Low (1-3)	0	0,0	
				Number of risks open >1 year	37	54,4	Very High (25)	1	2,7	100%
							High (15-20)	30	81,1	
							Moderate (8-12)	6	16,2	
							Low (4-6)	0	0,0	
							Very Low (1-3)	0	0,0	

COMMENT: This information shows that more than 50% of high risks have been at that level for more than 1 year. See comment at 3a above.

KPI	KPI Descriptor	Number of Committee Meetings	BAF reports to be submitted	Number	Number	Number within KPI timeframe	%	Target
4	A bi monthly Board Assurance Framework (BAF) report is	9	Financial Sustainability, Environmental	21	21	21	100,0	100%

COMMENT: See Appendix 2 for detail.

KPI	KPI Descriptor	Total number of Major or Extreme Adverse Events in reporting period	Status of SBARs	Number	Number submitted or due for SBAR	Number within KPI timeframe	%	Target
5	Decision Making SBAR for Major and Extreme Adverse Events* should be submitted to the risk management team in line with Adverse Events Policy GP/I9 - within 5 working days of reported date	187	Not submitted - still within timeframe	0	187	152	81,3	100%
			Not submitted - overdue	2				
			Submitted - within timeframe	152				
			Submitted - outwith timeframe	33				

COMMENT: Performance at over 80% is indicative of focused efforts by all parties over the last 3 years to improve completion of this key step after reporting a major or extreme adverse event. Such events require the service to complete the SBAR* and submit it

KPI	KPI Descriptor	Total number of Adverse Events reported as 'No Harm' severity in	Status of events	Number	Number closed or due for	Number within KPI timeframe	%	Target

6a	Adverse Events with severity reported as 'No Harm' should be closed within 10 working days of reported date	5350	Not closed - still within timeframe	8	5342	3213	60,1	100%
			Not closed - overdue	363				
			Closed - within timeframe	3213				
			Closed - outwith timeframe	1766				
COMMENT: The timescales in KPIs 6a,6b, and 6c are set out in Policy GP/I9 and are in line with the national framework for adverse events management. Discussion on local governance arrangements for incident review has taken place at the Adverse Events &								
KPI	**KPI Descriptor**	**Total number of Adverse Events reported as 'Minor and Moderate**	**Status of events**	**Number**	**Number closed or due for**	**Number within KPI timeframe**	**%**	**Target**
6b	Adverse Events with severity reported as 'Minor' or 'Moderate' closed within 60 working days of reported date	2674	Not closed - still within timeframe	198	2476	2338	94,4	100%
			Not closed - overdue	75				
			Closed - within timeframe	2338				
			Closed - outwith timeframe	63				
COMMENT: See 6a above.*								
KPI	**KPI Descriptor**	**Total number of Adverse Events reported as 'Major and Extreme'**	**Status of events**	**Number**	**Number closed or due for**	**Number within KPI timeframe**	**%**	**Target**
6c	Adverse Events with severity reported as 'Major' or 'Extreme' closed within 90 working days of reported date (or upgraded if applicable)	187	Not closed - still within timeframe	68	119	80	67,2	100%
			Not closed - overdue	34				
			Closed - within timeframe	80				
			Closed - outwith timeframe	5				
COMMENT: See 6a above.*								
KPI	**KPI Descriptor**	**Total Number of Actions created from LAER / SAER in reporting**	**Status of actions**	**Number**	**Number closed or due for**	**Number within KPI timeframe**	**%**	**Target**
7	Actions resulting from LAER and SAER reviews should be completed by target date (cohort based on events occurring during reporting period 01/04/18 - 31/07/20 (LAER & SAER review requirements set out in Policy GP/I9 from 01/04/18)	938	Incomplete - still within timeframe	38	900	452	50,2	100%
			Incomplete - overdue	139				
			Complete - within timeframe	452				
			Complete - outwith timeframe	309				
COMMENT: Weaknesses in performance were identified in Internal Audit report Adverse Event Management B19/20.As a result of the subsequent concern raised by the Audit and Risk Committee, further assurances are being provided to the Sept 2020 NHS Fife								

Appendix 2

Compliance with Risk KPI 4 - A BAF report is submitted to every meeting of the governance committee to which it is aligned

Committee		Jan 2020	Mar 2020	May 2020	Jul 2020
Finance, Performance & Resources (FPR)					
BAF	**Financial Sustainability**	√	√	*	√
	Environmental Sustainability	√	√	*	√
	Strategic Planning	√	√	*	√
Clinical Governance (CGC)					
BAF	**Quality & Safety**	√	√	*	√
	eHealth	√	√	*	√
	Strategic Planning	√	√	*	√
Staff Governance					
BAF	**Workforce Sustainability**	√	√	*	√

Note: * denotes report not produced. May 2020 meetings did not take place due to stage of COVID-19 pandemic.

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**17 September 2020**
Title:	**Update on NHS Fife Risk Management Workplan 2019-20 and Proposed Workplan for 2020-2021**
Responsible Executive:	**Helen Buchanan, Director of Nursing**
Report Author:	**Pauline Cumming, Risk Manager**

1 Purpose

This is presented to EDG for:

- Awareness

This report relates to a:

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

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

- Effective

2 Report summary

2.1 Situation

This report provides the Committee with an update on progress against the NHS Fife Risk Management Workplan 2019 - 2020 since the last report on 9 January 2020. It also outlines the Workplan for 2020-2021 to support delivery of the updated Risk Management Framework.

2.2 Background

The Workplan identifies the key pieces of work to be accomplished in year against stated timescales. The Committee requires assurance that the activities have been completed.

2.3 Assessment

Standard Reporting to the Audit & Risk Committee
Actions complete.

Scheduled Work
The Committee is asked to note the following specific updates:

Risk Appetite
The Board agreed its risk appetite in November 2019. Further work is required to develop this fully with associated risk tolerances. The risk appetite statement is due to be reviewed and updated by the end of November 2020. The review process will require the Board to consider the level and types of risk it is prepared to take in the context of the strategic objectives, the prevailing conditions and the organisation's attitude to risk.

Risk Key Performance Indicators (KPIs)
KPIs are being reported separately to the Committee.

NHS Fife Risk Management Framework including the Risk Register & Risk Assessment Policy GP/ R7
These have been reviewed and are discussed in a separate paper to the Committee. The updated Framework contains detail on assurance mapping based on Scottish Government and HM Treasury guidance and an outline of a proposed approach.

The Risk Management Annual Report which is being presented separately to the Committee, summarises activities undertaken to date in relation to all work plan commitments.

2.3.1 Quality/ Patient Care
Risk management seeks to minimise risk and support the delivery of safe, effective, person centred care.

2.3.2 Workforce
The arrangements for risk management are contained within current resource. Good risk management should empower staff to make decisions and improvements to ensure risks are identified and addressed, enhance the working environment, protect health and wellbeing and reduce staff exposure to risk.

2.3.3 Financial
There are no specific financial implications associated with this paper. Proportionate management of risk should assist in the efficient and effective use of scarce resources.

2.3.4 Risk Assessment/Management
The paper relates directly to activities intended to provide 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

Not applicable

2.3.7 Communication, involvement, engagement and consultation

Not applicable

2.3.8 Route to the Meeting

This paper has been considered in draft by the Director of Nursing.

2.4 Recommendation

The paper is provided for:

- Approval – subject to members' comments regarding any amendments necessary

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Risk Management Workplan Update 2019 - 2020 to NHS Fife Audit and Risk Committee on 170920 V0.1
- Appendix No 2, Risk Management Workplan Update 2020 - 2021 to NHS Fife Audit and Risk Committee on 170920 V0.1

Report Contact
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Appendix 1

RISK MANAGEMENT WORK PLAN 2019 - 2020 UPDATE

REPORTING TO THE AUDIT & RISK COMMITTEE		
ACTION	**DATE**	**STATUS**
Risk Management Work Plan 2019 - 20 to Audit & Risk Committee	Jan 2020	Complete
Report to Audit & Risk Committee on Board Assurance Framework	Jan, March & July 2020	Complete
Report to Audit & Risk Committee against Risk Management Work Plan	Dec 2019	Complete - to Committee 09/01/20
Report to Audit & Risk Committee on Board Assurance Framework	Jan, March & July 2020	Complete
Risk Management Annual Report 2019-20 to Audit & Risk Committee	June 2020	To Committee on 17/09/20
Risk Management Work Plan 2020-21 to Audit & Risk Committee	June 2020	To Committee on 17/09/20
Complete the review of the Risk Management Framework	Sept 2020	To Committee on 17/09/20
RISK MANAGEMENT ACTIVITY		
Support the development of risk management practice across the organisation	N/A	Business As Usual (BAU)
Continue to develop the Datix IT Risk Management system	N/A	BAU
Contribute to the further development of NHS Fife's assurance framework including participating in FTF Assurance Mapping working group and contribute to the review of exemplar risk - eHealth BAF	N/A	BAU
Further develop the management of and learning from adverse events in line with national framework and local policy	N/A	BAU
Continue to support organisational Duty of Candour implementation in line with legislative requirements	N/A	BAU

Appendix 2

RISK MANAGEMENT WORK PLAN 2020 - 2021

REPORTING TO THE AUDIT & RISK COMMITTEE		
ACTION	**DATE**	**STATUS**
Quarterly report on Corporate Risk Register	Dec 2020, March 2021	
Quarterly report on Board Assurance Framework	Dec 2020, March 2021	
Quarterly report on risk management Key Performance Indicators	Dec 2020, March 2021	
6 monthly report to against Risk Management Work Plan	March 2021, Sept 2021	
Risk Management Annual Report 2020-21	June 2021	

RISK MANAGEMENT ACTIVITY

ACTION	**DATE**	**STATUS**
Develop Risk Management Framework launch programme and implement.	End Oct 2020	
Review the governance infrastructure and processes, including the accountability arrangements that support risk management across the organisation.	End Nov 2020	
Undertake a wholesale review of the organisation's risk registers and current risk profile.	End Nov 2020	
Review and update the risk appetite statement.	End Dec 2020	
Embed risk appetite and tolerance across the organisation.	March 2021	
Strengthen assurance arrangements and specifically the structure, content and governance arrangements associated with the Board Assurance Framework.	March 2021	

File Name: Update on NHS Fife Risk Management Work Plan 2019-2020 to Audit & Risk Committee on 17/09/2020	V1.0	Date: September 2020
Author: Pauline Cumming		

Analyse risk management training needs, refresh existing resources, and provide training according to staff group and role requirements in order to support delivery of the Risk Management Framework.	March 2021	
Continue to develop the Datix IT Risk Management system in line with Datix work plan to ensure it remains fit for purpose and supports organisational requirements.	N/A	BAU
Overhaul Datix Risk Register Module including BAF structure.	End Nov 2020	
Transfer Legal Services Claims management activity from Datix Rich Client to DatixWeb.	End Dec 2020	
Complete the transfer of Complaints module to DatixWeb.	End Dec 2020	
Further develop the management and learning from of adverse events in line with national framework and local policy.	N/A	BAU
Continue to support organisational Duty of Candour implementation including the production of the Year 3 Duty of Candour Annual Report in line with legislative requirements.	June 2021	BAU

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**17 September 2020**
Title:	**Annual Assurance Statements for 2019-20**
Responsible Executive:	**Carol Potter, Chief Executive**
Report Author:	**Gillian MacIntosh, Board Secretary**

1 Purpose

This is presented to the Board for:

- Assurance

This report relates to a:

- Legal requirement
- Local policy

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

- Effective

2 Report summary

2.1 Situation

The purpose of this report is to present the Annual Assurance Statements for each standing Committee of the Board, and the assurance statement produced by the IJB's Chief Internal Auditor, for consideration by the Audit & Risk Committee as part of the overall annual accounts and assurance process for 2019/20.

2.2 Background

The Code of Corporate Governance requires all standing committees of the NHS Board to provide an Annual Report (Assurance Statement). As part of this Assurance Statement, each Committee must demonstrate that it is fulfilling its remit, implementing its work plan and ensuring the timely presentation of its minutes to the Board. These reports are designed to provide assurance that there are adequate and effective governance arrangements in place. Each Committee must identify any significant control weaknesses or issues at the year-end which it considers should be disclosed in the Governance Statement, and should specifically record and provide assurance that the Committee has carried out the annual self- assessment of its effectiveness.

2.3 Assessment

The Annual Assurance Statements for the Clinical Governance Committee, Finance, Performance & Resources Committee, Remuneration Committee and Staff Governance Committee are attached for consideration by members of the Audit & Risk Committee. Each has been discussed and approved by the respective Committee at their June/July 2020 cycle of meetings. Also included is the IJB's assurance statement from their Chief Internal Auditor, considered by the IJB's Audit & Risk Committee at their meeting on 10 July 2020.

2.3.1 Quality/ Patient Care

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

2.3.2 Workforce

N/A.

2.3.3 Financial

The production and review of year-end assurance statements are a key part of the financial year-end process.

2.3.4 Risk Assessment/Management

The identification and management of risk is an important factor in 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 respective assurance statements have been considered and approved by each Committee at the meetings below:

- Clinical Governance Committee, 8 July 2020
- Finance, Performance & Resource Committee, 7 July 2020
- Remuneration Committee, 2 June 2020
- Staff Governance Committee, 3 July 2020
- IJB Audit & Risk Committee, 10 July 2020

2.4 Recommendation

The paper is provided for:

- **Assurance**

Report Contact
Dr Gillian MacIntosh
Head of Corporate Governance & Board Secretary
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ANNUAL STATEMENT OF ASSURANCE FOR NHS FIFE CLINICAL GOVERNANCE COMMITTEE 2019/20

1. Purpose

1.1 To provide the Board with the assurance 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.

2. Membership

2.1 During the financial year to 31 March 2020, membership of the Clinical Governance Committee comprised: -

Dr Leslie Bisset	Chair / Non-Executive Member
Martin Black	Non-Executive Member
Sinead Braiden	Non-Executive Member (from 1 December 2019)
Wilma Brown	Area Partnership Forum Representative
Helen Buchanan	Director of Nursing
Cllr David Graham	Non-Executive Member
Paul Hawkins	Chief Executive (until 27 January 2020)
Rona Laing	Non-Executive Member
Dr Christopher McKenna	Medical Director
Dona Milne	Director of Public Health
Janette Owens	Area Clinical Forum Representative
Carol Potter	Chief Executive (from 28 January 2020)
John Stobbs	Patient Representative
Margaret Wells	Non-Executive Member

2.2 The Committee may invite individuals to attend the Committee meetings for particular agenda items, but the Chief Operating Officer (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), Head of Quality & Clinical Governance and Board Secretary will normally be in attendance at Committee meetings. Other attendees, deputies and guests are recorded in the individual minutes of each Committee meeting.

3. Meetings

3.1 The Committee met on seven occasions during the financial year to 31 March 2020, on the undernoted dates:

- 8 May 2019
- 3 July 2019
- 4 September 2019
- 14 October 2019
- 6 November 2019
- 16 January 2020
- 4 March 2020

3.2 The attendance schedule is attached at Appendix 1.

4. Business

4.1 As the 2019/20 Financial Year drew to a close, the Covid-19 pandemic required an unprecedented mobilisation effort on behalf of NHS Fife in order to address the developing public health emergency. At its March 2020 meeting, the Committee considered an update on NHS Fife's initial response to the start of the coronavirus outbreak. As cases increased and the Board subsequently placed on an emergency footing, staff responded with professionalism, speed and agility, effecting major service changes in an extremely short timescale. This report is written against that background, with the knowledge that the Committee's future schedule of business will adapt appropriately to reflect on the Board's ongoing response to Covid-19. Issues to consider in the forthcoming year will include ongoing implications for the Board's clinical governance oversight processes and structures, particularly in light of new responsibilities placed on the Health Board in relation to public health testing and care home support.

4.2 Minutes of Clinical Governance Committee meetings have been subsequently approved by the Committee and presented to Fife NHS Board. The Board also receives a verbal update at each meeting from the Chair, highlighting any key issues discussed by the Committee at its preceding meeting. The Committee maintains an rolling action log to record and manage actions agreed from each meeting, and reviews progress against deadline dates at subsequent meetings.

4.3 During the year, the Committee has undertaken a review of its own agenda management, in an attempt to reduce excessive meeting paperwork and the volume of appendices, enhance forward-planning of key items of business, and improve signposting on papers as relates to expected Committee actions. As an example, the Integrated Performance & Quality Report (IPQR) has been comprehensively revised, to include data originally within a stand-alone Quality Report, with the aim of reducing duplication of reporting where appropriate. This work remains ongoing, based on members' feedback as captured through the annual self-assessment exercise and an ongoing regular review of the Committee's workplan and key priorities.

4.4 The Committee carefully scrutinises at each meeting key indicators in areas such as performance in relation to falls, pressure ulcers, complaints and the number of Adverse Events (with a related presentation, at the Committee's request, delivered during the reporting year on the number of hypoglycaemic episodes). Specific scrutiny has been given in recent meetings to the rate of Staphylococcus aureus Bacteraemia (SABs), particularly within the community, with members receiving detailed reports on improvements planned to address the higher rate of infections amongst People Who Inject Drugs. Members have also considered in detail performance on Surgical Site Infections (SSIs), including a review of a related obstetrics improvement plan and new treatment pathways in relation to post-Caesarean SSIs, where Fife was identified as an outlier in comparison to national data.

4.5 The preparation of a robust plan for dealing with Winter demand, along with a review of the previous year's performance, were both considered by the Committee at a number of meetings. A lessons-learned report remained an important area of consideration by the Committee, to improve performance on an ongoing basis. The potential impact of Covid-19 risks on Winter Planning is recognised to be a significant issue going forward.

4.6 Members received updates on the implementation of a new Performance & Accountability Framework across NHS Fife, welcoming the structured, transparent and systematic approach to ensure the robust delivery of standards and targets across the areas of (i) Finance; (ii)

Operational Performance; (iii) Quality; and (iv) Workforce. The Committee also considered the Strategic Objectives 2019/20, describing what NHS Fife aims to achieve in year, in tandem with a looking-back review of Directors' Objectives for 2018/19. The Board's Annual Operational Plan (for both 2019/20 and 2020/21) has also been considered and its targets scrutinised by members. Individual reports covering an updated Waiting Times Improvement Plan, Primary Care Improvement Plan (including revised governance arrangements) and an action plan resulting from a HIS inspection of Care of Older People in Victoria Hospital and Glenrothes Hospital were also reviewed by members, with progress and actions to be addressed noted by members.

4.7 The Committee assessed planned changes to the governance and reporting structure put in place to cover partnership transformation programmes previously overseen by the Joint Strategic Transformation Group. A new Integrated Transformation Board (and 'Stage & Gate' programme approval / monitoring process) has been established during the year in order to improve its effectiveness, and this remains under development. Under the overarching topic of the Clinical Strategy, update reports were considered on Community Hospital redesign, Mental Health strategy review, Acute transformation (including a post-completion review of the initial Site Optimisation project stream), and medicines efficiency (including the programme's future structure). A presentation was delivered to the Committee on the implementation of the strategy for the Learning Disability Service.

4.8 Within the reporting year, a comprehensive review has been undertaken of public participation and engagement, with a view to revamping the groups in place to best support public involvement. A new structure has been agreed, to replace the previous Participation and Engagement Network (PEN) and Patient Focus Public Involvement (PFPI), which will help deliver the objectives defined in the national engagement plan. As the new structure becomes established, the Committee welcomes further updates on this important issue.

4.9 Papers were provided to the Committee on various capital projects, including progress with the approval and submission of Initial Agreement Documents for Kincardine & Lochgelly Health Centres and on the large-scale Elective Orthopaedic Centre to be established at Victoria Hospital. An outline business case for the implementation of Hospital Electronic Prescribing & Medicines Administration (HEPMA) was supported in principle by the Committee.

4.10 Annual reports were received from the Director of Public Health and individually on the subjects of Equality Outcomes, Fife Child Protection, Integrated Screening, Immunisation, Radiation Protection, Medical Education, Prevention & Control of Infection, Quality of Care Framework, Organisational Duty of Candour, Research & Development Strategy, Organisational Resilience Standards, and any relevant Internal Audit reports that fall under the Committee's remit. Considerable time and scrutiny was given to the annual Alcohol & Drug Partnership report and Drugs Related Deaths report, noting the important lessons-learned from a similar review undertaken in Tayside that has received significant national scrutiny. A review to enhance the Fife Alcohol and Drug Partnership has been recommended, to ensure that progress is made at pace. Further work around prescribed high risk medicines and scrutiny of post-mortem procedures has also been commissioned, which remains underway at the time of writing.

4.11 The Committee has received minutes and reports from its three sub-groups, namely the eHealth Board, Health & Safety Sub-Committee, and the Information Governance & Security Group, detailing their business during the reporting year. Updates to Terms of Reference and workplans for these groups have also been considered when necessary. It has been agreed to develop in 2020-21 guidance and a template for the format of sub-groups annual assurance statements, to improve the consistency and content of information provided.

4.12 In reference to the Health & Safety Sub-Committee, a review of its membership has been commissioned, to ensure that future meetings are well attended and participants routinely exceed the minimum required by quoracy. This will be undertaken in the next reporting year and is expected to enhance the Sub-Committee's overall effectiveness.

4.13 The Committee supported the new Digital & Information Strategy approved by the eHealth Board. It has also noted that an eHealth Governance review is currently underway, which is also expected to consider the membership, composition and remit of the eHealth Board, since the frequency of its meetings and attendance has been problematic in the recent period. This review is also anticipated to strengthen and clarify reporting lines of assurance to the Committee in the next reporting year around digital workstreams. In reference to the work of the Information Governance & Security Group, it is noted that 13 reportable incidents were escalated to the Information Commissioner's Office / Scottish Government within the 2019-20 year, the majority of which were however within the required 72 hour timescale and also resulted in no further action necessary on the Board's part. Improvements in compliance rates for mandatory Information Governance training, subject access request responses and progress in populating an Information Asset Register are welcomed by the Committee.

4.14 An annual statement of assurance has also been received and considered from the Clinical & Care Governance Committee of the Integration Joint Board, detailing how Clinical & Care Governance mechanisms are in place within all Divisions of the Fife Health & Social Care Partnership and that systems exist to make these effective throughout their areas of responsibility.

4.15 During the year, the Committee received regular reports on the subject of Brexit, particularly in relation to the potential impact of a 'no deal' or 'hard' Brexit, on issues such as access to treatment and medicines; cross-border co-operation on public health matters; nuclear medicine, diagnostics and treatment; eHealth procurement; and research and development . A watching brief remains, despite the stepping-down of Brexit-related emergency planning activity, as the national political position has stabilised.

5. Best Value

5.1 Since 2013/14 the Board has been required to provide overt assurance on Best Value. A revised Best Value Framework was considered and agreed by the NHS Board in January 2018. Appendix 2 provides evidence of where and when the Committee considered the relevant characteristics during 2019/20.

6. Risk Management

6.1 In line with the Board's agreed risk management arrangements, NHS Fife Clinical Governance Committee, as a governance committee of the Board, has considered risk through a range of reports and scrutiny, including oversight on the detail of the Board Assurance Framework in the areas of Quality & Safety, Strategic Planning and a newly introduced BAF report on eHealth. Progress and appropriate actions were noted.

6.2 As with other Board Committees, Clinical Governance Committee members contributed to work involved in developing a risk appetite threshold for the Board overall, to determine the nature and extent of the significant risks the Board is willing to take in order to achieve its strategic priorities. A dedicated session at the Committee was led by the Risk Manager in order to capture members' thoughts and comments, which were brought together in a subsequent Board Development Session.

7. Self Assessment

7.1 The Committee has undertaken a self assessment of its own effectiveness, utilising a revised questionnaire considered and approved by the Committee Chair. Attendees were also invited to participate in this exercise, which was carried out via an easily-accessible online portal. A report summarising the findings of the survey was considered and approved by the Committee at its March 2020 meeting, and action points are being taken forward at both Committee and Board level.

8. Conclusion

8.1 As Chair of the Clinical Governance Committee during financial year 2019-20, I am satisfied that the integrated approach, the frequency of meetings, the breadth of the business undertaken and the range of attendees at meetings of the Committee has allowed us to fulfil our remit as detailed in the Code of Corporate Governance. As a result of the work undertaken during the year, I can confirm that adequate and effective governance arrangements were in place throughout NHS Fife during the year.

8.2 I can confirm that that there were no significant control weaknesses or issues at the year-end which the Committee considers should be disclosed in the Governance Statement, as they may have impacted financially or otherwise in the year or thereafter.

8.3 I would pay tribute to the dedication and commitment of fellow members of the Committee and to all attendees. I would thank all those members of staff who have prepared reports and attended meetings of the Committee.

Signed:  Date: 8 July 2020

Dr Les Bisset, Chair
On behalf of the Clinical Governance Committee

Appendix 1 – Attendance Schedule
Appendix 2 – Best Value

NHS Fife Clinical Governance Committee Attendance Record
1st April 2019 to 31st March 2020

	08.05.19	03.07.19	04.09.19	14.10.19 (private)	06.11.19	16.01.20	04.03.20
Dr L Bisset (Chair)	√	√	√	√	√	√	√
Mr M Black	√	√	√	√	√	√	√
Ms S Braiden						√	√
W Brown	x	√	x	√	x	√	x
H Buchanan	√	x	√	√	x	√	x
Cllr D Graham	√	x	√	√	√	√	√
P Hawkins	x	x	√	x	x	x	
R Laing	√	√	√	√	√	√	√
Dr C McKenna	√	√	√	√	√	√	√
D Milne	√	√	√	√	√	√	x
J Owens	√	√	x	√	√	√	x
C Potter				As DoF		As Dep CEO	√
J Stobbs	√	√	√	√	√	√	√
M Wells	√	√	√	√	√	√	√

In attendance

M Kellet, Director of H&SC	√	√					
N Connor, Director of H&SC			√		√	√	√
Dr R Cargill, AMD, ASD	√	√	√		√	√	x
Dr L Campbell, ADN, ASD		√	√		√		
Dr S McCallum, AMD, H&SCP	√						
Dr H Hellewell, AMD, H&SCP		√	√		√	x	√
E Ryabov, Chief Operating Officer	√	√	x		x		
M Olsen, Interim Chief Operating Officer						√	x
A Mackay, Deputy Chief Operating Officer			√				√
E McPhail, Director of Pharmacy	√						

APPENDIX 1

	08.05.19	03.07.19	04.09.19	14.10.19 (private)	06.11.19	16.01.20	04.03.20
In attendance (cont.)							
S Garden, Director of Pharmacy			x		√	√	x
A Fairgrieve, Director of Estates & Facilities		√					
S Fraser, Ass. Director of Planning & Performance		√	x		x	√	x
L Douglas, Director of Workforce						x	√
B A Nelson, Director of Workforce	√		√				
Dr G MacIntosh, Board Secretary	√	x	√	√	√	√	√
H Woodburn, Head of Quality & Clinical Governance	√	√	√		√	√	√
E Muir, Clinical Effectiveness Coordinator	√	x	x				
J Crichton, Interim Director, Project Management Office							√
L Barker, AND, H&SCP							√
E O'Keefe, Consultant in Dental Public Health							√
D Steven, Pharmacy							√
A Verrecchia, APF Representative							√

Best Value Framework

Vision and Leadership

A Best Value organisation will have in place a clear vision and strategic direction for what it will do to contribute to the delivery of improved outcomes for Scotland's people, making Scotland a better place to live and a more prosperous and successful country. The strategy will display a clear sense of purpose and place and be effectively communicated to all staff and stakeholders. The strategy will show a clear direction of travel and will be led by Senior Staff in an open and inclusive leadership approach, underpinned by clear plans and strategies (aligned to resources) which reflect a commitment to continuous improvement.

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
The strategic plan is translated into annual operational plans with meaningful, achievable actions and outcomes and clear responsibility for action.	Winter Plan Capacity Plan	**FINANCE, PERFORMANCE & RESOURCES COMMITTEE** **CLINICAL GOVERNANCE COMMITTEE** **BOARD**	Annual Bi-monthly Bi-monthly	Winter Plan approval and performance review of previous year NHS Fife Clinical Governance Workplan is approved annually and kept up-to-date on a rolling basis Minutes from Linked Committees e.g. • NHS Fife Area Drugs & Therapeutics Committee • Acute Services Division, Clinical Governance Committee • NHS Fife Infection Control Committee • NHS Fife H&SCP Care & Clinical Governance Committee NHS Fife Integrated Performance & Quality Report is considered at every meeting

GOVERNANCE AND ACCOUNTABILITY

The "Governance and Accountability" theme focuses on how a Best Value organisation achieves effective governance arrangements, which help support Executive and Non-Executive leadership decision-making, provide suitable assurances to stakeholders on how all available resources are being used in delivering outcomes and give accessible explanation of the activities of the organisation and the outcomes delivered.

OVERVIEW

A Best Value organisation will be able to demonstrate structures, policies and leadership behaviours which support the application of good standards of governance and accountability in how the organisation is improving efficiency, focusing on priorities and achieving value for money in delivering its outcomes. These good standards will be reflected in clear roles, responsibilities and relationships within the organisation. Good governance arrangements will provide the supporting framework for the overall delivery of Best Value and will ensure openness and transparency. Public reporting should show the impact of the organisations activities, with clear links between the activities and what outcomes are being delivered to customers and stakeholders. Good governance provides an assurance that the organisation has a suitable focus on continuous improvement and quality. Out with the organisation, good governance will show itself through an organisational commitment to public performance reporting about the quality of activities being delivered and commitments for future delivery.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
Board and Committee decision-making processes are open and transparent.	Board meetings are held in open session and minutes are publically available. Committee papers and minutes are publically available	**BOARD** **COMMITTEES**	Ongoing	Clinical Strategy updates and Transformation Programmes considered on a rolling schedule Via the NHS Fife website
Board and Committee decision-making processes are based on evidence that can show clear links between activities and outcomes	Reports for decision to be considered by Board and Committees should clearly describe the evidence underpinning the proposed decision.	**BOARD** **COMMITTEES**	Ongoing	SBAR reports EQIA section on all reports

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
NHS Fife has developed and implemented an effective and accessible complaints system in line with Scottish Public Services Ombudsman guidance.	Complaints system in place and regular complaints monitoring.	**CLINICAL GOVERNANCE COMMTTEE**	Ongoing Bi-monthly	Single complaints process across Fife health & social care system NHS Fife Integrated Performance & Quality Report is discussed at every meeting. Complaints are monitored through the report.
NHS Fife can demonstrate that it has clear mechanisms for receiving feedback from service users and responds positively to issues raised.	Annual feedback Individual feedback	**CLINICAL GOVERNANCE COMMITTEE**	Ongoing Bi-monthly	Review of Participation & Engagement processes and groups undertaken during the reporting year NHS Fife Integrated Performance & Quality Report is discussed at every meeting. Complaints are monitored through the report.

USE OF RESOURCES

The "Use of Resources" theme focuses on how a Best Value organisation ensures that it makes effective, risk-aware and evidence-based decisions on the use of all of its resources.

OVERVIEW

A Best Value organisation will show that it is conscious of being publicly funded in everything it does. The organisation will be able to show how its effective management of all resources (including staff, assets, information and communications technology (ICT), procurement and knowledge) is contributing to delivery of specific outcomes.

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
There is a robust information governance framework in place that ensures proper recording and transparency of all NHS Fife's activities.	Information & Security Governance Group Annual Report eHealth Board minutes	**CLINICAL GOVERNANCE COMMITTEE**	Annual	Minutes and Annual Report considered, in addition to related Internal Audit reports
NHS Fife understands and exploits the value of the data and information it holds.	Annual Operational Plan Integrated Performance & Quality Report	**BOARD** **COMMITTEES**	Annual Bi-monthly	Integrated Performance & Quality Report considered at every meeting Particular review of performance in relation to SSIs and community-based SABs undertaken in current year

PERFORMANCE MANAGEMENT

The "Performance Management" theme focuses on how a Best Value organisation embeds a culture and supporting processes which ensures that it has a clear and accurate understanding of how all parts of the organisation are performing and that, based on this knowledge, it takes action that leads to demonstrable continuous improvement in performance and outcomes.

OVERVIEW

A Best Value organisation will ensure that robust arrangements are in place to monitor the achievement of outcomes (possibly delivered across multiple partnerships) as well as reporting on specific activities and projects. It will use intelligence to make open and transparent decisions within a culture which is action and improvement oriented and manages risk. The organisation will provide a clear line of sight from individual actions through to the National Outcomes and the National Performance Framework. The measures used to manage and report on performance will also enable the organisation to provide assurances on quality and link this to continuous improvement and the delivery of efficient and effective outcomes.

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
Performance is systematically measured across all key areas of activity and associated reporting provides an understanding of whether the organisation is on track to achieve its short and long-term strategic, operational and quality objectives	Integrated Performance & Quality Report encompassing all aspects of operational performance, Annual Operational Plan targets / measures, and financial, clinical and staff governance metrics. The Board delegates to Committees the scrutiny of performance Board receives full Integrated Performance & Quality Report and notification of any issues for escalation from Committees.	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance & Quality Report considered at every meeting Minutes from Linked Committees e.g. • Area Drugs & Therapeutics Committee • Acute Services Division, Clinical Governance Committee • eHealth Board • Infection Control Committee • Information Governance & Security Group
The Board and its Committees approve the format and content of the performance reports they receive	The Board / Committees review the Integrated Performance & Quality Report and agree the measures.	**COMMITTEES** **BOARD**	Annual	Integrated Performance & Quality Report considered at every meetings. Review of format undertaken in reporting year

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
Reports are honest and balanced and subject to proportionate and appropriate scrutiny and challenge from the Board and its Committees.	Committee Minutes show scrutiny and challenge when performance is poor as well as good; with escalation of issues to the Board as required	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance & Quality Report considered at every meetings Minutes of Linked Committees are reported at every meeting
The Board has received assurance on the accuracy of data used for performance monitoring.	Performance reporting information uses validated data.	**COMMITTEES** **BOARD**	Every meeting Annual	Integrated Performance & Quality Report considered at every meeting The Committee commissions further reports on any areas of concern, e.g. as with SSIs
NHS Fife's performance management system is effective in addressing areas of underperformance, identifying the scope for improvement, agreeing remedial action, sharing good practice and monitoring implementation.	Encompassed within the Integrated Performance & Quality Report	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance & Quality Report considered at every meeting Minutes of Linked Committees • Area Clinical Forum • Acute Services Division, Clinical Governance Committee • Area Drugs & Therapeutics Committee • Fife Resilience Forum

CROSS-CUTTING THEME – EQUALITY

The "Equality" theme is one of the two cross-cutting themes and focuses on how a Best Value organisation has embedded an equalities focus which will secure continuous improvement in delivering equality.

OVERVIEW

Equality is integral to all our work as demonstrated by its positioning as a cross-cutting theme. Public Bodies have a range of legal duties and responsibilities with regard to equality. A Best Value organisation will demonstrate that consideration of equality issues is embedded in its vision and strategic direction and throughout all of its work.

The equality impact of policies and practices delivered through partnerships should always be considered. A focus on setting equality outcomes at the individual Public Body level will also encourage equality to be considered at the partnership level.

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE:
NHS Fife meets the requirements of equality legislation.		**BOARD** **COMMITTEES**	Ongoing	Clinical Strategy updates regularly considered on a rolling schedule Mental Health Strategy and Digital & Information Strategy reviewed in current year All strategies have a completed EQIA
The Board and senior managers understand the diversity of their customers and stakeholders.	Equality Impact Assessments are reported to the Board and Committees as required and identify the diverse range of stakeholders.	**BOARD** **COMMITTEES**	Ongoing	Clinical Strategy updates regularly considered on a rolling schedule Mental Health Strategy and Digital & Information Strategy reviewed in current year All strategies have a completed EQIA

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE:
NHS Fife's policies, functions and service planning overtly consider the different current and future needs and access requirements of groups within the community.	In accordance with the Equality and Impact Assessment Policy, Impact Assessments consider the current and future needs and access requirements of the groups within the community.	**BOARD** **COMMITTEES**	Ongoing	All NHS Fife policies have a EQIA completed and approved. The EQIA is published alongside the policy when uploaded onto the intranet
Wherever relevant, NHS Fife collects information and data on the impact of policies, services and functions on different equality groups to help inform future decisions.	In accordance with the Equality and Impact Assessment Policy, Impact Assessments will collect this information to inform future decisions.	**BOARD** **COMMITTEES**	Ongoing	Review of Participation & Engagement processes and groups undertaken during the reporting year, which encompassed effectiveness of engagement with key groups of users

ANNUAL STATEMENT OF ASSURANCE FOR THE FINANCE, PERFORMANCE & RESOURCES COMMITTEE 2019/20

1. Purpose of Committee

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 these arrangements are working effectively.

2. Membership of Committee

2.1 During the financial year to 31 March 2020, membership of the Finance, Performance and Resources Committee comprised:

Rona Laing	Chair / Non-Executive Member
Dr Les Bisset	Non-Executive Member
Sinead Braiden	Non-Executive Member (until 30.11.19)
Eugene Clarke	Non-Executive Member
Alistair Morris	Non-Executive Member (from 01.12.19)
Wilma Brown	Stakeholder Member
Janette Owens	Stakeholder Member
Paul Hawkins	Chief Executive (until 27.01.20)
Carol Potter	Director of Finance (until 27.01.20) / Chief Executive (from 28.01.20)
Margo McGurk	Director of Finance (from 03.02.20)
Dr Chris McKenna	Medical Director
Helen Buchanan	Director of Nursing
Dona Milne	Director of Public Health

2.2 The Committee may invite individuals to attend the Committee meetings for particular agenda items, but the Chief Operating Officer (Director of Acute Services), Director of Health & Social Care, Director of Estates & Facilities, Director of Pharmacy & Medicines and Board Secretary will normally be in attendance at Committee meetings. Other attendees, deputies and guests are recorded in the individual minutes of each Committee meeting.

3. Meetings

3.1 The Committee met on seven occasions during the financial year to 31 March 2020, on the undernoted dates:

- 14 May 2019
- 16 July 2019
- 10 September 2019
- 14 October 2019

- 05 November 2019
- 14 January 2020
- 10 March 2020

3.2 The attendance schedule is attached at Appendix 1.

4. Business

4.1 As the 2019/20 Financial Year drew to a close, the Covid-19 pandemic required an unprecedented mobilisation effort on behalf of NHS Fife in order to address the developing public health emergency. Staff responded with professionalism, speed and agility, effecting major service changes in an extremely short timescale. This report is written against that background, with the knowledge that the Committee's future schedule of business will adapt appropriately to reflect on the Board's ongoing response to Covid-19. Issues to consider in the forthcoming year will be the implications for the Board's financial planning processes and efficiency savings targets, in addition to the continued challenges of addressing overspend within integrated services.

4.2 Minutes of Committee meetings have been approved by the Committee and presented to Fife NHS Board. The Board also receives a verbal update at each meeting from the Chair, highlighting any key issues discussed by the Committee at its preceding meeting. The Committee maintains an action register to record and manage actions agreed from each meeting, and reviews progress against deadline dates at subsequent meetings.

4.3 At each meeting the Finance, Performance and Resources Committee considers the most up-to-date financial position for the year for both revenue and capital expenditure. This function is of central importance, as the Committee provides detailed scrutiny of the ongoing financial position and all aspects of operational performance across NHS Fife activities, including those delegated to the Integration Joint Board.

4.4 Considerable time was spent in meetings discussing and reviewing the financial pressures facing the Board, the delivery of in-year savings and consideration of future year service changes and financial consequences. A detailed update on the Acute Services Division Savings Plan was reviewed at the July 2019 meeting of the Committee in a dedicated presentation session with members, with subsequent updates to following meetings.

4.5 The Committee has also received detailed reports on the Annual Operational Plan for 2019/20, subsequently approved by the Board in May 2019, and, in private session, the new version of the Plan for 2020/21. Briefings were also provided on additional funding secured via ADEL and details of qualifying expenditure through this source. A new five-year Procurement Strategy was reviewed and approved by the Committee in September 2019, setting out how the Board intends to ensure that its procurement activity delivers value for money and contributes towards NHS Fife's broader strategic objectives.

4.6 The Committee scrutinised operational performance at each meeting through review of the Integrated Performance & Quality Report (IPQR). During 2019/20 the IPQR was further developed to improve layout, content and provide clearer data analysis, trend and interpretation. There was increased clarity, and subsequently increased scrutiny, of matters within the IPQR of specific relevance to the Committee.

4.7 Members received updates on the implementation of a new Performance & Accountability Framework across NHS Fife, welcoming the structured, transparent and systematic approach to ensure the robust delivery of standards and targets across the areas of (i) Finance; (ii) Operational Performance; (iii) Quality; and (iv) Workforce. A summary of the key themes identified at the review meetings with services held in September 2019 was considered by the Committee at its January 2020 meeting. The Committee also considered the Strategic Objectives 2019/20, describing what NHS Fife aims to achieve in year, in tandem with a looking-back review of Directors' Objectives for 2018/19.

4.8 In September 2019, detailed updates, at the request of the Committee, were given on performance within the services of Psychological Therapies and CAMHS, particularly in relation to ongoing concerns about failure to meet RTT targets. The issues were explained in detail by the relevant service managers and Committee members scrutinised the various improvement actions and recovery plans. Further updates were delivered to the January and March 2020 meetings of the Committee, with members reviewing the actions underway to improve performance in these services.

4.9 The preparation of a robust plan for dealing with Winter demand, along with a review of the previous year's performance, were considered by the Committee at a number of meetings. A lessons-learned report remained an important area of consideration by the Committee, to improve performance on an ongoing basis. The potential impact of Covid-19 risks on Winter Planning is recognised to be a significant issue going forward.

4.10 During the year, the Committee received regular reports on the subject of Brexit, particularly in relation to the potential financial impact of a 'no deal' or 'hard' Brexit, on issues such as the economy, budget planning, procurement of medicines and equipment, and the supply chain in general. A watching brief remains, despite the stepping-down of Brexit-related emergency planning activity, as the national political position has stabilised.

4.11 The Committee has considered a regular update around the status of General Policies & Procedures, gaining assurance from improved performance in the review and updating of Board-level policies. Members have been supportive of efforts to move to a more streamlined review process, utilising electronic software solutions where appropriate, and this work is expected to develop over the coming year.

4.12 The Committee considered matters in relation to the following capital schemes:

- Kincardine & Lochgelly Health Centres Initial Agreement Documents
- Elective Orthopaedic Centre Outline Business Case
- Hospital Electronic Prescribing & Medicines Administration (HEPMA)

4.13 The Committee also received reports on the management of Capital schemes in general, and reviewed the Property & Asset Management Strategy update for 2019 in detail at its July meeting. A detailed presentation was given to members on the processes of the Scottish Capital Investment Manual (SCIM), to improve members' awareness of this key governance process. The annual PPP Monitoring Report for 2018-19, covering the sites of St Andrews Community Hospital and Phase 3 of the Victoria Hospital in Kirkcaldy, was considered by the Committee in January 2020, with members gaining assurance from the positive audit opinion detailed therein.

5. Outcomes

5.1 The Committee has, through its scrutiny and monitoring of regular finance reports and other one-off reports, been able to assure the Board that NHS Fife:

- complied with statutory financial requirements and achieved its financial targets for the financial year 2019/20;
- met specific reporting timetables to both the Board and the Scottish Government Health & Social Care Directorates;
- made adequate progress in the delivery of efficiency savings (on a recurring and non recurring mix), noting the continuing challenges within Acute and social care spend within the Fife Health & Social Care Partnership; and
- has taken account of planned future policies and known or foreseeable future developments in the financial planning process.

6 Best Value

6.1 Since 2013/14 the Board has been required to provide overt assurance on Best Value. A revised Best Value Framework was considered and agreed by the NHS Board in January 2018. Appendix 2 provides evidence of where and when the Committee considered the relevant characteristics during 2019/20.

7 Risk Management

7.1 In line with the Board's agreed risk management arrangements, the Finance, Performance & Resources Committee, as a governance committee of the Board, has considered risk through a range of reports and scrutiny, including oversight on the detail of the Board Assurance Frameworks covering Financial Sustainability, Strategic Planning and Environmental Sustainability. Progress and appropriate actions were noted. Within the Committee's remit specifically, the ongoing risks presented by the failure to achieve savings targets within Acute, in addition to ongoing pressures in the Partnership in relation to the Social Care budget and the potential impact of the Integration risk share arrangement, were considered in detail, with assurances sought over mitigating actions.

7.2 As with other Board Committees, Finance, Performance & Resources Committee members contributed to work involved in developing a risk appetite threshold for the Board overall, to determine the nature and extent of the significant risks the Board is willing to take in order to achieve its strategic priorities. A dedicated session at the Committee was led by the Risk Manager in order to capture members' thoughts and comments, which were brought together in a subsequent Board Development Session.

8 Self Assessment

8.1 The Committee has undertaken a self assessment of its own effectiveness, utilising a revised questionnaire considered and approved by the Committee Chair. Attendees were also invited to participate in this exercise, which was carried out via an easily-accessible online portal. A report summarising the findings of the survey was considered and approved by the Committee at its March 2020 meeting, and action points are being taken forward at both Committee and Board level.

9. Conclusion

9.1 As Chair of the Finance, Performance and Resources Committee at 31 March 2020, I am satisfied that the integrated approach, the frequency of meetings, the breadth of the business undertaken and the range of attendees at meetings of the Committee has allowed us to fulfil our remit as detailed in the Code of Corporate Governance. As a result of the work undertaken during the year, I can confirm that adequate financial planning and monitoring and governance arrangements were in place throughout NHS Fife during the year, including scrutiny of all aspects of non financial performance metrics.

9.2 I would pay tribute to the dedication and commitment of fellow members of the Committee and to all attendees. I would thank all those members of staff who have prepared reports and attended meetings of the Committee.

Signed: R. Laing Date: 7 July 2020

Rona Laing, Chair
On behalf of the Finance, Performance and Resources Committee

Appendix 1 – Attendance Schedule
Appendix 2 – Best Value

APPENDIX 1

FINANCE, PERFORMANCE AND RESOURCES COMMITTEE
ATTENDANCE SCHEDULE 2019/20

	14.05.19	16.07.19	10.09.19	14.10.19 (private)	05.11.19	14.01.20	10.03.20
R Laing (Chair)	√	√	√	√	√	√	√
Dr L Bisset	√	√	√	√	√	√	√
S Braiden (until 30.11.19)	√	x	√	√	√		
E Clarke	√	√	√	√	√	√	√
A Morris (from 01.12.19)						√	√
W Brown	√	√	√	√	x	x	√
J Owens	√	√	√	√	√	√	√
P Hawkins (until 27.01.20)	√	√	√	x	x	√	
C Potter	√	√	√	√	√	√	√
M McGurk (from 03.02.20)							√
Dr C McKenna	√	x	√	√	x	√	x
H Buchanan	√	x	√	√	x	√	√
D Milne	x	x	√	√	√	√	x

In attendance

M Kellet, Director of H&SC	√	x					
N Connor, Director of H&SC			√		√	√	x
A Fairgrieve, Director of Estates	√	√	√		√	√	√
E Ryabov, Chief Operating Officer	x	√	√		x		
M Olsen, Interim Chief Operating Officer						√	√
A Mackay, Deputy Chief Operating Officer	√				√		
E McPhail, Director of Pharmacy	x						
S Garden, Director of Pharmacy		√	√		√	x	√
Dr G MacIntosh, Board Secretary	√	x	√	√	√	√	√
R Robertson, Deputy Director of Finance	√				√	√	√
C Dobson, Divisional General Manager (West)		√					√
A Wilson, Capital Projects Director					√		

BEST VALUE FRAMEWORK

Vision and Leadership

A Best Value organisation will have in place a clear vision and strategic direction for what it will do to contribute to the delivery of improved outcomes for Scotland's people, making Scotland a better place to live and a more prosperous and successful country. The strategy will display a clear sense of purpose and place and be effectively communicated to all staff and stakeholders. The strategy will show a clear direction of travel and will be led by Senior Staff in an open and inclusive leadership approach, underpinned by clear plans and strategies (aligned to resources) which reflect a commitment to continuous improvement.

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
Resources required to achieve the strategic plan and operational plans e.g. finance, staff, asset base are identified and additional / changed resource requirements identified.	Financial Plan Workforce Plan Property & Asset Management Strategy	**FINANCE, PERFORMANCE & RESOURCES COMMITTEE** **STAFF GOVERNANCE COMMITTEE** **BOARD**	Annual Annual Annual Bi-annual Bi-monthly	Annual Operational Plan Financial Plan Workforce Plan Property & Asset Management Strategy Integrated Performance & Quality Report
The strategic plan is translated into annual operational plans with meaningful, achievable actions and outcomes and clear responsibility for action.	Winter Plan Capacity Plan	**FINANCE, PERFORMANCE & RESOURCES COMMITTEE** **CLINICAL GOVERNANCE COMMITTEE** **BOARD**	Annual Bi-monthly Bi-monthly	Winter Plan Minutes of Committees Integrated Performance & Quality Report

GOVERNANCE AND ACCOUNTABILITY

The "Governance and Accountability" theme focuses on how a Best Value organisation achieves effective governance arrangements, which help support Executive and Non-Executive leadership decision-making, provide suitable assurances to stakeholders on how all available resources are being used in delivering outcomes and give accessible explanation of the activities of the organisation and the outcomes delivered.

OVERVIEW

A Best Value organisation will be able to demonstrate structures, policies and leadership behaviours which support the application of good standards of governance and accountability in how the organisation is improving efficiency, focusing on priorities and achieving value for money in delivering its outcomes. These good standards will be reflected in clear roles, responsibilities and relationships within the organisation. Good governance arrangements will provide the supporting framework for the overall delivery of Best Value and will ensure open-ness and transparency. Public reporting should show the impact of the organisations activities, with clear links between the activities and what outcomes are being delivered to customers and stakeholders. Good governance provides an assurance that the organisation has a suitable focus on continuous improvement and quality. Outwith the organisation, good governance will show itself through an organisational commitment to public performance reporting about the quality of activities being delivered and commitments for future delivery.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
Board and Committee decision-making processes are open and transparent.	Board meetings are held in open session and minutes are publically available. Committee papers and minutes are publically available	**BOARD** **COMMITTEES**	On going	Internet Intranet
Board and Committee decision-making processes are based on evidence that can show clear links between activities and outcomes	Reports for decision to be considered by Board and Committees should clearly describe the evidence underpinning the proposed decision.	**BOARD** **COMMITTEES**	Ongoing	SBAR reports EQIA section on all reports

APPENDIX 2

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
NHS Fife conducts rigorous review and option appraisal processes of any developments.	Business cases	**BOARD** **FINANCE, PERFORMANCE & RESOURCES COMMITTEE**	Ongoing	Business Cases

USE OF RESOURCES

The "Use of Resources" theme focuses on how a Best Value organisation ensures that it makes effective, risk-aware and evidence-based decisions on the use of all of its resources.

OVERVIEW

A Best Value organisation will show that it is conscious of being publicly funded in everything it does. The organisation will be able to show how its effective management of all resources (including staff, assets, information and communications technology (ICT), procurement and knowledge) is contributing to delivery of specific outcomes.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
NHS Fife understands and measures and reports on the relationship between cost, quality and outcomes.	Reporting on financial position in parallel with operational performance and other key targets	**BOARD** **FINANCE, PERFORMANCE & RESOURCES COMMITTEE**	Bi-monthly	Integrated Performance & Quality Report
The organisation has a comprehensive programme to evaluate and assess opportunities for efficiency savings and service improvements including comparison with similar organisations.	National Benchmarking undertaken through Corporate Finance Network. Local benchmarking with similar sized organisation undertaken where information available. Participation in National Shared Services Programme Systematic review of activity / performance data through use of Discovery tool	**FINANCE, PERFORMANCE & RESOURCES COMMITTEE** **BOARD**	Annual Bi-monthly Ongoing	Financial Plan Integrated Performance & Quality Report Financial overview presentations

APPENDIX 2

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
Organisational budgets and other resources are allocated and regularly monitored.	Annual Operational Plan Integrated Performance & Quality Report	**FINANCE, PERFORMANCE & RESOURCES COMMITTEE**	Bi-monthly	Integrated Performance & Quality Report
NHS Fife has a strategy for procurement and the management of contracts (and contractors) which complies with the SPFM and demonstrates appropriate competitive practice.	Code of Corporate Governance Financial Operating Procedures	**FINANCE, PERFORMANCE & RESOURCES COMMITTEE**	Reviewed annually	Code of Corporate Governance Financial Operating Procedures
NHS Fife understands and exploits the value of the data and information it holds.	Annual Operational Plan Integrated Performance & Quality Report	**BOARD** **COMMITTEES**	Annual Bi-monthly	Annual Operational Plan Integrated Performance & Quality Report
Fixed assets including land, property, ICT, equipment and vehicles are managed efficiently and effectively and are aligned appropriately to organisational strategies.	Property and Asset Management Strategy	**FINANCE, PERFORMANCE & RESOURCES COMMITTEE**	Bi-annual Ongoing Bi-monthly Monthly	Property and Asset Management Strategy Report on asset disposal Integrated Performance & Quality Report Minutes of NHS Fife Capital Investment Group

PERFORMANCE MANAGEMENT

The "Performance Management" theme focuses on how a Best Value organisation embeds a culture and supporting processes which ensures that it has a clear and accurate understanding of how all parts of the organisation are performing and that, based on this knowledge, it takes action that leads to demonstrable continuous improvement in performance and outcomes.

OVERVIEW

A Best Value organisation will ensure that robust arrangements are in place to monitor the achievement of outcomes (possibly delivered across multiple partnerships) as well as reporting on specific activities and projects. It will use intelligence to make open and transparent decisions within a culture which is action and improvement oriented and manages risk. The organisation will provide a clear line of sight from individual actions through to the National Outcomes and the National Performance Framework. The measures used to manage and report on performance will also enable the organisation to provide assurances on quality and link this to continuous improvement and the delivery of efficient and effective outcomes.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
Performance is systematically measured across all key areas of activity and associated reporting provides an understanding of whether the organisation is on track to achieve its short and long-term strategic, operational and quality objectives	Integrated Performance & Quality Report encompassing all aspects of operational performance, AOP targets / measures, and financial, clinical and staff governance metrics. The Board delegates to Committees the scrutiny of performance Board receives full Integrated Performance & Quality Report and notification of any issues for escalation from Committees.	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance & Quality Report Code of Corporate Governance Minutes of Committees

APPENDIX 2

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
The Board and its Committees approve the format and content of the performance reports they receive	The Board / Committees review the Integrated Performance & Quality Report and agree the measures.	**COMMITTEES** **BOARD**	Annual	Integrated Performance & Quality Report
Reports are honest and balanced and subject to proportionate and appropriate scrutiny and challenge from the Board and its Committees.	Committee Minutes show scrutiny and challenge when performance is poor as well as good; with escalation of issues to the Board as required	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance & Quality Report Minutes of Committees
The Board has received assurance on the accuracy of data used for performance monitoring.	Performance reporting information uses validated data.	**COMMITTEES** **BOARD**	Every meeting Annual	Integrated Performance & Quality Report Annual Accounts including External Audit report

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REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
NHS Fife's performance management system is effective in addressing areas of underperformance, identifying the scope for improvement, agreeing remedial action, sharing good practice and monitoring implementation.	Encompassed within the Integrated Performance & Quality Report	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance & Quality Report Minutes of Committees

CROSS-CUTTING THEME – SUSTAINABILITY

The "Sustainability" theme is one of the two cross-cutting themes and focuses on how a Best Value organisation has embedded a sustainable development focus in its work.

OVERVIEW

The goal of Sustainable Development is to enable all people throughout the world to satisfy their basic needs and enjoy a better quality of life without compromising the quality of life of future generations. Sustainability is integral to an overall Best Value approach and an obligation to act in a way which it considers is most sustainable is one of the three public bodies' duties set out in section 44 of the Climate Change (Scotland) Act 2009. The duty to act sustainably placed upon Public Bodies by the Climate Change Act will require Public Bodies to routinely balance their decisions and consider the wide range of impacts of their actions, beyond reduction of greenhouse gas emissions and over both the short and the long term.

The concept of sustainability is one which is still evolving. However, five broad principles of sustainability have been identified as:

- promoting good governance;
- living within environmental limits;
- achieving a sustainable economy;
- ensuring a stronger healthier society; and
- using sound science responsibly.

Individual Public Bodies may wish to consider comparisons within the wider public sector, rather than within their usual public sector "family". This will assist them in getting an accurate gauge of their true scale and level of influence, as well as a more accurate assessment of the potential impact of any decisions they choose to make.

A Best Value organisation will demonstrate an effective use of resources in the short-term and an informed prioritisation of the use of resources in the longer-term in order to bring about sustainable development. Public bodies should also prepare for future changes as a result of emissions that have already taken place. Public Bodies will need to ensure that they are resilient enough to continue to deliver the public services on which we all rely.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
NHS Fife can demonstrate that it respects the limits of the planets environment, resources and biodiversity in order to improve the environment and ensure that the natural resources needed	Sustainability and Environmental report incorporated in the Annual Accounts process.	**FINANCE, PERFORMANCE & RESOURCES COMMITTEE** **BOARD**	Annual	Annual Accounts

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
for life are unimpaired and remain so for future generations.				Climate Change Template

CROSS-CUTTING THEME – EQUALITY

The "Equality" theme is one of the two cross-cutting themes and focuses on how a Best Value organisation has embedded an equalities focus which will secure continuous improvement in delivering equality.

OVERVIEW

Equality is integral to all our work as demonstrated by its positioning as a cross-cutting theme. Public Bodies have a range of legal duties and responsibilities with regard to equality. A Best Value organisation will demonstrate that consideration of equality issues is embedded in its vision and strategic direction and throughout all of its work.

The equality impact of policies and practices delivered through partnerships should always be considered. A focus on setting equality outcomes at the individual Public Body level will also encourage equality to be considered at the partnership level.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE:**
NHS Fife meets the requirements of equality legislation.		**BOARD** **COMMITTEES**	Ongoing	EQIA section on all reports
The Board and senior managers understand the diversity of their customers and stakeholders.	Equality Impact Assessments are reported to the Board and Committees as required and identify the diverse range of stakeholders.	**BOARD** **COMMITTEES**	Ongoing	EQIA section on all reports
NHS Fife's policies, functions and service planning overtly consider the different current and future needs and access requirements of groups within the community.	In accordance with the Equality and Impact Assessment Policy, Impact Assessments consider the current and future needs and access requirements of the groups within the community.	**BOARD** **COMMITTEES**	Ongoing	Clinical Strategy EQIA section on reports

APPENDIX 2

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE:
Wherever relevant, NHS Fife collects information and data on the impact of policies, services and functions on different equality groups to help inform future decisions.	In accordance with the Equality and Impact Assessment Policy, Impact Assessments will collect this information to inform future decisions.	**BOARD** **COMMITTEES**	Ongoing	EQIA section on reports

ANNUAL REPORT OF THE REMUNERATION COMMITTEE 2019/20

PURPOSE

The Remuneration Committee is established as a Committee of NHS Fife Board.

Its remit is to consider and agree performance objectives, performance appraisals and linked remuneration issues for those staff within the executive cohort and will oversee senior management pay arrangements.

Specifically, the Committee:

- Reviews action taken by the Chief Executive on recommendations made by the Committee, the Board, or the Scottish Ministers on remuneration or terms and conditions matters for the Chief Executive and the Executive Directors
- Gives assurance to the Board on the delivery of remuneration and terms and conditions issues, identifying progress, issues and actions being taken, where appropriate
- Will consider the job descriptions for the Chief Executive and the Executive Directors
- Considers and determines objective setting, performance appraisals and linked remuneration issues for the Chief Executive and the Executive Directors
- Hears and determines appeals against the decisions of the Consultant Discretionary Awards Panel

To fulfil its duties the Committee takes into account a range of factors including:

- Guidance issued from the Scottish Ministers, the Scottish Partnership Forum and other relevant sources

MEMBERSHIP

The membership of the Committee for the year ending 31 March 2020:

Mrs Tricia Marwick, Chair, Fife NHS Board

Mr Paul Hawkins, Chief Executive, Fife NHS Board (→Feb 2020)

Mrs Carol Potter, Chief Executive, Fife NHS Board (Feb 2020 →)

Mrs W Brown, Employee Director

Dr L Bisset, Non Executive Director

Mr M Black, Non Executive Director

In addition, the following people regularly attend the Committee meetings and participate in the business of the Sub-Committee:

Ms B A Nelson, Director of Workforce, Fife NHS Board (→ December 2019)

Mrs L Douglas, Director of Workforce, Fife NHS Board (January 2020 →)

Other attendees are recorded in the minutes of the Committee meetings.

MEETINGS

The Committee met on 3 occasions during the period from 1 April 2019 to

31 March 2020:

11th July 2019

26th November 2019

12th March 2020

The attendance schedule is attached as Appendix 1.

BUSINESS

Details of business items considered during the period 1 April 2019 to 31 March 2020 are attached at Appendix 2.

CONCLUSION

NHS Fife has demonstrated that it has clearly determined and reviewed its performance and that of its senior managers. It has robust arrangements in place to oversee the application of the remuneration arrangements for all of its managers in the executive cohort.

As Chair of the Remuneration Committee during financial year 2019/20, I am satisfied that the integrated approach, the frequency of meetings, the breadth of the business undertaken and the range of attendees at meetings of the Committee has allowed us to fulfill our remit as detailed in the Code of Corporate Governance. As a result of the work undertaken this year I can confirm that appropriate arrangements were in place for the implementation of the circulars and the Committee fulfilled its remit and purpose.

I would pay tribute to the dedication and commitment of fellow members of the Committee and to all attendees. I would thank all those members of staff who have prepared reports and attended meetings of the Committee.

……

Mrs Tricia Marwick, Chair, Fife NHS Board

Chair of Fife NHS Board Remuneration Committee

Appendix 1

NHS FIFE REMUNERATION COMMITTEE

ATTENDANCE RECORD 1 APRIL 2019 – 31 MARCH 2020

Name	**Designation**	**Organisation**	**Dates**		
			11.07.19	**26.11.19**	**12.03.20**
Mrs T Marwick	Chair	Fife NHS Board	✓	✓	✓
Mr P Hawkins	Chief Executive	Fife NHS Board	✓	✓	N/A
Mrs C Potter	Chief Executive	Fife NHS Board	N/A	N/A	✓
Mrs W Brown	Employee Director	Fife NHS Board	✓	X	✓
Dr L Bisset	Non-Exec Member	Fife NHS Board	✓	✓	✓
Mr M Black	Non-Exec Member	Fife NHS Board	✓	✓	✓

In Attendance:	**Designation**	**Organisation**	**Dates**		
			11.07.19	**26.11.19**	**12.03.20**
Ms B A Nelson	Director of Workforce	Fife NHS Board	✓	✓	N/A
Mrs L Douglas	Director of Workforce	Fife NHS Board	N/A	N/A	✓

Appendix 2

NHS FIFE REMUNERATION COMMITTEE

ITEMS OF BUSINESS CONSIDERED

BETWEEN 1 APRIL 2019 AND 31 MARCH 2020

Agenda items discussed at Remuneration Sub Committee meetings 2019/20

Regular items

- Minutes
- Matters Arising
- Items for Highlighting to Private Session of NHS Fife Board Committee

Meeting on 11th July 2019

NHS Fife Executive Cohort Annual Performance Review 2018/19

Annual Performance Management Review for Senior Managers not in the Executive Cohort 2018/19

NHS Fife Executive Cohort objectives 2019/20

Remuneration Committee Governance Arrangements and Terms of Reference

Cessation of Midwifery Posts

Remuneration Committee Self Assessment

Meeting on 26th November 2019

Matters Arising - Cessation of Midwifery Posts

- Outstanding Senior Manager Appraisals

Discretionary Points – retention for an individual

Executive/Senior Manager Cohort – Mid Year Reviews 2019/20

Circular PCS(ESM)2019/2 – Pay and Conditions of Service Executive and Senior Management Pay 2019/20

Feedback from Scottish Government on 2018/19 outcomes (NPMC letter)

NHS Fife Remuneration Committee Self Assessment 2019/20

Director of Workforce – commencing salary

Director of Health and Social Care Partnership – starting salary

Interim Director Programme Management Office (Fixed Term)

Meeting on 12th March 2020

Chief Executive – secondment

Chief Executive – remuneration

Director of Nursing – additional allowance Senior Responsible Officer, Orthopaedic Project

Executive Cohort Director of Finance (secondment) and Director of Strategy, Planning and Performance

Remuneration Committee Self Assessment 2019/20

B06-20 Annual Audit Report Recommendation 6 – update

Remuneration Committee Terms of Reference

Remuneration Committee Timetable and Workplan 2020/21

ANNUAL STATEMENT OF ASSURANCE FOR
NHS FIFE STAFF GOVERNANCE COMMITTEE FOR 2019/20

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 all services, including those devolved to the Integration Joint Board.

2. Membership

2.1 During the financial year to 31 March 2020, membership of the Staff Governance Committee comprised: -

Mrs Margaret Wells	Chair / Non-Executive Member
Mrs Wilma Brown	Employee Director
Ms Helen Buchanan	Director of Nursing
Mr Eugene Clarke	Non-Executive Director
Mrs Christina Cooper	Non-Executive Director
Mr Alistair Morris	Non-Executive Director (from 1 December 2019)
Mr Simon Fevre	Co-Chair, H&SCP Local Partnership Forum
Mr Paul Hawkins	Chief Executive (until 27 January 2020)
Ms Carol Potter	Chief Executive (from 28 January 2020)
Mr Andrew Verrecchia	Co-Chair, Acute Services Division Local Partnership Forum

2.2 The Committee may invite individuals to attend Committee meetings for particular agenda items, but the Director of Workforce, Chief Operating Officer (Director of Acute Services), Director of Health & Social Care, Head of Staff Governance, Head of Human Resources, Head of Workforce Development and Board Secretary will normally be in attendance at Committee meetings. Other attendees, deputies and guests are recorded in the individual minutes of each Committee meeting.

3. Meetings

3.1 The Committee met on seven occasions during the financial year to 31 March 2020, on the undernoted dates:

- 3 May 2019
- 28 June 2019
- 30 August 2019
- 14 October 2019 (private session)

- 1 November 2019
- 17 January 2020
- 6 March 2020

3.2 The attendance schedule is attached at Appendix 1.

4. Business

4.1 As the 2019/20 Financial Year drew to a close, the Covid-19 pandemic required an unprecedented mobilisation effort on behalf of NHS Fife in order to address the developing public health emergency. Staff responded with professionalism, speed and agility. This report is written against that background, with the knowledge that the Committee's future schedule of business will adapt appropriately to reflect on the Board's ongoing response to Covid-19. Issues to consider will be ensuring staff well-being and planning for remobilisation of services, whilst managing the continuing threat of disease outbreaks.

4.2 The Workforce Strategy 2019-2022 was approved by the Staff Governance Committee in June 2019 and subsequently authorised by the NHS Fife Board in July 2019. On behalf of the Committee, completion of the actions within the Workforce Strategy is being overseen by the Workforce Planning Group. The Committee has received information on the supporting Youth Employment Strategy, an important strand for enhancing recruitment of new staff and developing careers in a health care setting.

4.3 The Committee considered the publication of the independent 'Sturrock Review' in May 2019, along with the Scottish Government's response to the report's findings. Whilst the review dealt with the cultural issues related to allegations of bullying and harassment in NHS Highland specifically, the implications for all Boards were detailed to the Committee, and the report's recommendations were also a broader focus of discussion within the Board, APF and LPF. An internal action plan has been developed to address the Review's findings. The draft National Whistleblowing Standards have been detailed to the Committee, and it is anticipated that the Board's new Whistleblowing Champion, Non-Executive Board Member Ms Katy Miller, will contribute to the local implementation of this work, when she takes up her position as a Committee member from April 2020.

4.4 Reflecting on staff experience remains an important part of the Committee's business. The Committee has considered the Health & Social Care Staff Experience Reports for 2018 and 2019 in the reporting year. Measures aimed at improving the iMatter response rate have been agreed, in conjunction with Communications colleagues, to improve the Board's performance overall, and this has had a positive impact based on further reports supplied towards year-end. A summary of appraisal and personal development planning completion performance was considered by the Committee in June 2019, as was a report reflecting an improving position in Core Skills training compliance. The yearly update on Medical Revalidation & Appraisal was considered by the Committee at its November 2019 meeting and its findings noted.

4.5 The Committee receives regular updates on recruitment, including data on consultant recruitment (where an improved position has been reported) and on efforts to improving nursing and midwifery recruitment, particularly in partnership with local universities and colleges. Two significant digital projects achieved within the year were the delivery of the Electronic Employee Support System (eESS) and JobTrain within NHS Fife, each aimed at enhancing and streamlining the administrative processes to support recruitment and employee management activity.

4.6 Progress reports on the development of a number of 'Once for Scotland' employment policies have been supplied to members, with updates noting the launch of a new digital

platform for easy access to this information. The improved consistency of information made across Boards was welcomed by Committee members.

4.7 As with other Board Committees, Staff Governance members contributed to work involved in developing a risk appetite threshold for the Board overall, to determine the nature and extent of the significant risks the Board is willing to take in order to achieve its strategic priorities. A dedicated session at the Committee was led by the Risk Manager in order to capture members' thoughts and comments, which were brought together in a subsequent Board Development Session.

4.8 Throughout the reporting year, the Committee received updates from the Brexit Assurance Group, particularly focusing on the staff survey results for affected staff and areas of concern to where specific support could be directed. Linkages with the national 'Stay in Scotland' campaign were highlighted. The potential workforce issues of Brexit were also considered by the Committee. Support continues to be provided to staff, despite the stepping-down of Brexit-related activity, as the national political position has stabilised.

4.9 At each meeting of the Committee, members routinely scrutinise the relevant section of the Board Assurance Framework on Workforce Sustainability, and also receive regular updates on Absence Management performance and Well at Work activities. The Committee recognised the achievement of the Board retaining the Gold Health Working Lives Award within the reporting year. Performance activity is also reviewed each meeting based on data within the Integrated Performance & Quality Report, focused on measures to improve the average sickness absence rate amongst staff.

4.10 Each meeting also reviews in detail a particular strand of the Staff Governance standards, ensuring full coverage over the year's meeting schedule. The Committee received individual papers to demonstrate that staff are: well informed; appropriately trained and developed; involved in decisions; treated fairly and consistently, with dignity and respect, in an environment where diversity is valued; and provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community.

4.11 The Committee has reviewed its remit over the year and a number of clarifying changes to wording have been agreed. As part of this discussion, the capacity issues of staff-side representatives to nominate a dedicated deputy in the event of their absence has been noted and will be taken forward as an operational matter.

4.12 During the year, the Committee received a number of detailed presentations, covering a variety of relevant topics including: (i) Digital Readiness and related training needs amongst staff; (ii) the potential impact of implementing Safe Staffing legislation; (iii) an update on the Going Beyond Gold programme, reflecting on the positive benefits of mindfulness / good conversations; (iv) a Staff Story focused on the successful return to work by an employee with a long period of absence; and (v) improving Personal and Team Resilience with the Laboratories team. The usefulness of these sessions has been greatly recognised by members.

5. Best Value

5.1 Since 2013/14 the Board has been required to provide overt assurance on Best Value. A revised Best Value Framework was considered and agreed by the NHS Board in January 2018. Appendix 3 provides evidence of where and when the Committee considered the relevant characteristics during 2019/20.

6. Risk Management

6.1 In line with the Board's agreed risk management arrangements, the Staff Governance Committee, as a governance committee of the Board, has considered risk through a range of reports and scrutiny, including oversight on the detail of the Workforce Sustainability section of the Board Assurance Framework. Progress and appropriate actions were duly noted.

7. Self Assessment

7.1 The Committee has undertaken a self assessment of its own effectiveness, utilising a revised questionnaire considered and approved by the Committee Chair. Attendees were also invited to participate in this exercise, which was carried out via an easily-accessible online portal. A report summarising the findings of the survey was considered and approved by the Committee at its March 2020 meeting, and action points are being taken forward at both Committee and Board level.

8. Conclusion

8.1 As Chair of the Staff Governance Committee during financial year 2019/20, I am satisfied that the integrated approach, the frequency of meetings, the breadth of the business undertaken and the range of attendees at meetings of the Committee has allowed us to fulfil our remit as detailed in the Code of Corporate Governance. As a result of the work undertaken during the year, I can confirm that adequate Staff Governance planning and monitoring arrangements were in place throughout NHS Fife during the year.

8.2 I would pay tribute to the dedication and commitment of fellow members of the Committee and to all attendees. I would thank all those members of staff who have prepared reports and attended meetings of the Committee.

Signed: Date: 3 July 2020

Margaret Wells, Chair

Appendix 1 – Attendance Schedule
Appendix 2 – Best Value

NHS FIFE STAFF GOVERNANCE COMMITTEE
ATTENDANCE SCHEDULE 1 APRIL 2019 – 31 MARCH 2020

	03.05.19	28.06.19	30.08.19	14.10.19 (private)	01.11.19	17.01.20	06.03.20
Mrs M Wells	✓	✓	✓	✓	✓	✓	✓
Mrs W Brown	✓	✓	x	✓	x	✓	✓
Ms H Buchanan	✓	x	x	✓	✓	✓	x
Mr E Clarke	✓	✓	✓	✓	✓	✓	✓
Mrs C Cooper	✓	x	✓	✓	x	✓	✓
Mr S Fevre	✓	✓	✓	✓	x	✓	✓
Mr P Hawkins	x	x	x	x	x	x	
Mr A Morris						✓	✓
Ms C Potter				As DoF		As Dep CEO	x
Mr A Verrecchia	✓	x	✓	✓	✓	x	✓
In attendance							
Mr P Hayer, Depute for Co-Chair, ASD LPF						✓	
Ms B A Nelson, Director of Workforce (until 31.12.19)	✓	✓	✓	✓	✓		
Ms L Douglas, Director of Workforce (from 01.01.20)					Observer	x	Part
Mr M Kellet, Director of H&SC	✓	✓					
Ms N Connor, Director of H&SC			✓		✓	✓	x
Mr B Anderson, Head of Staff Governance	✓	✓	✓		✓	✓	✓
Ms R Waugh, Head of HR	x	✓	✓		✓	✓	x
Ms E Ryabov, Chief Operating Officer	x	✓	x		x		
Ms M Olsen, Interim Chief Operating Officer						✓	x
Mr A Mackay, Deputy Chief Operating Officer	✓		✓		✓		✓
Dr G MacIntosh, Board Secretary	✓	✓	✓	✓	✓	x	✓
Ms P Cummings, Risk Manager	✓						
Ms J Owens, Associate Director of Nursing		✓	✓				
Ms C Dobson, Divisional General Manager (West)							✓

Best Value Framework

Vision and Leadership

A Best Value organisation will have in place a clear vision and strategic direction for what it will do to contribute to the delivery of improved outcomes for Scotland's people, making Scotland a better place to live and a more prosperous and successful country. The strategy will display a clear sense of purpose and place and be effectively communicated to all staff and stakeholders. The strategy will show a clear direction of travel and will be led by Senior Staff in an open and inclusive leadership approach, underpinned by clear plans and strategies (aligned to resources) which reflect a commitment to continuous improvement.

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
NHS Fife acts in accordance with its values, positively promotes and measures a culture of ethical behaviours and encourages staff to report breaches of its values.	Whistleblowing Policy Code of Corporate Governance	**BOARD** **STAFF GOVERNANCE COMMITTEE**	Annual	Whistleblowing Champion appointed as a Board member Review of new National Whistleblowing Standards and preparation for their introduction Model Code of Conduct included in annually reviewed Code of Corporate Governance

APPENDIX 2

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
Resources required to achieve the strategic plan and operational plans e.g. finance, staff, asset base are identified and additional / changed resource requirements identified.	Financial Plan Workforce Plan Property & Asset Management Strategy	**FINANCE, PERFORMANCE & RESOURCES COMMITTEE** **STAFF GOVERNANCE COMMITTEE** **BOARD**	Annual Annual Annual Bi-annual Bi-monthly	Annual Operational Plan Financial Plan Workforce Plan Property & Asset Management Strategy Integrated Performance & Quality Report

GOVERNANCE AND ACCOUNTABILITY

The "Governance and Accountability" theme focuses on how a Best Value organisation achieves effective governance arrangements, which help support Executive and Non-Executive leadership decision-making, provide suitable assurances to stakeholders on how all available resources are being used in delivering outcomes and give accessible explanation of the activities of the organisation and the outcomes delivered.

OVERVIEW

A Best Value organisation will be able to demonstrate structures, policies and leadership behaviours which support the application of good standards of governance and accountability in how the organisation is improving efficiency, focusing on priorities and achieving value for money in delivering its outcomes. These good standards will be reflected in clear roles, responsibilities and relationships within the organisation. Good governance arrangements will provide the supporting framework for the overall delivery of Best Value and will ensure open-ness and transparency. Public reporting should show the impact of the organisations activities, with clear links between the activities and what outcomes are being delivered to customers and stakeholders. Good governance provides an assurance that the organisation has a suitable focus on continuous improvement and quality. Outwith the organisation, good governance will show itself through an organisational commitment to public performance reporting about the quality of activities being delivered and commitments for future delivery.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
Board and Committee decision-making processes are open and transparent.	Board meetings are held in open session and minutes are publically available. Committee papers and minutes are publically available.	**BOARD** **COMMITTEES**	Ongoing	Internet
Board and Committee decision-making processes are based on evidence that can show clear links between activities and outcomes	Reports for decision to be considered by Board and Committees should clearly describe the evidence underpinning the proposed decision.	**BOARD** **COMMITTEES**	Ongoing	SBAR reports EQIA forms

APPENDIX 2

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
NHS Fife can demonstrate that it has clear mechanisms for receiving feedback from staff and responds positively to issues raised.	Annual feedback Individual feedback	**CLINICAL GOVERNANCE COMMITTEE**	Annual Ongoing Quarterly Bi-monthly	Annual Review with Ministers Care Opinion Regular meetings with MPs/MSPs Integrated Performance & Quality Report

USE OF RESOURCES

The "Use of Resources" theme focuses on how a Best Value organisation ensures that it makes effective, risk-aware and evidence-based decisions on the use of all of its resources.

OVERVIEW

A Best Value organisation will show that it is conscious of being publicly funded in everything it does. The organisation will be able to show how its effective management of all resources (including staff, assets, information and communications technology (ICT), procurement and knowledge) is contributing to delivery of specific outcomes.

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
NHS Fife ensures that all employees are managed effectively and efficiently, know what is expected of them, their performance is regularly assessed and they are assisted in improving.	eKSF process and Executive and Senior Manager Performance reporting. Medical performance appraisal.	**STAFF GOVERNANCE COMMITTEE** **REMUNERATION COMMITTEE**	Annual and as required Bi-monthly	eKSF & iMatter reports Integrated Performance & Quality Report
NHS Fife understands and measures the learning and professional development required to support statutory and professional responsibilities and achieve organisational objectives and quality standards.	Medical revalidation report and monitoring Nursing revalidation.	**STAFF GOVERNANCE COMMITTEE**	Ongoing	Minutes of Staff Governance Committee

APPENDIX 2

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
Staff performance management recognises and monitors contribution to ensuring continuous improvement and quality.	Service Improvement and Quality are core dimensions of eKSF process. Executive and Senior Manager Objectives – core collective objectives include performance and leadership.	**STAFF GOVERNANCE COMMITTEE** **REMUNERATION COMMITTEE**	Ongoing	Minutes of Staff Governance Committee & Remuneration Committee

PERFORMANCE MANAGEMENT

The "Performance Management" theme focuses on how a Best Value organisation embeds a culture and supporting processes which ensures that it has a clear and accurate understanding of how all parts of the organisation are performing and that, based on this knowledge, it takes action that leads to demonstrable continuous improvement in performance and outcomes.

OVERVIEW

A Best Value organisation will ensure that robust arrangements are in place to monitor the achievement of outcomes (possibly delivered across multiple partnerships) as well as reporting on specific activities and projects. It will use intelligence to make open and transparent decisions within a culture which is action and improvement oriented and manages risk. The organisation will provide a clear line of sight from individual actions through to the National Outcomes and the National Performance Framework. The measures used to manage and report on performance will also enable the organisation to provide assurances on quality and link this to continuous improvement and the delivery of efficient and effective outcomes.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
Performance is systematically measured across all key areas of activity and associated reporting provides an understanding of whether the organisation is on track to achieve its short and long-term strategic, operational and quality objectives	Integrated Performance & Quality Report encompassing all aspects of operational performance, AOP targets / measures, and financial, clinical and staff governance metrics. The Board delegates to Committees the scrutiny of performance. Board receives full Integrated Performance & Quality Report and notification of any issues for escalation from Committees.	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance & Quality Report Code of Corporate Governance Minutes of Committees

APPENDIX 2

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
The Board and its Committees approve the format and content of the performance reports they receive.	The Board / Committees review the Integrated Performance & Quality Report and agree the measures.	**COMMITTEES** **BOARD**	Annual	Integrated Performance & Quality Report
Reports are honest and balanced and subject to proportionate and appropriate scrutiny and challenge from the Board and its Committees.	Committee Minutes show scrutiny and challenge when performance is poor as well as good, with escalation of issues to the Board as required	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance & Quality Report Minutes of Committees
The Board has received assurance on the accuracy of data used for performance monitoring.	Performance reporting information uses validated data.	**COMMITTEES** **BOARD**	Every meeting Annual	Integrated Performance & Quality Report Annual Accounts including External Audit report
NHS Fife's performance management system is effective in addressing areas of underperformance, identifying the scope for improvement, agreeing remedial action, sharing good practice and monitoring implementation.	Encompassed within the Integrated Performance & Quality Report	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance & Quality Report Minutes of Committees

CROSS-CUTTING THEME – SUSTAINABILITY

The "Sustainability" theme is one of the two cross-cutting themes and focuses on how a Best Value organisation has embedded a sustainable development focus in its work.

OVERVIEW

The goal of Sustainable Development is to enable all people throughout the world to satisfy their basic needs and enjoy a better quality of life without compromising the quality of life of future generations. Sustainability is integral to an overall Best Value approach and an obligation to act in a way which it considers is most sustainable is one of the three public bodies' duties set out in section 44 of the Climate Change (Scotland) Act 2009. The duty to act sustainably placed upon Public Bodies by the Climate Change Act will require Public Bodies to routinely balance their decisions and consider the wide range of impacts of their actions, beyond reduction of greenhouse gas emissions and over both the short and the long term.

The concept of sustainability is one which is still evolving. However, five broad principles of sustainability have been identified as:

- promoting good governance;
- living within environmental limits;
- achieving a sustainable economy;
- ensuring a stronger healthier society; and
- using sound science responsibly.

Individual Public Bodies may wish to consider comparisons within the wider public sector, rather than within their usual public sector "family". This will assist them in getting an accurate gauge of their true scale and level of influence, as well as a more accurate assessment of the potential impact of any decisions they choose to make.

A Best Value organisation will demonstrate an effective use of resources in the short-term and an informed prioritisation of the use of resources in the longer-term in order to bring about sustainable development. Public bodies should also prepare for future changes as a result of emissions that have already taken place. Public Bodies will need to ensure that they are resilient enough to continue to deliver the public services on which we all rely.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
NHS Fife promotes personal well-being, social cohesion and inclusion.	Healthy workforce	**STAFF GOVERNANCE COMMITTEE** **BOARD**	Ongoing	Well at Work Gold Award

APPENDIX 2

CROSS-CUTTING THEME – EQUALITY

The "Equality" theme is one of the two cross-cutting themes and focuses on how a Best Value organisation has embedded an equalities focus which will secure continuous improvement in delivering equality.

OVERVIEW

Equality is integral to all our work as demonstrated by its positioning as a cross-cutting theme. Public Bodies have a range of legal duties and responsibilities with regard to equality. A Best Value organisation will demonstrate that consideration of equality issues is embedded in its vision and strategic direction and throughout all of its work.

The equality impact of policies and practices delivered through partnerships should always be considered. A focus on setting equality outcomes at the individual Public Body level will also encourage equality to be considered at the partnership level.

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE:
NHS Fife meets the requirements of equality legislation.		**BOARD** **COMMITTEES**	Ongoing	EQIA section on all reports
The Board and senior managers understand the diversity of their customers and stakeholders.	Equality Impact Assessments are reported to the Board and Committees as required and identify the diverse range of stakeholders.	**BOARD** **COMMITTEES**	Ongoing	EQIA section on all reports
NHS Fife's Performance Management system regularly measures and reports its performance in contributing to the achievement of equality outcomes.		**STAFF GOVERNANCE**	Ongoing	Minutes

APPENDIX 2

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE:
NHS Fife ensures that all members of staff are aware of its equality objectives.	Induction Equality and Diversity is core dimension in eKSF Equality and Diversity Learn Pro Module	**STAFF GOVERNANCE**	Ongoing	iMatter reports eKSF reports Minutes
NHS Fife's policies, functions and service planning overtly consider the different current and future needs and access requirements of groups within the community.	In accordance with the Equality and Impact Assessment Policy, Impact Assessments consider the current and future needs and access requirements of the groups within the community.	**BOARD** **COMMITTEES**	Ongoing	Clinical Strategy EQIA section on reports
Wherever relevant, NHS Fife collects information and data on the impact of policies, services and functions on different equality groups to help inform future decisions.	In accordance with the Equality and Impact Assessment Policy, Impact Assessments will collect this information to inform future decisions.	**BOARD** **COMMITTEES**	Ongoing	EQIA section on reports

ANNUAL ASSURANCE STATEMENT

To the Director of Health and Social Care and the Chief Finance Officer

As Chief Internal Auditor of Fife Integration Joint Board (IJB), I am pleased to present my annual statement on the adequacy and effectiveness of corporate governance and the internal control systems of the Integration Joint Board for the year ended 31 March 2020.

Respective responsibilities of management and internal auditors in relation to corporate governance and internal control

Health and Social Care senior management is responsible for establishing an appropriate and sound system of corporate governance and internal control and monitoring the continuing effectiveness of these systems.

The Chief Internal Auditor is responsible for providing an annual overall assessment of the robustness of the corporate governance and internal control systems. However, only reasonable assurance can be given that control weaknesses or irregularities do not exist.

The IJB Audit and Risk Committee provides independent assurance on the adequacy of the risk management framework, the internal control environment and the integrity of the financial reporting and annual governance processes. In doing so, it places reliance on the NHS Fife and Fife Council systems of internal control that support compliance with each organisations' policies and promote achievement of each organisation's aims and objectives, as well as those of the IJB. By overseeing internal and external audit, the IJB Audit and Risk Committee plays a crucial role in ensuring effective assurance arrangements are in place.

Sound internal controls

The main objectives of the IJB's corporate governance and internal control systems are to:

- ensure development of and adherence to management policies and directives in order to achieve the IJB's objectives;
- safeguard assets;
- ensure the proper, economic, efficient and effective use of resources;
- secure the relevance, reliability and integrity of information, so ensuring as far as possible the completeness and accuracy of records and
- ensure compliance with statutory requirements.

A sound system of corporate governance and internal control reduces, but cannot eliminate, the possibility of:

- poor judgement;
- human error;
- control processes being deliberately circumvented by employees and others;
- management overriding controls;
- unforeseeable circumstances;
- failure to meet objectives or

- material errors, losses, fraud or breaches of law or regulations.

There are a number of areas of high-level control and direction across the IJB's activities which contribute positively to the standards of internal control in place, for example:

- ongoing development of a sound corporate governance framework, including initiation of a review of the Integration Scheme and the creation of the Integrated Transformation Board;
- a governance framework is in place, with further review of governance arrangements planned to follow the Integration Scheme review;
- a Strategic Risk Register, a Risk Management strategy and processes are in place, with further development planned to follow the Integration Scheme review.
- development of a medium-term financial strategy, and regular reviews of periodic and annual financial reports which indicate financial performance against forecasts;
- an approved strategic plan for the 2019-2022 and performance framework, with plans for improved performance reporting;
- unqualified annual accounts for the last 3 years (2016-17 was the first year of operational responsibilities);
- well-defined Chief Officer responsibilities and
- well-established IJB Audit and Risk Committee.

The work of internal audit

The IJB Chief Internal Auditor plays a critical role in delivering the IJB's strategic objectives by:

- championing best practice in governance;
- objectively assessing the adequacy of governance and management of existing risks;
- commenting on responses to emerging risks and proposed developments and
- giving an objective and evidence-based opinion on all aspects of governance, risk management and internal control.

Fife Council's Audit and Risk Management and the NHS FTF Audit Services, as IJB Internal Audit, provide the internal audit function for the IJB. Both operate in accordance with the Public Sector Internal Audit Standards which apply to Local Government. IJB Internal Audit undertakes an annual programme of work approved by the IJB Audit and Risk Committee based on a five-year strategic audit plan. The strategic audit plan is based on a formal risk assessment process and continually updated to reflect evolving risks and changes within the IJB.

An Internal Audit Output Sharing Protocol has been agreed between the IJB, Fife Council and FTF Audit and Management Services (NHS Fife) Chief to enable sharing of internal audit outputs in a controlled manner with Audit Committees for assurance purposes.

All IJB internal audit reports, including those identifying system weaknesses and/or non-compliance with expected controls, are issued to the Director of Health and Social Care, and copied to Divisional Managers, who are responsible for implementing all agreed recommendations in internal audit action plans.

The Chief Internal Auditor is responsible for determining whether appropriate action has been taken on internal audit recommendations or that management has understood and assumed the

risk of non-implementation. This is done by means of follow up procedures, and bi-annual reports to the IJB Audit and Risk Committee.

IJB internal audit reports are also issued to the IJB Audit and Risk Committee, the Chief Finance Officer and the External Auditor. Audit reports are provided to the Audit and Risk Committee for its scrutiny. Where necessary, the Audit and Risk Committee can seek further reports from the Director of Health and Social Care or the appropriate Divisional Manager.

Similar arrangements are in place both in NHS Fife and Fife Council, and the Chief Internal Auditor places reliance on any relevant work carried out by the internal audit functions of both organisations.

Basis of opinion

My evaluation of the control environment is informed by a number of sources:

- the assessment of risk completed during the preparation and updating of the IJB Strategic Audit Plan;
- internal audit work undertaken (in all three organisations) for the year to 31 March 2020, and work carried out in prior years with agreed improvements being implemented in that year or later;
- reports issued during the year by Audit Scotland;
- my knowledge of the IJB's governance, risk management and performance monitoring arrangements.

The level of assurance provided for the year ended 31 March 2020 by the audit work undertaken is not limited by the onset of COVID-19 as all audit fieldwork was completed in the year. In addition to the completed audit referenced in this report, cognisance has been taken of an audit where audit fieldwork was complete and findings discussed with the Service, but the current ongoing circumstances have not allowed progression to issue of a final report.

Audit Findings

Internal and External Audit findings provide evidence that the Health and Social Care Integration Joint Board is developing a sound system of corporate governance and internal control which is appropriately monitored and reviewed.

The internal and external audits carried out in 2019/20 identified that, overall, processes and procedures had met the control requirements, or are working towards them, and revealed only relatively minor non-compliance or system weakness. Where audits identify processes where control objectives have not been fully achieved or there is a lack of compliance, action is agreed to address these areas for improvement.

Key findings include

- The Risk Management review identified the need for clarity on whether development of a shared risk management strategy has been delegated to the IJB, and the need for a timetable to drive completion of the risk review actions. Completion of the IJB Risk

Management audit report action plan is awaiting the outcome of the IJB Integration Scheme review, as it will influence the action required.

- The IJB Governance Follow Up highlighted that risk management guidance for managers is still in draft, and that work on obtaining best value should be specifically recognised in Finance and Performance reports. The Governance Manual and the Medium Term Financial Strategy have now been completed, although further work is required to update the governance documents of the former, and the latter's approval has been delayed by COVID-19. However, a holding budget was approved by the IJB in March, and this also included approval ,on a holding basis, of the Medium Term Financial Strategy.

In addition, my opinion on the level of internal controls takes the following into account:

- the findings of Section 102 report requested by the Controller of Audit in relation to financial management and sustainability, slow progress in embedding good governance and management arrangements, and lack of progress in development of transformation and best value arrangements. Good progress has been made towards strengthening financial management. There has been a £3m reduction in the overspend this year, a Medium Term Financial Strategy has been developed and there is clear directional change towards financial sustainability. There is now a financial monitoring oversight board which considers recruitment, cross cutting and other lower level spend.
- However, further work is still required by the IJB, in conjunction with the Fife Council and NHS Fife in relation to addressing accountability, assurance and governance, clarity over the ownership of risks regarding delegated services, and to drive transformation change through collaborative relationships with Fife Council and NHS Fife. Latterly, progress has been impacted by the need to prioritise the COVID-19 response.
- In 2018/19, directions provided to FC and NHS Fife to carry out each of the functions delegated to IJB related only to financial allocations. In the last year, work has been progressed in terms of directions and there has been development in terms of non-financial directions. The first non- financial direction was approved at the IJB in February in relation to the mental health strategy.
- The IJB Finance and Performance Committee approved the adoption of an IJB Best Value Framework on 31 January 2019, including an assessment on an annual basis on how the IJB has demonstrated best value on management of resources, effective leadership and strategic direction, performance management, joint working with partners, service review/continuous improvement, governance and accountability and engagement with community during the year. A revised Performance Management Framework was approved by Committee in December 2019. Work is ongoing on refining the information to be reported on and an annual assessment is yet to be performed.
- The IJB's management during the Covid-19 pandemic tested how well risk management and business continuity arrangements operated in an emergency response, with innovation, new processes and working in partnerships, and technology being embraced in order to mitigate risks. This was achieved using revised governance arrangements, leadership and implementation including virtual meetings, conference calls, and systems remote access. A paper presented to the IJB on 26 June 2020 considered staff reflections and lessons learned. This information has been shared with NHS Fife resilience forum and will be shared with Fife Council IMT.

Level of opinion

Overall, internal controls were operating well and continued improvements to processes are being made. As part of each audit, a detailed action plan improving controls was agreed, and the outcome monitored. Where control failings or weaknesses were identified, management responded well and have taken appropriate remedial action in line with an agreed, monitored action plan. Follow-up audits show that, whilst not all agreed actions are achieved within the agreed timescales, work is continuing to complete all the action points agreed.

In determining the level of opinion to be provided, I have had regard to five possible categories as detailed in Appendix 2

Opinion

It is my opinion that a medium level of control exists, and that reasonable assurance can be placed upon the adequacy and effectiveness of the Health and Social Care Integration Joint Board's systems of corporate governance and the internal control system in the year to 31 March 2020.

However, it should be noted that there has been good progress on financial management, indications of positive movement on the review of governance arrangements, and plans developed such as the Medium Term Financial Strategy, which if progressed, would allow for a medium/high grade in future.

Avril Cunningham
Service Manager, Audit and Risk Management Services, Fife Council
2 July 2020

Evaluation Criteria

1	**High** level of assurance / well controlled - clean opinion	**:**	internal control objectives have been met - any non-compliance or weaknesses are insignificant.
2	**Medium/high** level of assurance / adequately controlled - clean opinion or qualified opinion	**:**	internal control objectives have been met - any non-compliance or weaknesses are relatively minor and / or relate to specific areas.
3	**Medium** level of assurance / inadequately controlled - qualified opinion	**:**	control objectives have not been fully achieved - control weaknesses or non-compliance are relatively minor but have been identified in a number of areas.
4	**Low/medium** level of assurance - qualified opinion or adverse opinion	**:**	control objectives have not been met - significant or material non-compliance and/or control weaknesses have been identified.
5	**Low** level of assurance – adverse opinion	**:**	control objectives overall have not been met – systemic significant or material non-compliance and/or control weaknesses have been identified.

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**17 September 2020**
Title:	**Draft Audit & Risk Committee Annual Statement of Assurance 2019-20**
Responsible Non-Executive:	**Martin Black, Committee Chair**
Report Author:	**Gillian MacIntosh, Board Secretary**

1 Purpose

This is presented to the Board for:

- Assurance

This report relates to a:

- Legal requirement
- Local policy

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

- Effective

2 Report summary

2.1 Situation

All formal Committees of the NHS Board are required to provide an Annual Statement of Assurance for the NHS Board. The requirement for these statements is set out in the Code of Corporate Governance. The Audit & Risk Committee is invited to review the draft of this year's report and comment on its content, with a view to approving a final paper at the Committee's next meeting.

2.2 Background

Each Committee must consider its proposed Annual Statement at the first Committee meeting of the new financial year. In normal circumstances, this would be the May meeting of the Committee, but an extension has been granted for the formal approval of the Financial Statements due to the present circumstances of the pandemic. The timing of submission to the Committee reflects that extension to the normal deadlines.

2.3 Assessment

The annual reports from the Board's other committees are included in a previous agenda item and their content has been considered in the drafting of this report. In addition to recoding practical details such as membership and rates of attendance, the format of the report has been reviewed this year to include a more reflective and detailed section (Section 4) on agenda business covered in the course of 2019-20, with a view to improving the level of assurance given to the NHS Board.

2.3.1 Quality/ Patient Care

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

2.3.2 Workforce

N/A.

2.3.3 Financial

The production and review of year-end assurance statements are a key part of the financial year-end process.

2.3.4 Risk Assessment/Management

The identification and management of risk is an important factor in 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 Committee Chair and Director of Finance and takes account of any initial comments thus received.

2.4 Recommendation

The paper is provided for:

- **Approval** – subject to members' comments regarding any amendments necessary

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

ANNUAL STATEMENT OF ASSURANCE
FOR THE AUDIT & RISK COMMITTEE 2019/20

1. Purpose of Committee

1.1 The purpose of the Audit & Risk Committee is to provide the Board with assurance that the activities of Fife NHS Board are within the law and regulations governing the NHS in Scotland and that an effective system of internal control is maintained.

1.2 The duties of the Audit & Risk Committee are in accordance with the principles and best practice outlined in the Scottish Government Audit & Assurance Committee Handbook, dated April 2018.

2. Membership of Committee

2.1 During the financial year to 31 March 2020, membership of the Audit & Risk Committee comprised:

Mr Martin Black	Chair / Non-Executive Member
Ms Sinead Braiden	Non-Executive Member
Cllr David Graham	Stakeholder Member
Ms Janette Owens	Area Clinical Forum Representative
Mrs Margaret Wells	Non-Executive Member

2.2 The Committee may choose to invite individuals to attend the Committee meetings for the consideration of particular agenda items, but the Board Chief Executive, Director of Finance, Director of Nursing (as the lead for risk), Board Secretary, Chief Internal Auditor and statutory External Auditor are normally in routine attendance at Committee meetings. Other attendees, deputies and guests are recorded in the individual minutes of each Committee meeting.

3. Meetings

3.1 The Committee met on five occasions during the year to 31 March 2020, on the undernoted dates:

- 16 May 2019
- 20 June 2019
- 5 September 2019
- 9 January 2020
- 13 March 2020

3.2 The attendance schedule is attached at Appendix 1.

4. Business

4.1 As the 2019/20 Financial Year drew to a close, the Covid-19 pandemic required an unprecedented mobilisation effort on behalf of NHS Fife in order to address the developing public health emergency. As cases of coronavirus increased and the Board subsequently placed on an emergency footing, staff responded with professionalism, speed and agility, effecting major service changes in an extremely short timescale. This report is written against that background, with the knowledge that the Committee's future schedule of business will adapt appropriately to reflect on the Board's ongoing response to Covid-19. Issues to consider in the forthcoming year

will include ongoing implications for the Board's strategic planning and risk management processes, as services begin to be remobilised and redesigned.

4.2 Minutes of Committee meetings have been approved by the Committee and presented to Fife NHS Board. The Board also receives a verbal update at each meeting from the Chair, highlighting any key issues discussed by the Committee at its preceding meeting. The Committee maintains an action register to record and manage actions agreed from each meeting, and reviews progress against deadline dates at subsequent meetings.

4.3 The range of business covered at the meeting demonstrates that the full range of matters identified in the Audit & Risk Committee's remit is being addressed. In line with its Constitution and Terms of Reference, the Committee has considered standing agenda items concerned with the undernoted aspects:

- Internal Control mechanisms;
- Internal & External Audit;
- Corporate Governance, including implementation of and compliance with the NHSScotland *Blueprint for Good Governance*;
- updates to the NHS Fife Code of Corporate Governance and the Board's Standing Orders;
- scrutiny of the Board's Annual Financial Accounts;
- Risk Management, including the Board Assurance Framework; and
- other relevant matters arising during the year.

4.4 In relation to the internal audit function, the Committee received information on the external quality evaluation of the FTF Internal Audit service, in accordance with Public Sector Internal Audit Standards. As key stakeholders and as part of the validated self-assessment exercise, Committee members were invited to submit a review questionnaire on the quality of the service provided. The final External Quality Assessment report and related action plan were considered by the Committee at its meeting in May 2019.

4.5 Members have reviewed and discussed in detail at meetings the annual audit plans; reports from the internal auditors covering a range of service areas; and management's progress in completing audit actions raised. In relation to the latter, the Committee has noted that further work is required to enhance the effectiveness and timeliness of completing audit recommendations, to reduce the number of outstanding actions, and the Director of Finance has undertaken to improve this as a priority action in the current year. At the January 2020 Audit & Risk Committee, it was agreed that any audit report which is categorised as Limited Assurance or No Assurance will be reported in full to the Audit & Risk Committee, with the Lead Executive Director invited to attend, to improve scrutiny of improvement activities required.

4.6 In reference to External Audit, the Committee has considered in detail the annual audit plan and the annual audit report. The annual audit report includes a report to those charged with governance on matters arising for the audit of the annual financial statements, as well as comment on financial sustainability, governance and best value. The Committee has also considered national reviews undertaken by Audit Scotland, including their report 'NHS in Scotland 2019', and its implications locally.

4.7 For assurance purposes, the Audit & Risk Committee has received and considered the annual assurance statements of each of the governance committees of the Board, namely: Clinical Governance Committee; Finance, Performance & Resources Committee; Remuneration Committee; and Staff Governance Committee. These detail the activity of each committee during the year and the business they have considered in discharging their respective remit. No significant issues were identified for disclosure in the financial statements. In reference to the assurance statement received from the Integration Joint Board, the findings of Section the 102 report requested by the Controller of Audit were highlighted. These were in relation to financial

management and sustainability of the Partnership; slow progress in embedding good governance and management arrangements; and lack of progress in development of transformation and best value arrangements. Improvements in these areas will be a high priority in the forthcoming year.

4.8 On behalf of the Board, the Audit & Risk Committee receives regular updates on the workstreams being progressed within NHS Fife for compliance with the NHSScotland *Blueprint for Good Governance*. NHS Fife's induction approach for new Non-Executive members has been recognised as best practice and has informed a model rolled out nationally via a Director's Letter to all Boards. In the reporting year, the Committee has considered the work being undertaken on the implementation of Model Standing Orders for the Board and a new covering template for Board agenda papers, which is part of the national work ongoing to develop a suite of standard documentation on a 'Once for Scotland' approach. NHS Fife, via the Board Secretary, is engaged in current work reviewing the Terms of Reference for Standing Committees, which is expected to result in new guidance being issued once this work is completed.

4.9 Over the year, members received an update on the implementation of a new Performance & Accountability Framework across NHS Fife, welcoming the structured, transparent and systematic approach to ensure the robust delivery of standards and targets across the areas of (i) Finance; (ii) Operational Performance; (iii) Quality; and (iv) Workforce.

4.10 Progress with fraud cases and counter fraud initiatives were discussed by the Committee in private session on a regular basis throughout the year. The Committee received quarterly fraud updates, which provided members with updates on NHS Fife fraud cases, counter fraud training delivered to staff, initiatives undertaken to identify and address fraud, and the work carried out by Practitioner & Counter Fraud Services in relation to detecting, deterring, disabling and dealing with fraud in the NHS. This has provided the Committee with the assurance that the risk of fraud is being managed and addressed across NHS Fife.

4.11 During the year, members of the Committee have engaged in a number of training opportunities, covering best practice arrangements for Audit & Risk Committees. A discussion session with the Internal and External Auditors was held in March 2020, outlining the year-end processes each undertake as part of the review of the financial statements and systems of internal control. A follow-up training session covering the annual accounts scrutiny process has been scheduled for September 2020, prior to the Committee's formal consideration of the 2019-20 financial statements.

5. Best Value

5.1 Since 2013/14 the Board has been required to provide overt assurance on Best Value. A revised Best Value Framework was considered and agreed by the NHS Board in January 2018. Appendix 3 provides evidence of where and when the Committee considered the relevant characteristics during 2019/20.

6. Risk Management

6.1 All NHS Boards are subject to the requirements of the Scottish Public Finance Manual (SPFM) and must operate a risk management strategy in accordance with the relevant guidance issued by Scottish Ministers. The general principles for a successful risk management strategy are set out in the SPFM.

6.2 In line with the Board's agreed risk management arrangements, the Audit & Risk Committee, as a governance committee of the Board, has considered risk through a range of reports and scrutiny, including oversight on the detail of the Board Assurance Framework. Progress and appropriate actions were noted, and a number of changes to mitigating and operational risks amended, including those to reflect external developments such as Brexit. A stand-alone eHealth BAF was introduced during the year and is currently being used to pilot a new Risk Assurance Mapping

process, which work is being taking forward in tandem with a number of other territorial boards. This work also intends to encompass the assurances required yearly from Executive Directors and the annual assurance reporting to the Board via its Committees.

6.3 The Committee received updates on activity related to the risk management workplan, including the ongoing discussions with Board members to determine the Board's risk appetite thresholds, in delivery of the risk management framework. A short-life working group, involving all Board standing Committee Chairs, was established in 2018 to help formalise a set of risk appetite statements and to define definitions of risk appetite and risk tolerance. This completed its work in the reporting year, as presented to the Board's Development Session in October 2019. Specific responsibilities and processes relating to all aspects of the Board's risk appetite and tolerance will be described in the updated version of the Risk Management Framework to be presented to the Committee and the Board in September 2020, with a plan developed to support implementation. The updated Risk Management Framework will also include a new suite of Key Performance Indicators and the process for formal reporting through the governance structure.

7. Self Assessment

7.1 The Committee has undertaken a self assessment of its own effectiveness, utilising a revised questionnaire considered and approved by the Committee Chair. Attendees were also invited to participate in this exercise, which was carried out via an easily-accessible online portal. A report summarising the findings of the survey was considered and approved by the Committee at its March 2020 meeting, and action points are being taken forward at both Committee and Board level.

8. Conclusion

8.1 As Chair of the Audit & Risk Committee during financial year 2019/20, I am satisfied that the integrated approach, the frequency of meetings, the breadth of the business undertaken and the range of attendees at meetings of the Committee has allowed us to fulfil our remit as detailed in the Code of Corporate Governance. As a result of the work undertaken during the year, I can confirm that adequate and effective governance arrangements were in place throughout NHS Fife during the year. Audit & Risk Committee members conclude that they have given due consideration to the effectiveness of the systems of internal control in NHS Fife, have carried out their role and discharged their responsibilities on behalf of the Board in respect of the Committee's remit as described in the Standing Orders.

8.2 I can confirm that that there were no significant control weaknesses or issues at the year end which the Committee considers should be disclosed in the Governance Statement, as they may have impacted financially or otherwise in the year or thereafter.

8.4 I would pay tribute to the dedication and commitment of fellow members of the Committee and to all attendees. I would thank all those members of staff who have prepared reports and attended meetings of the Committee.

Signed: _____ Date: _____

Martin Black, Chair
On behalf of the Audit & Risk Committee

Appendix 1 – Attendance Schedule
Appendix 2 – Best Value

AUDIT & RISK COMMITTEE
ATTENDANCE RECORD 2019/20

	16.05.19	20.06.19	05.09.19	09.01.20	13.03.20
Mr M Black	√	√	√	√	√
Ms S Braiden	√	√	√	√	√
Mrs J Owens	√	√	√	√	x
Cllr D Graham	√	√	x	√	√
Ms M Wells	√	√	x	√	√

In attendance

Mr P Hawkins, Chief Executive (until 27 January 2020)	✓	✓	x	✓	
Mrs C Potter, Director of Finance (until 27 January 2020) / Chief Executive (from 28 January 2020)	✓	✓	✓	✓	x
Mrs M McGurk, Director of Finance (from 3 February 2020)					✓
Ms H Buchanan, Director of Nursing	✓	✓	✓	✓	x
Dr G MacIntosh, Board Secretary	✓	✓	✓	✓	✓
Mr T Gaskin, Chief Internal Auditor	x	✓	x	✓	x
Mr B Hudson, Regional Audit Manager, Fife	✓	x	✓	✓	✓
Mr A Brown, Principal Auditor		✓			
Ms Z Headridge, Audit Scotland					✓
Mr B Howarth, Audit Scotland		✓			
Mrs P Fraser, Audit Scotland					✓
Mrs P Tate, Audit Scotland	✓	✓			
Mr A Croxford, Thomson Cooper (Annual Accounts Endowments)		✓			

APPENDIX 2

BEST VALUE FRAMEWORK

Vision and Leadership

A Best Value organisation will have in place a clear vision and strategic direction for what it will do to contribute to the delivery of improved outcomes for Scotland's people, making Scotland a better place to live and a more prosperous and successful country. The strategy will display a clear sense of purpose and place and be effectively communicated to all staff and stakeholders. The strategy will show a clear direction of travel and will be led by Senior Staff in an open and inclusive leadership approach, underpinned by clear plans and strategies (aligned to resources) which reflect a commitment to continuous improvement.

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
The Board has identified the risks to the achievement of its strategic and operational plans are identified together with mitigating controls.	Each strategic risk has an Assurance Framework which maps the mitigating actions/risks to help achieve the strategic and operational plans. Assurance Framework contains the overarching strategic risks related to the strategic plan.	**COMMITTEES** **AUDIT & RISK COMMITTEE** **BOARD**	Bi-monthly 5 times per year 2 times per year	Board Assurance Framework (to FP&R/CG/SG Committees) Board Assurance Framework (to A&R Committee) Board

GOVERNANCE AND ACCOUNTABILITY

The “Governance and Accountability” theme focuses on how a Best Value organisation achieves effective governance arrangements, which help support Executive and Non-Executive leadership decision-making, provide suitable assurances to stakeholders on how all available resources are being used in delivering outcomes and give accessible explanation of the activities of the organisation and the outcomes delivered.

OVERVIEW

A Best Value organisation will be able to demonstrate structures, policies and leadership behaviours which support the application of good standards of governance and accountability in how the organisation is improving efficiency, focusing on priorities and achieving value for money in delivering its outcomes. These good standards will be reflected in clear roles, responsibilities and relationships within the organisation. Good governance arrangements will provide the supporting framework for the overall delivery of Best Value and will ensure open-ness and transparency. Public reporting should show the impact of the organisations activities, with clear links between the activities and what outcomes are being delivered to customers and stakeholders. Good governance provides an assurance that the organisation has a suitable focus on continuous improvement and quality. Outwith the organisation, good governance will show itself through an organisational commitment to public performance reporting about the quality of activities being delivered and commitments for future delivery.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
Board and Committee decision-making processes are open and transparent.	Board meetings are held in open session and minutes are publically available. Committee papers and minutes are publically available	**BOARD** **COMMITTEES**	On going	Internet Intranet
Board and Committee decision-making processes are based on evidence that can show clear links between activities and outcomes	Reports for decision to be considered by Board and Committees should clearly describe the evidence underpinning the proposed decision.	**BOARD** **COMMITTEES**	Ongoing	SBAR reports EQIA forms

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
NHS Fife has a robust framework of corporate governance to provide assurance to relevant stakeholders that there are effective internal control systems in operation which comply with the SPFM and other relevant guidance.	Explicitly detailed in the Governance Statement.	**AUDIT & RISK COMMITTEE** **BOARD**	Annual Annual Ongoing	Code of Corporate Governance review Annual Assurance statements Compliance with NHS Scotland Blueprint

USE OF RESOURCES

The “Use of Resources” theme focuses on how a Best Value organisation ensures that it makes effective, risk-aware and evidence-based decisions on the use of all of its resources.

OVERVIEW
A Best Value organisation will show that it is conscious of being publicly funded in everything it does. The organisation will be able to show how its effective management of all resources (including staff, assets, information and communications technology (ICT), procurement and knowledge) is contributing to delivery of specific outcomes.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
NHS Fife maintains an effective system for financial stewardship and reporting in line with the SPFM.	Statutory Annual Accounts process	**AUDIT & RISK COMMITTEE**	Annual	Statutory Annual Accounts Assurance Statements SFIs
NHS Fife understands and exploits the value of the data and information it holds.	Annual Operational Plan Integrated Performance & Quality Report	**BOARD** **COMMITTEES**	Annual Bi-monthly	Annual Operational Plan Integrated Performance & Quality Report

PERFORMANCE MANAGEMENT

The “Performance Management” theme focuses on how a Best Value organisation embeds a culture and supporting processes which ensures that it has a clear and accurate understanding of how all parts of the organisation are performing and that, based on this knowledge, it takes action that leads to demonstrable continuous improvement in performance and outcomes.

OVERVIEW

A Best Value organisation will ensure that robust arrangements are in place to monitor the achievement of outcomes (possibly delivered across multiple partnerships) as well as reporting on specific activities and projects. It will use intelligence to make open and transparent decisions within a culture which is action and improvement oriented and manages risk. The organisation will provide a clear line of sight from individual actions through to the National Outcomes and the National Performance Framework. The measures used to manage and report on performance will also enable the organisation to provide assurances on quality and link this to continuous improvement and the delivery of efficient and effective outcomes.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
Performance is systematically measured across all key areas of activity and associated reporting provides an understanding of whether the organisation is on track to achieve its short and long-term strategic, operational and quality objectives	Integrated Performance & Quality Report encompassing all aspects of operational performance, AOP targets / measures, and financial, clinical and staff governance metrics. The Board delegates to Committees the scrutiny of performance Board receives full Integrated Performance & Quality Report and notification of any issues for escalation from Committees.	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance & Quality Report Code of Corporate Governance Minutes of Committees

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
The Board and its Committees approve the format and content of the performance reports they receive	The Board / Committees review the Integrated Performance Report and agree the measures.	**COMMITTEES** **BOARD**	Annual	Integrated Performance Report
Reports are honest and balanced and subject to proportionate and appropriate scrutiny and challenge from the Board and its Committees.	Committee Minutes show scrutiny and challenge when performance is poor as well as good; with escalation of issues to the Board as required	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance & Quality Report Minutes of Committees
The Board has received assurance on the accuracy of data used for performance monitoring.	Performance reporting information uses validated data.	**COMMITTEES** **BOARD**	Every meeting Annual	Integrated Performance & Quality Report Annual Accounts including External Audit report
NHS Fife's performance management system is effective in addressing areas of underperformance, identifying the scope for improvement, agreeing remedial action, sharing good practice and monitoring implementation.	Encompassed within the Integrated Performance & Quality Report	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance & Quality Report Minutes of Committees

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
NHS Fife overtly links Performance Management with Risk Management to support prioritisation and decision-making at Executive level, support continuous improvement and provide assurance on internal control and risk.	Board Assurance Framework	**AUDIT & RISK COMMITTEE** **BOARD**	Ongoing	Board Assurance Framework Minutes of Committees

CROSS-CUTTING THEME – SUSTAINABILITY

The "Sustainability" theme is one of the two cross-cutting themes and focuses on how a Best Value organisation has embedded a sustainable development focus in its work.

OVERVIEW

The goal of Sustainable Development is to enable all people throughout the world to satisfy their basic needs and enjoy a better quality of life without compromising the quality of life of future generations. Sustainability is integral to an overall Best Value approach and an obligation to act in a way which it considers is most sustainable is one of the three public bodies' duties set out in section 44 of the Climate Change (Scotland) Act 2009. The duty to act sustainably placed upon Public Bodies by the Climate Change Act will require Public Bodies to routinely balance their decisions and consider the wide range of impacts of their actions, beyond reduction of greenhouse gas emissions and over both the short and the long term. The concept of sustainability is one which is still evolving. However, five broad principles of sustainability have been identified as:

- promoting good governance;
- living within environmental limits;
- achieving a sustainable economy;
- ensuring a stronger healthier society; and
- using sound science responsibly.

Individual Public Bodies may wish to consider comparisons within the wider public sector, rather than within their usual public sector "family". This will assist them in getting an accurate gauge of their true scale and level of influence, as well as a more accurate assessment of the potential impact of any decisions they choose to make. A Best Value organisation will demonstrate an effective use of resources in the short-term and an informed prioritisation of the use of resources in the longer-term in order to bring about sustainable development. Public bodies should also prepare for future changes as a result of emissions that have already taken place. Public Bodies will need to ensure that they are resilient enough to continue to deliver the public services on which we all rely.

REQUIREMENT	**MEASURE / EXPECTED OUTCOME**	**RESPONSIBILITY**	**TIMESCALE**	**OUTCOME / EVIDENCE**
NHS Fife can demonstrate that it is making a contribution to sustainable development by actively considering the social, economic and environmental impacts of activities and decisions both in the shorter and longer term.	Sustainability and Environmental report incorporated in the Annual Accounts process.	**AUDIT & RISK COMMITTEE** **BOARD**	Annual	Annual Accounts Climate Change Template

CROSS-CUTTING THEME – EQUALITY

The "Equality" theme is one of the two cross-cutting themes and focuses on how a Best Value organisation has embedded an equalities focus which will secure continuous improvement in delivering equality.

OVERVIEW
Equality is integral to all our work as demonstrated by its positioning as a cross-cutting theme. Public Bodies have a range of legal duties and responsibilities with regard to equality. A Best Value organisation will demonstrate that consideration of equality issues is embedded in its vision and strategic direction and throughout all of its work.

The equality impact of policies and practices delivered through partnerships should always be considered. A focus on setting equality outcomes at the individual Public Body level will also encourage equality to be considered at the partnership level.

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE:
NHS Fife meets the requirements of equality legislation.		**BOARD** **COMMITTEES**	Ongoing	EQIA form on all reports
The Board and senior managers understand the diversity of their customers and stakeholders.	Equality Impact Assessments are reported to the Board and Committees as required and identify the diverse range of stakeholders.	**BOARD** **COMMITTEES**	Ongoing	EQIA form on all reports
NHS Fife's policies, functions and service planning overtly consider the different current and future needs and access requirements of groups within the community.	In accordance with the Equality and Impact Assessment Policy, Impact Assessments consider the current and future needs and access requirements of the groups within the community.	**BOARD** **COMMITTEES**	Ongoing	Clinical Strategy EQIA forms on reports

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE:
Wherever relevant, NHS Fife collects information and data on the impact of policies, services and functions on different equality groups to help inform future decisions.	In accordance with the Equality and Impact Assessment Policy, Impact Assessments will collect this information to inform future decisions.	**BOARD** **COMMITTEES**	Ongoing	EQIA forms on reports

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**17 September 2020**
Title:	**Scottish Government Portfolio Audit & Risk Committee: Significant Issues that are considered to be of wider interest / Draft Governance Statement**
Responsible Executive:	**Margo McGurk, Director of Finance**
Report Author:	**Robert MacKinnon, Associate Director of Finance**

1 Purpose

This is presented for:

- Approval

2 Report summary

2.1 Situation

The Audit & Risk Committee of NHS Fife has a responsibility to ensure any significant issues that are considered to be of wider interest are brought to the attention of the Scottish Government Portfolio Audit & Risk Committee.

2.2 Background

This is an annual return made by all NHS Board Audit & Risk Committees and follows the agreed format as detailed in the Scottish Public Finance Manual (SPFM) and the letter from the Health Finance Directorate dated 15 July 2020 (Annex 1). The report is informed by the assurances received to support the Accountable Officer's Annual Governance Statement, note the latter is in draft until the Statutory Annual Accounts for 2019/20 are finalised through the external audit process. For 2019/20 there were also 2 further Finance Guidance Notes issued to ensure that changes to internal Board processes, as a result of COVID 19, were appropriately reflected in the Significant Issues return and the Governance Statement.

2.3 Assessment

2.3.1 The letter is set out at Annex 2 with the Governance Statement as a supporting attachment.

2.3.2 Workforce

The Governance Statement reflects the control environment supporting staff governance.

2.3.3 Financial

The Governance Statement reflects the control environment supporting financial governance.

2.3.4 Risk Assessment/Management

The Governance Statement reflects the effectiveness of risk management arrangements operating across the organisation.

2.3.5 Equality and Diversity, including health inequalities

No specific issues to report regarding equality and diversity.

2.3.6 Other impact

N/A.

2.3.7 Communication, involvement, engagement and consultation

Appropriate communication, involvement, engagement and consultation within the organisation and with key external stakeholders was conducted in the preparation of the paper.

2.3.8 Route to the Meeting

A draft of the letter was approved by the Chair of the Audit & Risk Committee on 1 September to permit a draft submission to the Scottish Government.

2.4 Recommendation

The paper is provided for: **Approval**

The Committee is invited to review the letter and the draft Governance Statement to inform approval of the response to Scottish Government.

3 List of appendices

- Annex 1 – Letter dated 15 July 2020 from Health Finance, Corporate Governance & Value Directorate Richard McCallum, Interim Director
- Annex 2 – Draft Response Letter dated 1 September 2020 from Martin Black, Chair of NHS Fife Audit & Risk Committee

Report Contact
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Richard McCallum, Interim Director

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NHS Board Chairs
Chair, Mental Welfare Commission

Copied to:
NHS Board Chief Executives
Chief Executive, Mental Welfare Commission
NHS Board Directors of Finance
Head of Corporate Services, Mental Welfare Commission

15th July, 2020

Dear Chair

SIGNIFICANT ISSUES THAT ARE CONSIDERED TO BE OF WIDER INTEREST

The guidance in the Scottish Public Finance Manual (SPFM) requires Audit Committees of NHS Scotland Boards to notify the Scottish Government portfolio Audit and Risk Committee of any significant issues that are considered to be of wider interest.

https://www.gov.scot/publications/scottish-public-finance-manual/audit-committees/audit-committees/

The Chair of your Board's Audit Committee should provide details of any significant issues of fraud which arose during 2019-20 which they consider should be brought to the attention of the Health and Social Care Assurance Board.

This should be informed by the assurances received to support the Governance Statement in your Board's Annual Accounts and it is therefore appropriate for the Audit Committee to consider this statement at the same time as the Accounts and the Governance Statement. We recognise that, due to the impact of the COVID-19 response, this letter is being issued later than in previous years and that some Audit Committees may have considered and approved significant issue returns in advance of the receipt of this letter. Where this is the case, Chairs are asked to consider if any of the matters set out in this letter require to be included and – if so – to make a short supplementary return.

Audit committees have a role in providing the assurance required to underpin the governance statement provided by the Principal Accountable Officer (the Scottish Government Permanent Secretary) as part of the consolidated accounts of the Scottish Government. Your Board's Audit Committee is therefore required, at the earliest opportunity, to notify the Health and Social Care Assurance Board if it considers that it has identified a significant problem which may have wider implications. The Health and Social Care Assurance Board will in turn report relevant issues to the Scottish Government Assurance and Audit Committee.

COVID-19 – revised guidance

Two Finance Guidance Notes (FGNs) have been issued by Scottish Government and should be read alongside the SPFM to ensure that changes to internal processes, as a result of COVID-19, are appropriately reflected in 2019-20 significant issues letters and Governance Statements.

FGN2020/03	COVID-19 Accountable Officer Guidance and Funding Ask Template	March 2020
FGN2020/04	COVID-19 - short-term changes to approval process for operational property transactions	April 2020

In addition, Boards should refer to:

- my letter of 20 March (and subsequent correspondence) on Mobilisation Plans; and
- my letters of 25 March and 11 June (as appropriate) requesting detail on temporary changes to governance and the rationale for these changes.

All statements **including a copy of the governance statement** should be submitted by **31 August 2020**, in line with draft accounts submission per the revised timetable, to nhsaccounts@gov.scot.

Please do not hesitate to contact Beth Grieve (bethany.grieve@gov.scot) if you require further information.

Yours faithfully

Richard McCallum
Interim Director of Health Finance and Governance

Fife NHS Board

DRAFT

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Interim Director of Health Finance & Infrastructure
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EH1 3DG

Date	1 September 2020
Your Ref	
Our Ref	RM/Martin Black/
Enquiries to	Mrs M McGurk
Extension	Ext 28139
Direct Line	01592 648139
Email	margo.mcgurk@nhs.scot

Dear Mr McCallum

SIGNIFICANT ISSUES THAT ARE CONSIDERED TO BE OF WIDER INTEREST

I refer to your letter dated 15 July 2020, addressed to the Chair of Fife NHS Board.

As Chair of the Audit and Risk Committee, I have considered this letter and agreed that a number of issues of potential wider significance are included within the Board's Governance Statement. A copy of the draft Governance Statement is, therefore, attached to this letter which will be considered formally at the Audit and Risk Committee when it meets on 17 September 2020.

In relation to 2019/20, I would highlight the following which supplement the disclosures included within the draft Governance Statement.

The Impact of COVID-19
With reference to the impact and response to the COVID-19 pandemic, I wish to advise that there will continue to be an impact in 2020/21. NHS Fife was on track to achieve the end of March milestones agreed with SGHSCD, however elective targets were impacted when the direction from SGHSCD was to step down all non-urgent elective activity to ensure adequate capacity for Covid-19 related admissions and treatments.

Turning to your **letters of 25 March and 11 June requesting detail on temporary changes to governance and the rationale for these changes,** further to the information in the Governance Statement and as per the Board's responses to your correspondence, from July 2020, regular meetings of the Board's Governance Committees have been reinstated, to consider prioritised business relating to COVID-19 and agenda items that otherwise need approval or discussion.

Regarding **Finance Guidance Note 2020/04, COVID-19 - short-term changes to approval process for operational property transactions**, the Board has not exercised any right under the COVID-19 guidance concerning property transactions and does not expect to.

In respect of **Finance Guidance Note 2020/03 - COVID-19 Accountable Officer Guidance and Funding Ask Template** and correspondence/returns around Mobilisation Plans, Local Mobilisation

Plans/returns with details of costs in line with Scottish Government reporting requirements and timescales were submitted.

For 2020/21, the performance set out in the Annual Operational Plan (AOP) submitted to SGHSCD in 2020 will require to be reviewed. The AOP has not been approved by Scottish Government, but is continually being reviewed with the Local Implementation Plans to form an addendum to the original AOP.

In line with this, the Board's overall strategy will require to be reviewed, ensuring that it is underpinned by the transformation programme. All of the supporting strategies will be reviewed to reflect a post Covid-19 environment, i.e. workforce, finance, digital, clinical. The strategies of the Integration Joint Board will be considered and formed together as part of the overall revised strategy.

Fraud and related matters
In addition whilst there have been no significant issues raised in respect of fraud, updates on fraud/potential fraud cases being investigated by Counter Fraud Services are reported to the Audit And Risk Committee at each meeting.

I trust that this letter will meet the reporting requirements. Please do not hesitate to contact myself or Margo McGurk, Director of Finance if you require any further information.

Yours sincerely

MARTIN BLACK
Fife NHS Board, Audit & Risk Committee Chair

Encl.

Appendix

Draft Governance Statement

Scope of Responsibility

As Accountable Officer, I am responsible for maintaining an adequate and effective system of internal control that supports compliance with the organisation's policies and promotes achievement of the organisation's aims and objectives, including those set by Scottish Ministers. Also I am responsible for safeguarding the public funds and assets assigned to the organisation. These financial statements consolidate the Fife Health Board Endowment Fund. This statement includes any relevant disclosure in respect of these Endowment Accounts.

Purpose of Internal Control

The system of internal control is based on an ongoing process designed to identify, prioritise and manage the principal risks facing the organisation. The system aims to evaluate the nature and extent of risks, and manage risks efficiently, effectively and economically.

The system of internal control is designed to manage rather than eliminate the risk of failure to achieve the organisation's aims and objectives. As such, it can only provide reasonable and not absolute assurance.

The process within the organisation accords with guidance from Scottish Ministers in the Scottish Public Finance Manual (SPFM) and supplementary NHS guidance, and has been in place for the year up to the date of approval of the annual report and accounts.

The SPFM is issued by Scottish Ministers to provide guidance to the Scottish Government and other relevant bodies on the proper handling and reporting of public funds. The SPFM sets out the relevant statutory, parliamentary and administrative requirements, emphasises the need for efficiency, effectiveness and economy, and promotes good practice and high standards of propriety.

Governance Framework

The Board has collective responsibility for health improvement, the promotion of integrated health and community planning through partnership working, involving the public in the design of healthcare services and staff governance.

Members of Health Boards, as detailed on page 12, are selected on the basis of their position, or the particular expertise, which enables them to contribute to the decision making process at a strategic level.

The Board meets every two months to progress its business and holds a Development Session in intervening months to discuss topical and strategic issues for NHS Fife. The Code of Corporate Governance, which is revised on an annual basis, identifies Committees and Sub-Committees that report to the Board to help it fulfil its duties.

These include the following governance Committees:

- Clinical Governance;
- Audit & Risk;
- Staff Governance;
- Remuneration; and
- Finance, Performance & Resources.

Clinical Governance Committee

Principal Function:
To provide the Board with the assurance that appropriate clinical governance mechanisms and structures are in place and effective throughout the whole of Fife Health Board's responsibilities, including health improvement activities.

Membership:
- Six Non-Executive or Stakeholder Members of the Board
- Chief Executive
- Medical Director
- Nurse Director
- Director of Public Health
- A Staff Side Representative of NHS Fife Area Partnership Forum
- One Representative from Area Clinical Forum
- One Patient Representative

Chair:
Dr Les Bisset, Non-Executive Board Member

Frequency of Meetings:
As necessary to fulfil its remit and not less than six times per year.

Audit and Risk Committee

Principal Function:
To provide the Board with the assurance that the activities of Fife Health Board are within the law and regulations governing the NHS in Scotland and that an effective system of internal control is maintained. The duties of the Audit and Risk Committee are in accordance with the Scottish Government Audit and Assurance Committee Handbook, dated March 2018, and associated Treasury guidance on assurance mapping.

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

Chair:
Martin Black, Non-Executive Board Member

Frequency of Meetings:
As necessary to fulfil its remit and not less than four times per year.

Staff Governance Committee

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

Membership:
- Four Non-Executive Members of the Board
- Employee Director (as a Stakeholder member of the Board by virtue of holding the Chair of the Area Partnership Forum)
- Chief Executive
- Nurse Director
- Staff Side Chairpersons of the Local Partnership Forums

Chair:
Margaret Wells, Non-Executive Board Member

Frequency of Meetings:
As necessary to fulfil its remit but not less than four times a year.

Remuneration Committee

Principal Function:
To consider and agree performance objectives and performance appraisals for staff in the Executive cohort, to oversee performance arrangements for designated senior managers, and to direct the appointment process for the Chief Executive and Executive Members of the Board.

Membership:
- Fife NHS Board Chairperson
- Two Non-Executive Members of the Board
- Chief Executive
- Employee Director

Chair:
Tricia Marwick, Chairperson of Fife NHS Board

Frequency of Meetings:
As necessary to fulfil its remit but not less than three times a year.

Finance, Performance & Resources Committee

Principal Function:
To keep under review the financial position and performance against key non-financial targets of the Board and to ensure that suitable arrangements are in place to secure economy, efficiency and effectiveness in the use of all resources, and that the arrangements are working effectively.

Membership:
- Six Non-Executive or Stakeholder Members of the Board
- Chief Executive
- Director of Finance
- Medical Director
- Director of Public Health
- Nurse Director

Chair:
Rona Laing, Non-Executive Board Member

Frequency of Meetings:
As necessary to fulfil its remit but not less than four times per year.

Other Governance Arrangements

The conduct and proceedings of the NHS Board are set out in its Standing Orders. These specify the matters which are solely reserved for the NHS Board to determine, the matters which are delegated under the scheme of delegation and the matters which are remitted to a Standing Committee of the NHS Board. In April 2020, the Board adopted the new Model Standing Orders for NHS Boards, created to support the implementation of the NHS Blueprint for Good Governance.

The Standing Orders also include the Code of Conduct that Board members must comply with, and, along with the Standing Financial Instructions, these documents are the focus of the NHS Board's Annual Review of Governance Arrangements. The annual review also covers the remits of the NHS Board's Standing Committees.

All committees of the Board are required to provide an Annual Statement of Assurance to the Audit & Risk Committee and Board, describing their membership, attendance, frequency of meetings,

business addressed, outcomes and assurances thus provided, Best Value, risk management and to demonstrate they have fully fulfilled their roles and remit. The format and content of these reports have been improved in the current year.

All NHS Board Executive Directors undertake a review of development needs as part of the annual performance management and development process. Access to external and national programmes in line with development plans and career objectives is also available.

Ongoing work to improve Board effectiveness builds on the proposals originally approved by the Board in 2017 and 2018, in relation to the Chair's review of governance arrangements in NHS Fife. It also reflects the requirements of the NHS Scotland Blueprint for Good Governance (https://learn.nes.nhs.scot/28418/board-development/blueprint-for-good-governance) that is presently being implemented across all Boards. In mapping the Board's arrangements for governance against the standards given in the national Blueprint, detailed consideration has been given as to whether the right systems are in place to provide appropriate levels of assurance and to identify areas where improvements can be made. In the current year, an internal audit review has been undertaken of NHS Fife's compliance with the Blueprint, with the conclusion that 'comprehensive assurance' can be taken from the implementation work progressed thus far.

During 2019, Board members were each invited to complete a diagnostic self-assessment questionnaire, to identify common themes and areas for improved effectiveness at Board-level. The outcome of the self-assessment process was presented to Board members at the April 2019 Development Session and, following discussion, an action plan approved at the May 2019 Board meeting. A progress update was considered by the Board in November 2019. A summary of the self-assessment process, noting the largely positive evaluation of governance arrangements in place in NHS Fife, can be found at the link below:

https://www.nhsfife.org/nhs/index.cfm?fuseaction=publication.pop&pubid=21E9E46E-A871-A7F2-8EE9149CDCDEF4AE

Each year, Board committees also undertake a detailed self-assessment exercise, via the format of an online questionnaire. Response rates frequently reach 100% of members and attendees. The regular review of Board committee effectiveness is an important tool in identifying areas where improvements can made, such as in enhancing training opportunities, and is an central part of the internal year-end assurance process.

The Chief Executive is accountable to the NHS Board through the Chair of the Board. The Remuneration Committee agrees the Chief Executive's annual objectives in line with the Board's strategic and corporate plans.

Non-executive Directors have a supported orientation to the organisation, as well as a series of development sessions. An enhanced induction programme has been established to support new members. This programme, developed originally by NHS Fife, has been used to create national guidance issued to all Boards across Scotland, as an example of best practice. Opportunities for ongoing member support also exist at a national level via the NHSScotland Board Development website (https://learn.nes.nhs.scot/17367/board-development) and related resources.

To ensure that the NHS Board complies with relevant legislation, regulations, guidance and policies, a distribution process is in place to ensure that all Circulars and communications received from the Scottish Government Health and Social Care Directorate (SGHSCD), internal policies and procedures, are directed to Senior Managers who are held responsible for implementation. An internal audit follow-up review of this process in the current year identified no material issues with its operation. A process to monitor compliance with regulations and procedures laid down by Scottish Ministers and the SGHSCD is in place.

In accordance with the principles of Best Value, the Board aims to foster a culture of continuous improvement. The Board Committees ensure Best Value is achieved through the Committees having Best Value written into their Terms of Reference and the annual work-plans. Directors and Managers are encouraged to review, identify and improve the efficient and effective use of resources.

NHS Fife has a Whistleblowing policy in place and a dedicated Whistleblowing Champion, Katy Miller, took up position on the Board as a full Non-Executive Member in February 2020. The Board's Staff Governance Committee has undertaken initial review of the draft National Whistleblowing Standards to be rolled out across all NHS Boards in 2020. The Board is committed to achieving the highest possible standards of service and the highest possible ethical standards in public life in all of its practices. To achieve these ends, it encourages staff to use internal mechanisms for reporting any malpractice or illegal acts or omissions by its staff. The Board wishes to create a working environment which encourages staff to contribute their views on all aspects of patient care and patient services. All staff have a duty to protect the reputation of the service they work within. The Board does not tolerate any harassment or victimisation of staff using this policy, and treats this as a serious disciplinary offence, which will be dealt with under the Board's Management of Employee Conduct policy.

There is in place a well-established complaints system whereby members of the public can make a formal complaint to the Board regarding care or treatment provided by or through the NHS, or how services in their local area are organised if this has affected care or treatment. Information on our complaints procedures is available on the NHS Fife website.

The Board is committed to working in partnership with staff, other public sector organisations and the third sector. NHS Fife strives to consult all of its key stakeholders. We do this in a variety of ways. How we inform, engage and consult with patients and the public in transforming hospitals and services is an important part of how we plan for the future. To fulfil our responsibilities for public involvement, we routinely communicate with, and involve, the people and communities we serve, to inform them about our plans and performance.

An Integrated Performance & Quality Report (IPQR) was presented to each Clinical Governance Committee, Finance, Performance & Resources Committee, Staff Governance Committee and Board meeting. This provides detailed monitoring information on a range of measures covering financial and clinical delivery. The NHS Board also considers at each meeting the most up-to-date information available in reference to the latest financial position. In addition, an Executive Summary is prepared for the NHS Board and incorporates all matters escalated by each Committee from its own review of the IPQR.

During 2019-20 the Board, as the Corporate Trustee for the Fife Health Board Endowment Funds, kept under review the overall governance for charitable funds, including the approach to the management and oversight of endowment funds, as well as the supporting business model.

Integration Joint Board (IJB)

Members of NHS Fife Board have a role on the Integration Joint Board and its Committees and therefore maintain an input and responsibility for their respective professional remits at all times. This is particularly relevant for the role of the Director of Health & Social Care as the Accountable Officer for the IJB and a direct report to the NHS Fife Chief Executive. The Chief Executive maintains responsibility for all aspects of governance relating to health services across Fife.

Minutes of the IJB are considered at the Clinical Governance Committee of the NHS Board and an annual assurance statement is also provided from the IJB's Chief Internal Auditor and the IJB's Clinical & Care Governance Committee to support the assurance process. The Integrated Performance & Quality Report encompasses all aspects of delegated services.

The approach adopted for health and social care within Fife is the 'fully delegated' model, with the IJB responsible for governance and assurance of all operational activities for its delegated functions. During 2019-20 the NHS Board and supporting governance committees have maintained an overarching assurance role in relation to both clinical and financial governance, and therefore oversight of the adequacy and effectiveness of controls for delegated functions. The operational and governance framework of the IJB will continue to be developed during 2020-21 to ensure clarity and consistency of approach.

In February 2020, the Accounts Commission published a Section 102 report on the Fife Integration Joint Board. The report highlighted significant concerns about the financial management and sustainability of the Partnership; the slow rate of progress in embedding good governance and

management arrangements; and lack of progress in development of transformation and best value arrangements. Some progress in addressing financial sustainability challenges and the establishment of improved financial planning was noted. Ongoing improvements in these areas will be a high priority for Partners and the IJB in the forthcoming year.

A joint review of the Fife Integration Scheme was scheduled to conclude by 31 March 2020. A number of changes to the current Scheme were agreed by the date; however, a number of areas (including the risk share arrangement) required further consideration. As a result of the Covid-19 pandemic the review was temporarily paused. The key stakeholders, NHS Fife, Fife Council and the IJB recommenced the review in May 2020 and it is expected that this will be concluded across the parties by the end of the calendar year. The IJB Chief Officer has advised the Scottish Government of this revised timeline for completion.

Review of Adequacy and Effectiveness

As Accountable Officer, I am responsible for reviewing the adequacy and effectiveness of the system of internal control. My review is informed by:

- Discussions with executive and senior managers who are responsible for developing, implementing and maintaining internal controls across their areas;
- Letters of Assurance from each Director;
- Reports from other inspection bodies;
- The work of the internal auditors, who submit to the Audit & Risk Committee regular reports, which include their independent and objective opinion on the effectiveness of risk management, control and governance processes, together with recommendations for improvement;
- Comments by the external auditors in their management letters and other reports;
- The completion of self-assessment questionnaires considering the Board's own performance and that of its Committees;
- The range of topics covered at Board Development sessions, to develop the knowledge and awareness of both Executive and Non-Executive Board members;
- The Board's agreed approach to Risk Management is established within the Governance Committees;
- The work of the other assurance Committees and groups supporting the Board: Staff Governance Committee, Remuneration Committee, Finance, Performance & Resources Committee, and the Clinical Governance Committee (which also embraces Information Governance);

Data Quality

The Board receives numerous reports which include detailed information covering financial, clinical and staffing information. In general these reports are considered by the Executive Directors Group and at a Governance Committee prior to being discussed at the Board. This allows for detailed consideration of the content, completeness and clarity of the information being provided to the Board.

Assurance on the information included in reports also comes from the overall approach to the management of information (through the Information Governance & Security Group) and validation processes and assurances on the quality of information provided from internal audit and other scrutiny bodies.

Risk Management

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

NHS Scotland bodies are subject to the requirements of the Scottish Public Finance Manual (SPFM) and must operate a risk management strategy in accordance with relevant guidance issued by Scottish Ministers. The general principles for a successful risk management strategy are set out in the SPFM.

All of the key areas within the organisation maintain a risk register. All risk registers are held on Datix (Risk Management Information System). Training and support for all Datix Modules are provided by the Risk Management team either through formal training sessions or customised training, e.g. for individuals, specialities and teams.

For the period 2019-20, the high level risks identified as having the potential to impact the delivery of NHS Fife's strategic objectives, and related operational high level risks, have been reported as part of the Board Assurance Framework (BAF), bi-monthly to the governance committees and thereafter to the Audit & Risk Committee and the Board.

The scope of the BAF has continued to evolve and now includes eHealth - Delivering Digital and Information Governance & Security. The latter was first reported to the NHS Fife Clinical Governance Committee on 6 November 2019.

As the BAF is the key source of evidence that links strategic objectives to risk and assurance, and the main tool that the Board uses in discharging its overall responsibility for internal control, it is essential that the committees and the Board can take confidence from the assurances provided or, in the absence of such assurances, challenge and seek further information or action.

The December 2018 Audit & Risk Committee meeting received a report on the requirements set out in the Scottish Public Finance Manual (SPFM) Audit Committee Handbook, revised in March 2018. The paper also referred to HM Treasury guidance on frameworks for assurance mapping. In considering the paper, the Committee agreed 'that ongoing work on reviewing the Board's corporate governance arrangements, in line with national proposals for Boards to adopt a 'model blueprint' of good corporate governance, would take cognisance of the guidance in the revised Handbook, particularly as relates to the effective operation of the Audit & Risk Committee in its approach to risk and assurance.'

In order to progress this work locally, it has been agreed that consideration should be given to developing an assurance map for NHS Fife, which would assist in the work to ensure risk management arrangements are sufficiently robust. In 2019-20, the four Boards covered by the FTF Internal Audit Service (Fife, Forth Valley, Lanarkshire and Tayside) set up a small working group involving members from each Board, to agree a proposed process for assurance mapping, together with associated documentation, templates and timescales. The attendees vary from Board Secretaries to Risk Managers. Three meetings have taken place to date thus far, in October and November 2019 and in late February 2020. Topics discussed included relevant guidance on risk mapping; the principles behind various mapping approaches; and the design of a template that could be used to test an exemplar risk from each Board based on the 'three lines of assurance' format. It was agreed that, in Fife, the exemplar risk for review would be the eHealth BAF and that the review would be facilitated by Internal Audit. An assurance mapping exercise commenced on the eHealth BAF in early 2020. This work has been delayed due to the Covid-19 pandemic but it is intended it will restart in the coming months. It is anticipated that this work and related learning will enhance our local processes and ensure the development of a more efficient and effective assurance framework.

The revised processes relating to the Corporate Risk Register will be approved as part of the update of the Risk Management Framework. The Code of Corporate Governance will be updated as necessary thereafter to reflect the revised arrangements.

The Audit & Risk Committee is responsible for reviewing the effectiveness of the organisational Risk Management framework. During 2019-20, risk management reports were provided to the Audit & Risk Committee by the Director of Nursing, as Lead Executive for Risk. These provided updates on the risk management workplan, including the implementation of the overall risk management framework.

During 2019-20, the work to develop the Board's risk appetite continued. A Board Risk Appetite Short Life Working Group identified a definition and methodology for classifying risk appetite. This work was further developed through consultation with the governance committees and at Board Development Sessions during 2019. The risk appetite classifications were agreed at the Board meeting on 27 November 2019. These will be reflected in the updated Risk Management Framework and a plan of work to support implementation is presently under development.

Risk Management Key Performance Indicators (KPIs) have been approved; these will be reported to the Audit & Risk Committee and the Clinical Governance Committee from September 2020.

Disclosures

Disclosures are required where there are any significant control weaknesses or issues which may have impacted financially or otherwise in the year or thereafter.

The following are highlighted:

- For 2019-20, 2595 individuals have exceeded the Treatment Time Guarantee to have their treatment provided within 12 weeks. A letter of apology was sent to each patient and every effort was made to treat patients in as short a time as possible. A Waiting Times Improvement Plan is being implemented and progress and improvement actions continues to be monitored through monthly performance reviews within the Acute Services Division.

- An unannounced Healthcare Environment Inspection (HEI) was conducted at Glenrothes Hospital in March 2019, the hospital having been last inspected in April 2014. The inspection reported on areas where NHS Fife was performing well and areas for improvement, identifying two areas of good practice and three requirements for improvement. During the visit the Board received positive feedback about the standards of cleanliness and staff knowledge of standard infection control precautions. It was, however, noted that not all staff were aware of and completed mandatory requirements for infection prevention and control education and that all patient equipment was safe and clean. An action plan was prepared in response to the areas for improvement identified, with all actions since completed. The published report can be accessed by the link below.

  http://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/hei_fife_reports/glenrothes_hospital_may_19.aspx

  A further unannounced inspection of Glenrothes Hospital, by Healthcare Improvement Scotland, was conducted in July 2020, focused on Safety and Cleanliness and Care of Older People in Hospital; publication of the report is expected in September 2020.

- There were 13 personal data related incidents or data protection breaches reported to the Information Commissioner's Office (ICO) during 2019/20 (2 breaches were reported in 2018/19). During 2019/20, NHS Fife was also required to record and report personal data breaches within GP Practices, as NHS Fife is now joint data controller of data held within GP Practices and provides Data Protection services to them. Of the 13 reports noted above, 5 related to GP practices; this explains part of the increased level of reported breaches from the previous year.

  Of the 13 reported in total, 8 related to confidentiality data breaches (4 in relation to NHS Fife and 4 in General Practice) and 5 related to the availability of data due to unplanned information system outages (4 in relation to NHS Fife and 1 in relation to General Practices). One of the 5 reported breaches in relation to availability of data for NHS Fife was rejected by the ICO as it pertained to a deceased person. For 11 of the remaining 12 reports submitted, the ICO took no further action but made a series of recommendations. One report remains outstanding at the time of writing.

  None of the reported breaches resulted in any patient harm or financial penalties being imposed. Good progress has been made during 2019/20 in implementing the Information Governance team business improvement plan, which supports the reporting process for this important area of information governance.

COVID-19 Pandemic – Governance Arrangements

In recognition of the challenges caused by the rapid mobilisation of services to address Covid-19, approval to revise governance arrangements across NHS Boards was given by the Scottish Government Director of Health Finance, Corporate Governance & Values in a letter to Board Chairs, dated 25 March 2020. Individual NHS Boards were invited to submit their specific proposals for governance during the pandemic period to the Office of the Chief Executive; NHS Fife returned their own submission on 30 March.

At the April 2020 Board meeting, NHS Fife Board members considered a paper outlining the Board's planned approach to governance whilst NHS Fife continued to deal with the Covid-19 pandemic, based on the principles contained in the submission made to the Scottish Government. The aims were to ensure that NHS Fife could:

- effectively respond to Covid-19, and at the same time appropriately discharge its governance responsibilities;
- maximise the time available for management and operational staff to deal with the significant challenges of addressing Covid-19 demand within clinical services; and
- minimise the need for people to travel to and physically attend meetings, thus mitigating the risk of disregarding government guidance on social distancing and limiting travel outwith one's own home.

Since the outbreak of the pandemic in mid-March, the Board has held (on 8 April and 27 May) two full meetings remotely, utilising both tele- and video-conferencing, with a prioritised agenda in place for each Board meeting. Whilst it has not been possible to meet physically in a public setting due to the ongoing lockdown restrictions and social distancing measures, from the May Board meeting onwards, representatives from the local media were invited to listen in via Teams, and this worked successfully. Board papers continue to be published in advance on the NHS Fife website, as do the Board minutes after each meeting has taken place.

A meeting of the Chair, Vice-Chair and members of the Executive Team has taken place each week since mid-March, with a full minute circulated to Board members for their information. The Chair and Vice-Chair additionally have regular contact with the Chief Executive and other key members of the Executive Team on priority items as and when required. Regular meetings with local elected representatives (MPs/MSPs) also continue to operate.

Whilst the scheduled dates in May for the Board's committees were stood down, a series of Covid-19 related briefing sessions were held for each Committee in June, prior to the resumption of Board committees in July. Agendas for committee meetings reflect the priorities of the Board's ongoing response to Covid-19, in addition to the consideration of business otherwise requiring approval, such as agenda items linked to the approval of the annual accounts. The Chair, Vice-Chair and Committee Chairs liaise with the Executive Team to identify what business must be considered by the Board and its committees and when, if necessary, meetings need to go ahead. Some routine business has been suspended or deferred, and each Committee's workplan has been reviewed to ensure that new items related to Covid-19 are covered appropriately.

NHS Fife has also put in place an organisational Command structure to provide direction, decision-making, escalation and communication functions during the pandemic period. Initially meetings of Gold Command were scheduled daily. By the end of June this was reduced this to weekly as a result of the reduction in Covid-related activity and reporting from its supporting Silver and Bronze groups. Routine meetings such as the weekly meeting of the Executive Team, and a formal, monthly Executive Directors' Group (EDG), were resumed in June.

In light of the ongoing impact of Covid-19 on NHS Fife, it is anticipated that the Board's strategic framework will require to be reviewed, in tandem with reassessment of the transformation programme and its relationship to the remobilisation / redesign of key services. As part of that work, the strategies of the IJB will also need to be considered and it is expected that all of the Board's supporting strategies will require review, to appropriately reflect a post-Covid environment.

During the 2019-20 financial year, no other significant control weaknesses or issues have arisen, in the expected standards for good governance, risk management and control.