FTF Internal Audit Service

Annual Internal Audit Report 2020/21

Report No. A06/22

Issued To: C Cowan, Chief Executive
J McCusker, Chair

S Urquhart, Director of Finance
NHS Forth Valley Directors / System Leadership Team

G Bowden, Audit Follow Up Co-ordinator
A Gibson, Corporate Risk Manager

Audit & Risk Committee
External Audit

Contents

Draft Report Issued	30 June 2021
Management Responses Received	9 July 2021
Target Audit & Risk Committee Date	15 July 2021
Final Report Issued	9 July 2021

INTRODUCTION AND CONCLUSION

1. This annual report to the Audit & Risk Committee provides details on the outcomes of the 2020/21 internal audit and my opinion on the Board's internal control framework for the financial year 2020/21.

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

- The Board has adequate and effective internal controls in place.
- The 2020/21 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 & 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 2020/21 incorporated the requirements of the NHSScotland Governance Statement and were based on a joint risk assessment by Internal Audit and the Director of Finance. The resultant audits range from risk based reviews of individual systems and controls through to the strategic governance and control environment.

6. The authority, role and objectives for Internal Audit are set out in Section 15.3 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 & Risk Committee with an annual assurance statement on the adequacy and effectiveness of internal controls. The Audit & Assurance Committee Handbook states:

The Audit & Risk 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 January 2020, was informed by detailed review of formal evidence sources including Board, Standing Committees, System Leadership Team (SLT), and other papers. The ICE noted many actions to enhance governance and achieve transformation and concluded that NHS Forth Valley's assurance structures were adequate and effective but did make 6 recommendations for improvement by year end. The status of previous recommendations is summarised in table 1 below.

9. During the year we worked with management to review and update outstanding internal audit recommendations to take account of Covid19, including those arising from previous ICE report.

10. Throughout the year, our audits have provided assurance and made recommendations for improvements. Of these, the ICE was the most significant. We have undertaken detailed follow up of the agreed actions arising from that report as well as testing to identify any 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 Covid19 and the governance arrangements in place during the year. Some areas for further development were identified and will be followed up in the 2021/22 ICE and, where applicable, our detailed findings have been included in the NHS Forth Valley 2020/21 Governance Statement.

11. Our assessment of the progress taken to address ICE recommendations is detailed in table 1 on page 11. NHS Forth Valley has demonstrated good progress with only minor slippage on some actions. Several of the more strategic actions are not yet due for completion but are progressing well. We will comment on the effectiveness of the action taken in the 2021/22 ICE.

12. For 2020/21, the Governance Statement format and guidance were included within the NHSScotland Annual Accounts Manual. 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 whole, which would therefore include activities under the direction of IJBs.

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

    'During the previous financial year, no significant control weaknesses or issues have arisen, and no significant failures have arisen in the expected standards for good governance, risk management and control. Attention is, however, drawn to the key risks reported to Forth Valley NHS Board during 2020/21 and in particular to the treatment time guarantees underpinned by statute'.

14. Our audit work 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 2020/21, provides assurance for the Chief Executive as Accountable Officer.

15. 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.

16. All Executive Directors and Senior Managers were required to provide a statement confirming that adequate and effective internal controls and risk management arrangements were in place throughout the year across all areas of responsibility and, in an enhancement to previous years, to consider five specific themes in their responses. These assurances have been reviewed and no control issues, breaches of Standing Orders / Standing Financial Instructions were identified.

17. The Governance Statement reflects the necessary changes to Board governance and operating arrangements due to Covid19 and the work to remobilise. The Governance Statement includes details of the Boards performance and risk profile and future changes to organisational and supporting strategies. The risk assessment and management section of the Governance Statement is particularly helpful in describing the risk profile of the organisation, including the impact of and response to the Covid19 pandemic. All elements of the Governance Statement have been considered by Internal Audit in previous Annual Internal Audit Reports and the ICE and have been followed up in detail in this report.

Key Themes

18. As noted in the ICE, during the first part of the year the Board maintained and improved its governance arrangements and has performed well in exceptionally difficult circumstances, facing the unprecedented challenges created by Covid19. We welcome significant improvements in governance since the ICE report was issued, including the development of a Healthcare Strategy risk, the ongoing refresh of the Healthcare Strategy and Board approval of the Governance Improvement Plan.

19. This report contains a number of recommendations that reflect the changes to the risk environment in which the Board operates. There are opportunities now to enhance governance further through the application of assurance mapping principles and our report contains recommendations aimed at ensuring coherence between Governance Structures, Performance Management, Risk Management and Assurance. The allocation of risk to Standing Committees is very welcome and our report highlights areas where this can be developed further to allow more focused consideration of these risks, and in particular how to provide assurances over risks whose component parts include the loci of many Standing Committees.

20. Whilst there have been positive improvements in many areas, we would highlight known issues in Information Security and Information Governance, where the Board's own systems have identified that improvements are necessary to achieve minimum standards which will require additional resources.

Key developments since the issue of the ICE included:

- The third iteration of the Remobilisation Plan covering the period April 2021 – March 2022 was presented to the Board in May, as soon as possible after the Scottish Elections. The initial Mobilisation Plan and subsequent System-Wide Remobilisation Plans were developed in partnership and adopted a whole system approach to support the initial response to Covid19 and the ensuing recovery. The plan set out a summary of actions being taken to build on the work currently underway to resume services, informed by Service/Partnership Remobilisation Plans appended to the Remobilisation Plan. It articulates outcomes and associated risk and mitigations and summarises the organisation's priorities for 2021/22 and beyond.
- Overall, there has been good progress on recommendations from the ICE. Where action is still to be concluded, the Board has been informed of the planned approach and timescales, as well as associated improvement plans.

- There has been a continuing focus on Good Governance including development of a Governance Improvement Plan and a Board development session on assurance, with a Board Assurance Framework and risk appetite development event planned.
- A Healthcare Strategy risk has been agreed.
- Development of a revised Healthcare Strategy and supporting strategies, including a Quality Strategy is ongoing.
- Improvements in staff governance arrangements have been evidenced through enhanced assurance arrangements for the Staff Governance Committee, and development of the interim Workforce Plan.

21. During 2020/21 we delivered 18 audit products, including 1 from 2019/20. These audits reviewed the systems of financial and management control operating within the Board and provided opinions on the adequacy of controls in these areas. Summarised findings or the full report for each review were presented to the Audit & Risk Committee throughout the year.

22. A number of our reports, including the ICE and Sustainability work, have been wide ranging and complex audits which have relevance to a wide range of areas within Forth Valley. These should provide the basis for discussion around how NHS Forth Valley can best build on the very good work already being done to improve and sustain service provision.

23. Board management continue to respond positively to our findings and action plans have been agreed to improve the systems of control. Board staff have maintained a system for the follow-up of audit recommendations and reporting of results to the Audit & Risk Committee. In January 2021, Internal Audit assisted the Board by carrying out a Red, Amber, Green (RAG) status assessment of outstanding recommendations and removing from the Audit Follow Up system actions which had been completed, or were consolidated and superseded by recommendations in the 2020/21 ICE report. As reported to the 12 March 2021 Audit & Risk Committee, 63% of audit actions due were complete, 37% of audit actions were not yet due for responses and no audit actions were overdue.

ADDED VALUE

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

    - Examining a wide range of controls in place across the organisation.
    - In conjunction with Local Authority Internal Auditors, undertaking IJB internal audits and providing a Chief Internal Auditor Service.
    - For Clackmannanshire & Stirling Integrated Joint Board (IJB), updating and enhancing the IJB Governance Statement self assessment checklist and providing support with regard to Audit & Risk Committee arrangements.
    - Providing opinion on and evidence in support of the Governance Statement at year-end and conducting an extensive Internal Control Evaluation which permitted remedial action to be taken in-year. This review made recommendations focussed on enhancements to ensure NHS Forth Valley 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.
- Provision of Committee Assurance principles and risk guidance, suggested for adoption by Standing Committees.
- The Chief Internal Auditor provided a 'How do we Know' assurance presentation to the January 2021 Board development session.
- Providing best practice examples of assurance and risk reporting for Standing and other committees, with a particular focus on the Staff Governance Committee.
- 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 Forth Valley the risk chosen as a pilot was Strategic Risk 002 - Unscheduled Care. Work will continue as part of the 2021/22 Annual Internal Audit Plan.
- Providing advice to inform the development of the Strategic Risk Register.
- Internal audit A17A/21 considered governance arrangements and the embedding of risk management processes within the Acute Services Directorate. We provided advice and examples of best practice to inform the operation of the Acute Services Directorate Governance and Risk Management Group.
- Internal audit A20/21 provided advice on the governance and operation of the Medical Devices Group.
- Continuing to contribute to the development of IJB risk management and clinical and care governance arrangements.
- Providing the Fraud Liaison Officer function for NHS Forth Valley, including provision of advice, support on referrals from Counter Fraud Services and on internal investigations, quarterly reporting to the Audit & Risk Committee, provision of the Fraud Policy and inclusion of fraud in relevant HR Policies.
- Assisting and working jointly with Board staff and Counter Fraud Services to further develop the Board's counter fraud arrangements and liaising with Counter Fraud Services and the Board to disseminate Intelligence Alerts to key officers.

25. Internal Audit have also used any time made available by necessary senior management prioritisation of Covid19 duties to reflect on our working practices, both to build on action taken in response to previous External Quality Reviews and to adapt to a post Covid19 environment. This has included:

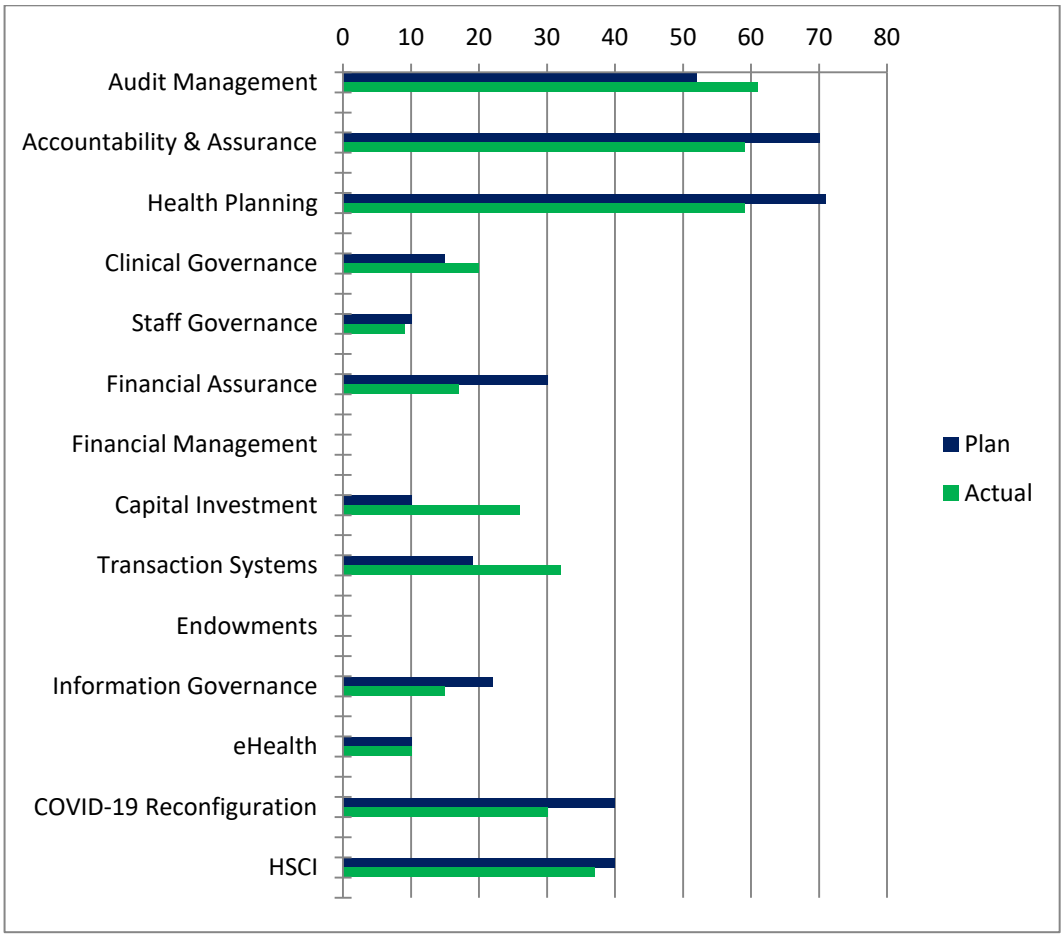
- Attendance at Board and Standing Committee meetings to inform our opinion on the organisation's governance arrangements and the control environment.
- Revision of the internal audit reporting protocol and flowchart.
- Development of a revised client quality questionnaire.
- Update and enhancement of the FTF Intelligence Library.
- Review of internal documentation and processes including analytical review and performance review, again to ensure we add value wherever possible.
- Review and update of our risk assessment categorisation.
- Ongoing development of the FTF website.

- Review and update of the FTF self assessment against the Public Sector Internal Audit Standards.

26. The 2020/21 Annual Internal Audit Plan included provision for delivering audit services, together with council colleagues, and providing the Chief Internal Auditor function to Clackmannanshire & Stirling Integrated Joint Boards as well as contributing to the audit plan of Falkirk IJB. Internal Audit Plans were agreed for each IJB. Internal Audit has continued to highlight governance and assurance aspects of integration and the need for clear lines of accountability and ownership of risk as well as the requirement for revised Strategic Commissioning Plans and working with partners.

INTERNAL AUDIT COVER

27. **Figure 1: Internal Audit Cover 2020/21**



28. Figure 1 summarises the 2020/21 outturn position against the planned internal audit cover. The initial Annual Internal Audit Plan was approved by the Audit Committee at its meeting on 16 June 2020. It was agreed at that time that the plan would be revised as changes to the risk profile and other factors became better known, and the Audit Committee approved amendments in March 2021. We have delivered 375 days against the planned 389 days.

29. Following a recommendation from the External Quality Assessment (EQA) carried out on Internal Audit in 2018/19, we continue with the agreed process of risk assessing outstanding 2020/21 audits for inclusion in the 2021/22 plan.

30. A summary of 2020/21 performance is shown in Section 3.

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

31. Due to prioritisation of Covid19 duties, the FTF Partnership Board met only once in 2020/21. The Partnership Board is chaired by the NHS Tayside Director of Finance and the FTF client Directors of Finance are members. The FTF Management Team attends all meetings. During the year the Partnership Board reviewed the Internal Audit Shared Service Agreement 2018-2023 and the Internal Audit Service Specification, as well as approving the 2020/21 budget. The Partnership Board also approved revised risk assessment definitions for internal audit reporting.

32. 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).

33. 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.

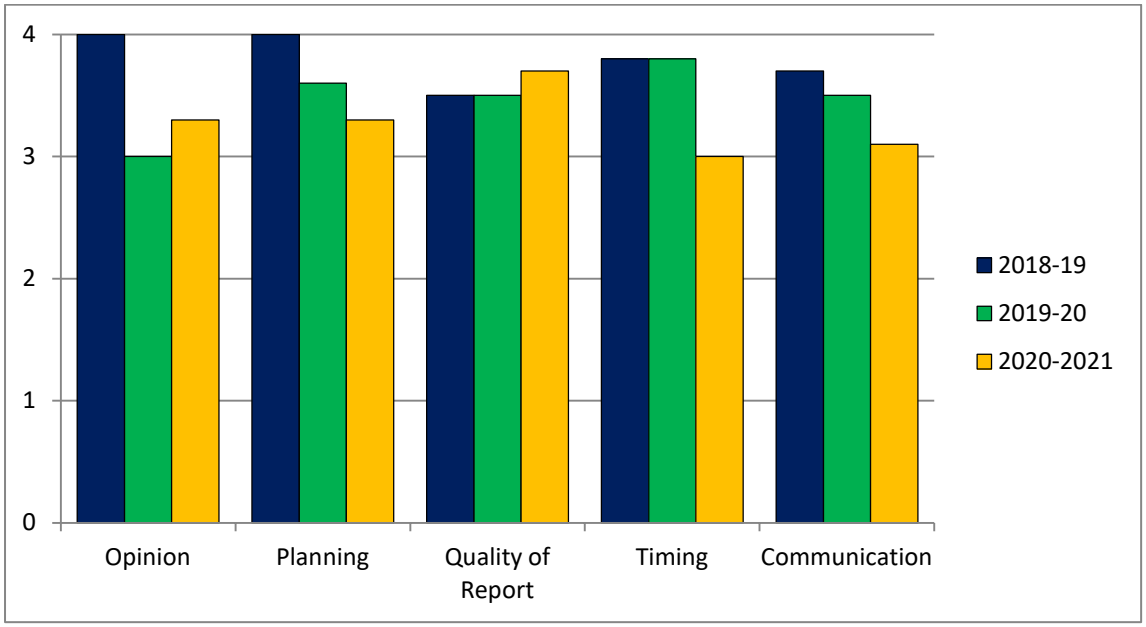
34. Internal and External Audit liaise closely to ensure that the audit work undertaken in the Board fulfils both regulatory and legislative requirements. Both sets of auditors are committed to avoiding duplication and securing the maximum value from the Board's investment in audit.

35. Public Sector Internal Audit Standards (PSIAS) require an independent external assessment of internal audit functions once every five years. The most recent External Quality Assessment (EQA) of the NHS Forth Valley Internal Audit Service in 2018/19, concluded that *'it is my opinion that the FTF Internal Audit service for Fife and Forth Valley generally conforms with the PSIAS.'* FTF has updated its self assessment and this will be reported to the NHS Forth Valley Audit and Risk Committee in early 2021/22.

36. 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.

37. Figure 2: Summary of Client Satisfaction Surveys

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



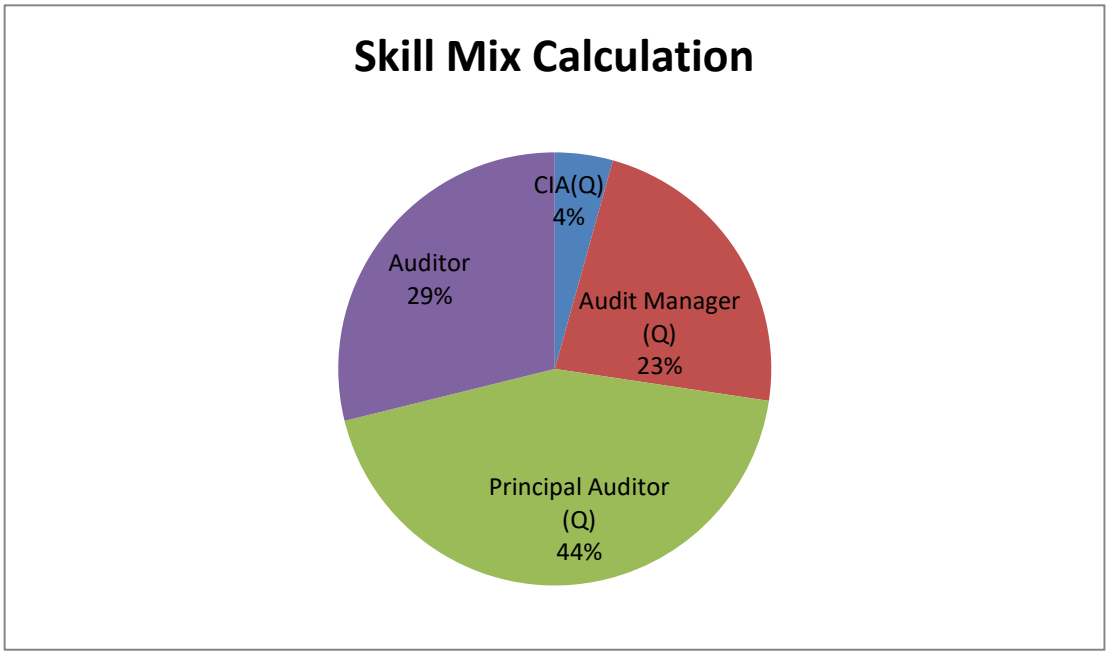
38. Other detailed performance statistics are shown in Section 3.

STAFFING AND SKILL MIX

39. Figure 3 below provides an analysis, by staff grade and qualification, of our time. In 2020/21 the audit was delivered with a skill mix of 71%, which substantially exceeds the minimum service specification requirement of 50% and reflects the complexities of the work undertaken during the year.

40. **Figure 3: Audit Staff Skill Mix 2020/21**

Audit Staff Inputs in 2020/21 [days] Q= qualified input.



ACKNOWLEDGEMENT

41. 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.

42. My team and I have greatly appreciated the positive support of the Chief Executive, Director of Finance, the Audit Follow Up Co-ordinator and the Audit & Risk Committee.

A Gaskin, BSc. ACA
Chief Internal Auditor

TABLE 1 - ICE 2020/21 (A08/21) - Update of Progress Against Actions		
Agreed Management Actions with Dates	**Agreed Management Actions with Dates**	**Assurance Against Progress**
1. Sustainability & Transformation • Timetable to support the development of Healthcare Strategy - **March 2021** • Stock take of extant Healthcare strategy with stakeholder engagement - **May / July 2021** • Healthcare Strategy consultation - **August 2021** • Healthcare Strategy to be presented for NHS Board for approval - **September 2021** *Action Owner: Chief Executive*	• Timetable reported to Board on 25 May 2021 • Review of existing strategy and stakeholder engagement planned for July / August 2021 • Consultation planned for July / August 2021 • Healthcare Strategy scheduled for Board approval November 2021	 **On track**
2. Strategy Risk • Strategy/Transformation Corporate Risk to be developed and agreed by SLT and presented to the Board for approval - May 2021 • Next Strategic Risk Register review to consider COVID-19 factors how these relate to the Board's strategic/corporate risks - May 2021. *Action Owners: Chief Executive, supported by the Head of Policy & Performance and the Corporate Risk Manager*	• 'SRR014: Healthcare Strategy' was added during the Q1 2021/22 risk review presented to the SLT on 17 May 2021. This risk is still pending Board approval • Although consideration has been made towards the impact of Covid19 to the new Healthcare Strategy risk, this consideration is not evident across all strategic risks in the Q1 2021/22 risk review report. SRR012 Covid19 Remobilisation Plans remains a separate risk	 **Minor slippage on agreed timelines**
3. Governance and Year End Assurances • Implementation of Board and Assurance Committee template - April 2021	• Per the Governance Improvement Plan presented to the Board on 30 March 2021, the Board template will be adopted by the Board, Assurance Committees and Board operational and advisory fora by June 2021	 **On track**

• Governance update to NHS Board will seek endorsement of 'principles' - March 2021 • If adopted each Assurance Committee will be asked to conduct a review of their short and longer term governance arrangements - August 2021 *Action Owner: Chief Executive*	• NHS Forth Valley's Governance Improvement Plan focuses on the agreed governance model, notably fiduciary, strategic, and generative actions to underpin the Board's commitment to being an effective high performing NHS Board. The Governance Improvement Plan was presented and endorsed by the Board on 30 March 2021 • Assurance Committee terms of reference, membership including Non-Executive Chair and Corporate Director leads and support to be reviewed by June 2021 • Development of an Assurance Strategy which will set out a Board-wide Assurance System linking risk and performance is due by October 2021	
4. Risk Management • The Corporate Risk Manager to prepare a progress report setting out a response to each of the Internal Audit points raised against risk management with a timescale for completion and this report will be presented to SLT for approval and subsequently to the Audit Committee on a regular basis – **June 2021** *Action Owners: Chief Executive, supported by the Head of Policy and Performance and the Corporate Risk Manager*	• This progress report will now be included in the Risk Management annual report to the July 2021 Audit & Risk Committee. The annual report will include an update on the key areas, an update to the overall workplan and timeline	 On track
5. Clinical Governance • Revision to the Clinical Governance Strategy which will sit within the Quality Strategy which is whole system, encompassing HSCPs and Clinical & Care Governance – **December 2021** • Continue to refine the clinical risk management aspects within	• Quality Strategy is being developed as per presentation to 1 March 2021 System Leadership Team and due December 2021 • Quarterly reporting of strategic risks aligned to Clinical Governance Committee started in June 2021. More detailed scrutiny of strategic	 **On track**

the Strategic Risk process – **December 2021** *Action Owners: Medical Director, supported by the Head of Clinical Governance and the Head of Efficiency, Improvement and Innovation.*	risks and mitigating strategies to be developed as reporting becomes embedded	
6. Staff Governance Committee and Workforce • Refresh of Workforce Strategy and Plan - December 2021 • Develop an Staff Governance Annual Workforce Plan - June 2021 • Undertake a Covid19 workforce related risk review - May 2021 • Introduce a Staff Governance 'Assurance Report' - June 2021 • HR Dashboard to be operational - May 2021 *Action Owner: HR Director*	**6. Staff Governance Committee and Workforce** • Draft Interim workforce plan, aligned to remobilisation plan, submitted to Scottish Government • Work on 'Our People Strategy 2018 – 2021' underway and expected to be completed by December 2021 • Annual Staff Governance Committee (SGC) Assurance Plan and Work Plan 2021/22 presented to the SGC in May 2021 • Covid19 workforce related risk review to be presented to the Staff Governance Committee in September 2021 • Staff Governance Committee Annual Report was presented to the Board on 25 May 2021 in private session • Development of suite of workforce dashboards within the Pentana Person-Centred Portal with presentation to SLT on 31 May 2021 and presented for approval to the SGC due 17 September 2021	 **Minor slippage on agreed timelines**

Corporate Governance

Strategic risks:

- **SRR012 COVID-19 Remobilisation - If NHS FV does not deliver an effective remobilisation plan in response to COVID-19 there is a risk we fail to manage demand on services and miss opportunities for long term change / improvement.**
- **SRR013 Brexit. f there is a continued lack of clarity around the terms and conditions of the UK's exit from the European Union, there is a risk there may be negative and / or unforeseen impacts on healthcare, impeding NHS Forth Valley's ability to prepare and contingency plan for a smooth transition.**
- ***New risk* - SRR014 Healthcare Strategy. If the planned review of the NHS Forth Valley Healthcare Strategy (2016-2021) does not incorporate learning from the COVID-19 pandemic and does not align with government policy and / or Integration Authorities Strategic Commissioning Plans there is a risk the Board's vision, corporate objectives and key priorities will be incorrect, resulting in services that are not sustainable in the long term and an inability to delivery transformation.**

Remobilisation

A Forth Valley System-Wide Remobilisation Planning Session on 22 February 2021 focused on a step change towards recovery and renewal, and on development of the Remobilisation Plan. Following submission of the draft NHS Forth Valley System-Wide Remobilisation Plan April 2021 to March 2022 (RMPv3) to Scottish Government (SG) on 2 March 2021 and SG feedback on 4 March 2021, the RMPv3 was approved by the Forth Valley NHS Board on 25 May 2021, at the earliest opportunity following the Scottish elections.

The same Board meeting committed to refreshing the Healthcare Strategy and approved an associated timetable. The NHS Board vision, values and corporate objectives will also be refreshed following a period of engagement from July to August 2021. Updates on development of the Healthcare Strategy 2021/2026 will be reported to the NHS Board, the Board Committees and Advisory Forums, with the final Strategy presented to the NHS Board for approval in November 2021.

The ICE report 2020/21 report recommended establishing greater formality of governance and reporting of remobilisation progress to the SLT. The 16 June 2021 SLT approved Terms of Reference for a Corporate Management Team (CMT) which will provide system wide governance and oversight of the Remobilisation Plan and contribute to the strategic long term direction of the NHS Board. The CMT had its first meeting on 5 July 2021.

Healthcare Strategy

As recommended in the 2020/21 ICE report, a Healthcare Strategy risk was agreed by SLT in May and will be presented to Audit & Risk Committee Board in July 2021. Given its strategic importance, this risk should be monitored by the Performance & Resources Committee (P&RC).

The new risk identified future actions including the stock take of the 2016-21 strategy, the need for a forward plan and timeline and the requirement to work with the IJBs and other stakeholders to inform and influence strategy.

The Governance Improvement Plan approved by Board on 25 May 2021 includes actions for the Board to develop and agree strategic priorities and direction, monitor implementation of strategic direction and develop and monitor supporting strategies.

Risk Management

The quarter 4 Strategic Risk Register (SRR) update presented to the 30 March 2021 Board captured 10 strategic risks, 7 of which were described as 'very high' and 3 of which were 'high'. The Covid19 risk score remains Red, with a risk score of 20 and a target risk score of 6. The March 2021 Board approved a full review of the SRR, reflecting a number of comments made in the ICE.

The risk profile remained largely static throughout the year as noted within the ICE. However, towards the end of the year three risks were closed and the May SLT approved the new Healthcare Strategy risk and reduction of the Brexit risk score, for approval at the July Board.

Implementation of our recommendation to ensure that the impact of Covid19 is fully reflected in all strategic risks is not yet fully apparent, although we do note that some excellent work in the Scheduled Care and Finance risk for example. There has been considerable improvement in risk management arrangements since our ICE report. In particular:

- Strategic risks have been aligned to Standing Committees and assurance reporting commenced in February 2021.
- Standing Committee risk deep dives have been introduced.
- The SLT now regularly reviews the full SRR.
- A Board Development Session covering the Board Assurance Framework and risk appetite was scheduled for 8 June 2021, albeit this was postponed due to operational exigencies.
- The Corporate Risk Manager has commenced a review of the existing strategic and operational risk registers, including assessing the functionality of the Safeguard and Pentana systems as a risk management database.
- Recruitment of 3 Risk Management Officers, aligned to Directorates/Partnerships has commenced.
- The NHS Forth Valley Corporate Risk Manager is working with colleagues from the IJBs and Local Authorities to develop a Forth Valley wide Risk Management Strategy which will set out responsibilities and provision of assurances for risks related to health services managed by the Chief Officers/Directors of Health & Social Care and reporting to the Chief Executive. Internal Audit has provided a good practice example to assist with this development.

The following recommendations from the 2020/21 ICE are ongoing and an update will be provided in the Risk Management annual report to the July 2021 Audit & Risk Committee:

- Board input to horizon scanning to identify emerging risks.
- Incorporation of assurance mapping principles and, in particular, ensuring that Standing Committees provide robust scrutiny of risks, controls and assurances under their purview.
- Completion of review and refresh of operational risks, to be further progressed when all Risk Management Officers are in post.

Good Governance

The Chief Executive provided a Governance Review report to the 30 March 2021 Board meeting and a Governance Improvement Plan has been developed with SMART actions,

outcomes and timescales. The Improvement Plan includes review of the Corporate Governance framework and, importantly, includes development of an Assurance Strategy which will set out a Board-wide Assurance System linking risk and performance, as well as further development of assurance mapping.

We are pleased to note the following developments since publication of the ICE report in January 2021:

- Development of the Head of Policy & Performance role
- Appointment of a Board Secretary to support good governance
- Introduction of the Staff Governance Committee assurance plan in May 2021
- Expansion of the previous Audit Committee role to that of an Audit & Risk Committee with strategic risk updates presented to each meeting
- All NHS Forth Valley Standing Committees were able to deliver year end assurances through their annual reports despite the challenging circumstances

Performance

A Recovery Scorecard reporting on the System-Wide Remobilisation Plan is presented to each Board and Performance & Resources Committee (P&RC) meeting. While it was agreed by the May 2021 Board that there should be no or limited changes to the scorecard for a period of approximately 6 months to ensure work is embedded, the Recovery Scorecard remains fluid and a review was planned for June 2021.

The performance management process needs to be appropriately supported with the right level of infrastructure and resources, in particular digital. We were therefore pleased to note that, in supporting the organisational development of Pentana and the wider performance agenda, the February 2021 P&RC approved funding for 2 Senior Information Analysts and recruitment is underway. In addition, the new Corporate Performance Manager will commence at end of July 2021. These appointments will provide the technical information management support required to enable, for example, automation of scorecards and development and preparation of data to enable linkage to Pentana. The Corporate Performance Manager will manage the project and an update on progress will be presented to the August P&RC.

The Scheduled Care risk, aligned to the Clinical Governance Committee, reflects work carried out to articulate the pressure on scheduled care as a result of long-standing imbalance in demand and capacity, additional pressures due to Covid19 and possible pent up demand due to reduction in referral rates. A presentation to the April P&RC on 'Sustainable Delivery of Waiting Times Standards and Quality Care' explored this risk in detail and described how sustainability would be created through transformational change, maximising elective care and use of the national treatment centre. A Sustainability update presentation is scheduled for the 29 June 2021 P&RC.

The fluctuating position for 4 hour target compliance remains a focus for the Board; overall compliance with the 4 hour target in April 2021 was 84.1%, against a target of 95%. The 26 April 2021 SLT received a presentation on the challenges associated with Unscheduled Care Delivery and achievement of the 4 hour Access Performance and it was agreed that the delivery plan would be updated by end of June 2021. Internal Audit provided comments on this risk as part of A11/21 – Assurance Framework to inform its update.

Other areas

At their 25 May 2021 meeting, the Board noted the steps being taken to enhance Covid19 surveillance and response, and the ongoing roll out of the Covid19 vaccination programme. The Board also approved value added recurring investments in several initiatives including business cases for the Falkirk Community Hospital site and primary care premises; an updated response to the GMS Contract; proposals to invest in care at home and stroke services; the proposal previously presented to P&RC to remobilise, recover and redesign elective care services and a proposal to use eRostering to improve job planning.

A12/21 – Policies & Procedures provided moderate assurance and concluded that the Policy, Procedure and Guideline Development Framework was well designed and that for the sample of policies and procedures tested, procedures for developing policies were being followed, with appropriate approval. Management have agreed action by the end of September 2021 to clarify responsibilities for oversight, approval and monitoring of the Policy Management Framework, covering both clinical and non-clinical policies and ensuring changes in working practices as a result of Covid19 are reflected in policies.

Emergency Department (ED) review

In response to concerns raised by staff side, the Chief Executive commissioned an independent external review to consider both the culture and governance notably: corporate, clinical and staff governance arrangements and how these affected nursing staff working within ED. The final report received on 9 June has been shared with staff. In December, 2020 a retrospective review of the safety and assurance measures within the Emergency Department was completed and, as reported to the February 2021 Clinical Governance Committee, provided assurance regarding safety system measures. In addition a Significant Adverse Event Review has been commissioned to provide further assurance.

Both reports were presented to the February CGC in private session but due to an oversight, did not feature in the CGC annual report 2020/21. The Medical Director has advised that this has been picked up and an addendum to the CGC annual report will be issued. A special SGC meeting on 5 March 2021 also received an update on this review, albeit the SGC annual report which included the matter was taken in private session. The Board has also been updated on this matter in closed session to ensure it complies with a duty of care to all its employees.

Action Point Reference 1 Governance improvements & annual assurances	
Finding:	
While the Board is currently held in public, some items, such as the Staff Governance Committee and Performance & Resources Committee annual reports were considered in closed session, as permitted under the Board's Standing Orders.	
Audit Recommendation:	
To ensure transparency and to demonstrate good governance we recommend that Standing Orders be amended so that Board and Standing Committees items considered under Reserved Business or in a closed session are shown on the agenda and minutes, and the applicable Freedom of Information provision clearly stated. The 15 July 2021 Audit & Risk Committee should be provided with a paper setting out the key issues and risks identified from the Standing Committee annual reports, and confirming consistency with Directors' assurances and the Governance Statement.	
Assessment of Risk:	
Merits attention	 There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**
Management Response/Action:	
Standing Orders will be amended to ensure all closed sessions are shown on the agenda and minutes with applicable FOI exemptions referenced.	
Action by:	**Date of expected completion:**
Board Secretary	**September 2021**

Action Point Reference 2 Good Governance & Risk Management

Finding:

This report demonstrates that governance and risk management arrangements have improved considerably, despite challenging circumstances. Some enhancements will be implemented in 2021/22.

Audit Recommendation:

Further suggested enhancements include:

I. **Standing Committee annual reports:**

- Annual reports should be structured along the main areas of business as defined in the Committee's Terms of Reference and / or Assurance Plan so that assurances / updates against each area are easily identifiable allowing definite conclusions to be made.
- Performance information should be enhanced, highlighting areas of poor performance and assessing whether actions being taken are effective (also see below re overt linkages to risk).
- References should be made to the annual report(s) of sub-committees, including an overt opinion on the performance / assurance provided from the report(s).
- An evaluation of the movement in strategic risks aligned to the Standing Committee and areas where actions were not effective should be included.
- Annual reports should reflect consideration of key risks and concerns and how these will be reflected in the workplan for the year ahead.

II. Forward planners should be introduced for the Audit & Risk Committee and P&RC. In time, these forward planners should incorporate an assurance plan, linking to key risks and responsibilities of the committees as set out in their Terms of Reference to help ensure that all necessary assurances are received during the year.

III. Performance and assurance reports should clearly state which risks they are providing assurance on. In the longer term, officers could work towards quantifying the level of assurance provided by assurance and performance reports.

IV. Internal Audit reports, and in particular the ICE, should be routinely considered by the relevant Standing Committee.

Risk Management:

- Risk reporting to Standing Committees and routine risk deep dives should allow more detailed scrutiny of strategic risk reports. Appendix A of the Committee Assurance Principles documents (shared by internal audit) provides suggested questions for risk owners and questions for committees which may be useful in shaping discussion.
- As risk reporting matures, consideration will need to be given to assurances around risks with elements that fall under the remit of more than one committee. For example, the Scheduled Care risk is aligned to the Clinical Governance Committee but contains workforce elements, and the Primary Care risk is aligned to the Staff Governance Committee, but contains Infrastructure and digital elements.

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

Management Response/Action:
• **Standing Committee Annual Reports will adopt the enhancements as recommended by Internal Audit.** • **Forward Planners will be introduced for the Audit & Risk Committee and Policy & Resources Committee.** • **Performance and assurance reports will reference the risk that assurance is being provided on.** • **Internal Audit reports including the ICE report will routinely be considered by relevant Standing Committees.**

Action by:	Date of expected completion:
Chief Executive and Head of Policy and Performance	**September 2021**

Action Point Reference 3 Performance Management

Finding:

Scottish Government guidance was that the RMPv3 would be the Annual Operational Plan (AOP) for 2021/22. However, the national format for these remobilisation plans will not easily translate into SMART performance measures which will allow monitoring of achievement of key objectives.

The Recovery Scorecard is manually updated on a weekly basis and is not automatically generated by the Pentana system. A quality, timely and effective performance management process will only be sustainable in the longer term if consideration is given to appropriate investment in resources and infrastructure to support this critical function.

Audit Recommendation:

In the short term, consideration should be given as to how the RMPv3 will generate holistic and/or local SMART targets which can be monitored by the P&RC and how assurance can be provided that Forth Valley is on track to achieve the outcomes within the RMPv3.

In the longer term, performance management systems to monitor achievement of outcomes set out in the revised Healthcare Strategy should be reviewed and consideration given to how this can be measured.

The Terms of Reference of the Performance & Resources Committee include the requirement to 'To oversee the ongoing development of a performance management culture'. As previously recommended in internal audit report A14/19 - Operational Performance Reporting, consideration should be given to the reinstatement of a system of Directorate Performance Reviews, which are already in place for finance considerations.

The Recovery Scorecard is continuously evolving to ensure relevant performance measures are adequately captured. Our high level review of the Recovery Scorecard identified some potential enhancements which have been shared with the Recovery Scorecard Short Life Working Group.

Assessment of Risk:

Moderate  Weaknesses in design or implementation of controls which contribute to risk mitigation.

Requires action to avoid exposure to moderate risks to achieving the objectives for area under review.

Management Response/Action:

Directorate and Partnership Performance Reviews will be reinstated, a Review is planned for Mental Health Services and this will inform our approach going forward

KPIs aligned to the RMP 3 will be considered as part of the review of the Recovery Scorecard.

Action by:	Date of expected completion:
Chief Executive & Head of Policy & Performance	**September 2021**

Clinical Governance

Strategic risks:

- **SRR002 Unscheduled Care - If NHS FV fails to deliver on the 6 Essential Actions Improvement Programme there is a risk we will be unable to deliver and maintain appropriate levels of unscheduled care, resulting in service sustainability issues and poor patient experience (including the 4 hour access standard).**
- **SRR004 Scheduled Care - If there are delays in delivery of scheduled care there is a risk that NHS FV will be unable to meet its obligations to deliver the National Waiting Times Plan targets for 2020-21, resulting in poor patient experience and outcomes.**

The March 2021 SLT received a briefing paper and presentation on development of the new Quality Strategy (2021 – 2026), which will encompass the Clinical Governance Strategy and is scheduled for issue by December 2021.

Our high level review of the draft Quality Strategy welcomed the intention to include HSCP activity and highlighted the opportunity to incorporate committee assurance principles, most notably a focus on risk both in terms of the items to be considered and the way that assurances are provided. It has been recognised that further work is required to ensure that that there are no gaps in assurances across the system and no unnecessary duplication. This intention is also reflected in February 2021 Clinical Governance Committee (CGC) minutes in relation to the annual report as well as in papers to the March 2021 Clinical Governance Working Group (CGWG) and the June 2021 CGC.

Management have confirmed that integrated Clinical & Care Governance structures will be described within the new Quality Strategy, to ensure there is a mechanism to allow a holistic review of risk and issues across Forth Valley and to identify interface risks. The Medical Director has confirmed that work continues to explore assurance mechanisms with the IJBs, pending clarification of implementation of the Feeley report.

Clackmannanshire & Stirling IJB internal audit - CS07-21 reviewed the adequacy of revised Clinical and Care Governance arrangements, with a focus on the nature and source of assurance to the IJB on the quality of all services it commissions, and made a number of recommendations to enhance the quality of assurances to the IJB.

We would expect the strategy to fully reflect clinical governance arrangements with due prominence given to the provision of effective, as well as safe, services throughout. We would also expect realistic medicine to be included. There would be benefit in incorporating any recommendations arising from the recent Emergency Department review, when available.

Quarterly reporting to CGC and CGWG on the strategic risks for Scheduled Care and Unscheduled Care started in June 2021. Both risks are scored at 20 – High, with target scores of 9. The Corporate Risk Manager attends CGWG and CGC meetings and following a verbal update to the 9 February 2021 CGC, a full risk report was presented to the June 2021 meeting. The CGC noted that as organisational and directorate level risk profiles develop, the CGC will receive expanded reporting on a larger range of risks.

During the first wave of Covid19, the SGHSCD instructed Health Boards to cease some treatments and diagnoses. This was accompanied by changes in patient self-referral and we know that these two factors will inevitably result in patient harm. However, the Scheduled Care risk (SRR004) still focuses on Waiting Times targets, which are no longer a key issue and does not fully capture the impact of cessation of treatment/diagnosis on patients. There

is a risk to the Board that failure to prioritise effectively and plan for the impending changes to case-mix and population need could cause additional, preventable, death and harm. We have been informed that the Medical Director and Associate Medical Directors have undertaken work to quantify potential harm, which will form the basis of a presentation to the CGC and will inform an update of the Unscheduled Care risk.

The Unscheduled Care risk has a number of workforce elements which are not fully articulated in the workforce planning risk. While the alignment of the risk to the CGC is appropriate, assurances on the management of this risk should address workforce issues.

The Clinical Governance Committee (CGC) met three times during the year. The restricted February 2021 CGC agenda still included the four key reports - Safety & Assurance, Standards & Reviews, Healthcare Associated Infections and Person Centeredness as well as review of Terms of Reference and draft CGC annual report, as well as considering the draft Clinical Governance Working Group (CGWG) annual report. The CGC annual report concluded 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 Standing Orders. As a result of the work undertaken during the year, I can confirm that adequate scrutiny of Clinical Governance arrangements were in place throughout NHS Forth Valley during the year'.*

Enhancements to Clinical Governance arrangements have continued in year including:

- Update of CGC Terms of Reference to more clearly link to Public Health.
- Further refinement of the CGC and CGWG Forward Planners which reflect the 'Vincent Framework' for Measuring and Monitoring Safety in the NHS.
- Development of the Safety and Assurance report which includes the Scottish Patient Safety Programme work streams. The report currently includes directorate assurances from Acute, Mental Health, Pharmacy and Woman & Children with Health & Social Care Partnership assurance reports planned next.
- Refinement of the Standards & Reviews report on external clinical standards and guidance and inspections, reviews and accreditation visits including Covid19 related standards and guidance, to ensure appropriate dissemination and actions are in place.
- A new streamlined process for undertaking Significant Adverse Event Reviews (SAERs) is being tested and will be documented in a refreshed, re-launched Adverse Events Management Policy. Implementation and effectiveness of the new policy will need to be closely monitored.

A development session on Incident Reporting, Significant Adverse Event Reviews and Duty of Candour took place on 21 April 2021 with a focus on ensuring staff awareness of roles and responsibilities in reporting, signing off incidents and the organisational duty of candour process. The Duty of Candour annual report was scheduled to be presented to the June 2021 CGC. However, due to staffing changes within the Clinical Governance department the report will now be presented to the August meeting.

HIS carried out an Acute Hospital Covid19 focused inspection at Forth Valley Royal Hospital on 2 February 2021 which identified four areas of good practice as well as two recommendations which were implemented by 31 March 2021.

The need to suppress the transmission of Covid19 and prevent/control nosocomial related infections and care home outbreaks features in the Remobilisation Plan April 2021 – March 2022. Data and accompanying narrative for both patient and staff infection was provided in the Healthcare Acquired Infection Annual report, presented to the June 2021 CGC.

Action Point Reference 4 Clinical Governance arrangements	
Finding:	
The CGC and CGWG both have extensive remits and lengthy agendas. Our review of minutes and papers identified duplication of reporting. For example, the Safety and Assurance report, Standards & Reviews report, Complaints and Feedback Performance Report and Significant Adverse Events Reports are presented to both the CGC and CGWG.	
Audit Recommendation:	
We recommend a review of reporting to the CGC and CGWG to ensure there are no gaps in reporting, to eliminate duplication and to ensure that there is a focus on key risks and priorities. The Committee Assurance principles may well be helpful in this review.	
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 above comments are accepted and will form the basis of actions, presented to the Clinical Governance Working Group and Clinical Governance Committee. **There may be some misalignment though of internal audit expectations of a Quality Strategy and the organisation's. A direction for the Clinical Governance Strategy will emerge from the Quality Strategy and will be clearly featured within but may require further development. Similarly, the discussion of risk is unlikely to be detailed within this Quality Strategy.**	
Action by:	**Date of expected completion:**
Medical Director and Heads of Quality and Clinical Governance	**November 2021**

Staff Governance

Strategic risks:

- **SRR001: Primary Care - If there is insufficient funding and recruitment there is a risk that NHS FV will not implement the Primary Care Improvement Plan, resulting in an inability to fulfil the Scottish Government Memorandum of Understanding as part of the GP contract, jeopardising GP practice sustainability.**
- **SRR009: Workforce Plans - If NHS FV does not implement effective strategic workforce planning (including aligning funding requirements) there is a risk that we will not have a workforce in future that is the right size, with the right skills and competencies, organised appropriately within a budge we can afford, resulting in sub-optimal service delivery to the public.**

Our ICE report provided a summary of staff governance activity to the end of December 2020 and a number of enhancements to improve assurances to the Staff Governance Committee (SGC) were agreed with the Director of HR for completion by end of 2021. Since the ICE report was issued in January 2021, an assurance workplan, structured around the Staff Governance Standard was introduced in May 2021. We will continue to provide advice and comment as the system matures, particularly in relation to assurances around risk and compliance with the Staff Governance Standard. Strategic risk assurance reporting started in March 2021 and, as with other risks, will develop further throughout the year.

SGC quarterly meetings paused in early 2020 under Covid19 governance and were re-started remotely in August 2020.

Internal Audit has previously highlighted the need for robust workforce planning, noting that monitoring of workforce planning has not yet been included within the controls relating to the Workforce Plan strategic risk. A draft Interim Workforce Plan was submitted by the deadline of 30 April 2021 to the Scottish Government and was approved by the SGC on 14 May 2021, but has not yet been presented to the Board for approval.

Internal audit review of the draft Interim Workforce Plan confirmed compliance with Scottish Governance guidance including use of the template issued and reflection of workforce elements of the Covid19 remobilisation plan. It will be a priority to ensure that the Interim Workforce Plan is translated into SMART targets and that progress against these is reported to the SGC to allow effective monitoring; the format of these reports should be considered carefully to ensure that assurances are relevant, reliable and sufficient and that they clearly link to risks and controls.

The Integrated Workforce Plan 2022-2025 is now due to be submitted in March 2022. It would be preferable to have revised reporting and assurance arrangements in place before that time, so that the full plan can be prepared with these requirements in mind.

The SGC has received regular updates on measures put in place to secure the health and well-being of staff during the Covid19 pandemic including:

- Quarterly Health and Safety reports and minutes of the H&S Board, including updates on infection control.
- A Covid19 Health & Safety & Occupational Health Report covering social distancing, testing, vaccinations and Covid19 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).
- The Covid19 RIDDOR reporting process was further developed and implemented during Quarter 4 and assurances on the revised process were provided to the SCG. The revised

process more effectively identifies Covid19 positive staff who contracted the virus whilst at work, along with the total incidents reported to the Health & Safety Executive.

- A report on Covid-related Health and Safety developments.
- A section on health and wellbeing within each HR Director's report to the SGC.

The pandemic has exacerbated many existing workforce risks and Management have recently completed a review of all Covid19 workforce related issues with an associated impact / likelihood for each which will be presented to the September 2021SG. It is recommended that SR0009 Workforce Plan risk is redefined into a wider Workforce Sustainability risk, which includes Covid19 and non Covid19 elements.

The Strategic Risk relating to Primary Care (SRR001), which is aligned to the SGC, will be reviewed by Internal Audit during the scheduled audit of the Primary Care Improvement Plan in 2021/22. This audit will assist the SGC by reviewing the controls in detail and providing an opinion on whether the controls are operating as intended.

Sickness absence for the year (excluding Covid19 related absences which are recorded as Special Leave) for 2020/21 was reported at 5.67% which is lower than last year (5.91%), but remains higher than the Scottish average.

Management informed us that 22% of staff had completed appraisals on TURAS as of 31 March 2021, against the National Standard of 80% and acknowledged a lack of reporting to the SGC on training and development and stated that the SGC will receive an update on steps being taken to improve this.

A 'Person Centred Portal' is at an advanced stage and HR have developed a suite of workforce dashboards within the portal, which are due to be presented for approval to the SGC on 17 September 2021. Directorates/HSCP HR Workforce Performance Groups were established in April 2021 and review their workforce information monthly.

A Whistleblowing Oversight Core Group (WBOG) was established in February 2021 to plan for the implementation of the National Whistleblowing Standards, which came into effect on 1 April 2021. A Whistleblowing Implementation Group (WIG) will deliver key elements and actions within the implementation plan and report on them to the WBOG, with the SGC receiving reports on progress and impact. The SGC Annual Report 20/21 provided an update on the implementation of the extant 'Once for Scotland' Whistleblowing Policy. However, the SGC did not receive an annual Whistleblowing report nor any data on Whistleblowing cases during 2020/21.

The SGC Annual Report 2020/2021 was approved, subject to the agreed changes by the SGC in March 2021 and was presented to the Board on 25 May 2021 in closed session. The SGC Annual Report includes a positive statement of assurance from the Chair of the SGC for financial year 2020/21.

On 25 May 2021 the Board approved the Remuneration Committee, as per The Staff Governance Framework (4th Edition), as a committee of the NHS Board, with membership extended to the Chairs of Board Committees. The Remuneration Committee shall produce an Annual Report to the NHS Board and it is proposed the first meeting of the newly constituted committee will be in mid July following an induction led by the Director of HR for new members.

Action Point Reference 5: Workforce Planning	
Finding:	
The interim workforce plan contains narrative covering key themes across the Board, but not measurable key workforce targets against which performance can be measured.	
Audit Recommendation:	
It will be a priority to ensure that the interim workforce plan is translated into SMART targets and that progress against these is reported to the SGC to allow effective monitoring; the format of these reports should be considered carefully to ensure that assurances are relevant, reliable and sufficient and that they clearly link to risks and controls. The Integrated Workforce Plan 2022-2025 is now due to be submitted in March 2022, it would be preferable to have revised reporting and assurance arrangements in place before that time, so that the full plan can be prepared with these requirements in mind.	
Assessment of Risk:	
Moderate 	Weaknesses in design or implementation of controls which contribute to risk mitigation. **Requires action to avoid exposure to moderate risks to achieving the objectives for area under review.**
Management Response/Action:	
The format and content of reporting arrangements will be considered for implementation prior to completion of the Integrated Workforce Plan 2022-2025, in order to provide relevant assurances.	
Action by:	**Date of expected completion:**
Director of Human Resources	**November 2021**

Financial Governance

Strategic Risks:

- **SRR005 Financial Break Even - If NHS FV financial plans are not aligned to strategic plans and external drivers of change, there is a risk that our cost base for our services over the medium to long term could exceed our future funding allocation, resulting in an inability to achieve and maintain financial sustainability, and a detrimental impact on current/future service provision.**
- **SRR010 Estates and Supporting Infrastructure - If there is insufficient Capital funding to develop and improve the property portfolio there is a risk the Estate and supporting infrastructure will not be maintained in line with national and local requirements.**

As reported to the 25 May 2021 Board, the draft financial outturn position to 31 March 2021, subject to external audit review, receipt of final Scottish Government budget allocations, and on final outturn positions for Integration Authorities was:

- A surplus of £0.244m against a Revenue Resource Limit of £757.423m.
- A break-even position against Capital Resources of £15.129m.
- Cash target achieved with a closing bank balance of £0.035m at 31st March 2021, and,
- 2020/21 savings delivered of £20.7m, of which £14.0m (68%) are non recurring which included £5.2m support from Scottish Government in relation to Covid19 savings delays.

At its meeting on 31 March 2020 the Board approved a 5 Year Financial Plan and 5 Year Capital Plan 2021/22 – 2025/26, noting that plans will be subject to constant review. The 2021/22 financial plan was based on NHS Forth Valley's continuing response to the pandemic and on delivering recovery / remobilisation priorities whilst incorporating a baseline uplift of 1.5% (following an announcement from the Scottish Government in January 2021).

Initial savings targets were set out in the 2020/21 financial plan against a number of themes, supported by a new Cost Improvement Board that has been established to work with the Corporate Project Management Office (CPMO) team to support the management and delivery of savings requirements in the new financial year. Savings in 2020/21 have come largely from unsustainable non-recurring sources which will increase the financial gap in future based on current resource and expenditure assumptions, £32.4m of savings will be required to deliver financial balance in 2021/22 which will be extremely difficult. In the longer term, financial sustainability will only be achieved through the redesign of services and very clear priorities. Finance performance review meetings will be held every two months to increase focus around savings and cost improvements.

Financial reporting throughout the year to the P&RC and Board remained consistent and the position was clearly presented despite the challenges imposed by the pandemic. Operational risks, including the impact of Covid19, were highlighted within the finance report to the February 2021 P&RC and March 2021 Board, although these were not clearly linked to Strategic risks, particularly SRR005.

Financial governance arrangements have been enhanced by reporting on waivers of Standing Orders to the Audit & Risk Committee. The P&RC receive regular updates on current major capital projects and property transactions including the impact of Covid19. A draft Property Capital Plan 2021 was presented to the SLT on 12 April 2021 and provides the detailed property priorities for the organisation for 2021/22. It was noted that the plan was

developed following the review of achievements and slippage in 2020/21, including the impact of the pandemic and against the backdrop of the years 2021/22 to 2024/25 and the national position in relation to capital funding. It will be important to ensure that plans for the revision of the Property and Asset Management Strategy and the plans for the individual categories of assets therein are reviewed in alignment with the scheduled review of the Healthcare Strategy in 2021/22 to ensure clear linkages. A detailed review of property strategy including the impact of Covid19 on current and future property requirements will be included within the scope of the Primary Care Improvement audit and the Capital Planning audit, both scheduled for 2021/22.

A Best Value update annual report is scheduled for presentation to the Audit & Risk Committee on 15 July 2021. Discussions are currently on-going around enhancements to the content of previous Best Value annual reports to ensure that the process is providing meaningful insights along with the necessary assurances to NHS Forth Valley's internal Governance arrangements.

Overall, the economic impact of Covid19 will continue to have a significant impact on the financial environment in both the short and medium to longer term. Both UK and Scottish Government Budgets currently only set out one-year spending plans with longer term, post Covid19 economic strategies emerging later. Given this uncertainty, there will be a need to continually review and adapt NHS Forth Valley financial plans over coming months and years as resource availability and projected costs become clearer.

Internal audit report A26/21, Ordering, Requisitioning and Receipt provided recommendations to improve the financial delegation process for Pecos approvals. Action to ensure consistent use of the authorised signatory form to record Pecos approvals was agreed, along with maintenance of a single system that retains all financial delegations across the Board, whether Pecos or non Pecos related.

Internal audit A23/21 – Payroll, provided moderate assurance. Management agreed recommendations relating to: assessing and mitigating any risks associated with a change in controls over permanent amendments associated with the eESS interface; review of the Finance Department risk register to ensure that the controls in place adequately mitigate against the implications of Covid19; re-establishment of Key Performance Indicators.

Information Governance

Digital

The mid-term review of the NHS Forth Valley's Digital and eHealth Strategy 2018-22, presented to the March 2021 Digital and eHealth Programme Board (DEHPB) noted that the Strategy may finish early in light of planned National Digital Strategy refresh, which will include learning from the Covid19 response. The Digital and eHealth Strategy would, in any event, have required revision to take account of the Board's new Healthcare Strategy.

It was reported to the March 2021 DEHPB that 16 of the 28 original projects/programmes of work, were scheduled to be delivered by the end of March 2021, of which 2 projects would now not be delivered within the timeframe due to delays in national projects and the need to prioritise additional programmes and accelerate others in order to respond to Covid19 and deliver remobilisation plans. An update on Digital and eHealth Delivery Plan projects was also presented to the February 2021 P&RC.

The Digital & eHealth Delivery Plan 2021/2022 was formally approved by the DEHPB at its meeting on 11 March 2021 and noted that considerable work is still required on Network Information Systems Regulation (NISR) and Cyber Security.

Following a recommendation in A29/21 - eHealth Strategic Planning and Governance, the March 2021 DEHPB approved amendments to the eHealth Programme Board Terms of Reference to include reference to the regular reporting of the implementation of the Digital and eHealth Delivery Plan to the P&RC.

Risk and assurance reporting

Risk 'deep dive' reports on the Information Governance (IG) and the IT Infrastructure strategic risks have not yet been reported to the P&RC, and although a verbal update was provided to the IGC in January 2021, there is no periodic assurance reporting to the Information Governance Committee (IGC). We do however note that the quarterly digital report to the P&RC includes infrastructure issues. In Quarter 3 2020/21 May 2021, the strategic IG risk score increased from 16 to 20. Internal audit report A29/20 – Information Assurance & Information Security follow up, recommended a refresh of the Information Governance Corporate risk and the addition of 'Information Governance and Security' assessment to Board and Committee templates. Neither has yet been addressed.

The Information Governance annual report 2020/21 highlighted the need for resources to address key items. The additional resource required over the next 2 years has been included in the approved financial plan and the Director of Finance has advised that the recurring commitments will be revisited as they become clearer over that period, and will be addressed in future plans. In addition, a phased investment plan is in place to resource the

priority developments around GDPR / information asset register. Appropriate resourcing is key to mitigating the IG risk and we would expect that this control would feature within the IG strategic risk, with monitoring in place.

An updated Covid19 Risk Assessment presented to the IGC in September 2020 downgraded the risk relating to Covid19 working practices to major from extreme. However, there was no evaluation of the mitigation strategies in place that supported the lowering of the risk. There have been no subsequent updates made to this assessment despite the continuously evolving environment. This Covid19 risk assessment should be updated and incorporated within the relevant Strategic risk(s).

The Cyber Security Awareness Strategy has recently been updated taking into consideration feedback from the 2021 NIS audit. We have been informed that a strategic risk for Cyber resilience will be introduced from quarter 2 of 2021/22 and the status of the existing strategic IT infrastructure will be reviewed.

SRR.011 IT Infrastructure Risk states; *"If there are significant technical and cyber vulnerabilities there is a risk the NHS FV IT Infrastructure could fail, resulting in potential major incidents or impact to service delivery"* with a current risk score of 16 and target of 6. Covid19 has increased the risk to information security, with a number of cyber-attacks being attempted recently but this has not resulted in a change to the risk score. This may be because the overall risk score reflects improvements in the other aspects e.g. focus on NIS, CISCO monitoring tool, and increased staff resource. Therefore, we welcome the development of a specific Cyber risk and the planned review of SRR.011.

Other current controls in place to support and manage cyber security are noted in the Strategic Risk Register (SRR) with an update on some aspects presented through the Capital Projects, Equipment & eHealth Projects report. There was also a presentation on Cyber Security to the P&RC in February 2021. An action is noted on the SRR against the Associate Director of Digital & eHealth to re-establish the Cyber Security Group by 30-June 2021 which should help enhance the assurance process further. As with other risks, we would expect assurance reporting on SRR003 and SRR011 to the P&RC develop further over the coming year with a particular focus on the areas of concern noted in this section.

External reviews

The Network and Information Systems Regulations (NISR) audit report was issued in October 2020. The June IGC was informed that actions are largely on-track to complete Critical and Urgent recommendations either before or shortly after the next regulatory audit, which took place at the end of June 2021. The Information and Cyber Security team have now been assigned dedicated time to focus on NIS compliance matters which was reported to have improved the implementation of NIS controls.

The NIS highlights report to the IGC on 10 June 2021 showed that:

- Of 4 Critical (Black) Audit Recommendations, 3 were complete and 1 was in progress (due to be completed by June 2021)
- Of 15 Urgent (Red) recommendations, 4 were complete and 11 were in progress (3 of which were due to be completed in June 2021)
- Of 104 actions overall, 18% were complete, 23% were in progress and 59% not started. Of those in progress or not started, 29% of those were expected to be completed by June 2021 for audit, which would represent a rapid acceleration if achieved.

Progress on NIS recommendations was reported to the P&RC in February 2021 through the Capital Projects, Equipment & eHealth Projects update and an update was also included with the Information Governance Annual Report 2020/21, presented to the P&RC in April 2021,

which highlighted progress against recommendations, categorised by importance. A post-audit meeting with the Scottish Government took place on 15 December 2020 to review the recommendations and ensure planned work would appropriately satisfy the requirements as set down by the Competent Authority and since then, progress has been made in some key areas. Internal audit A14&A28/21 – Organisational Response to External Reports recommended that the P&RC should receive a regular Highlight Report on NISR, to include a risk assessment of black (critical) and red (urgent) recommendations, and clearly stating any risks to achievement of actions steps being taken to ensure overall compliance with NIS regulations.

Whilst we note that that the Cyber Security / Resilience Group, to be reinstated by 30 June 2021, should provide better tracking of progress on NIS, to help coordinate efforts of the new tools, staff and resources, this should be accompanied by specific assurances to the P&RC on the effectiveness of these arrangements and the subsequent impact on related risks.

Information Governance

The Information Governance Annual report 2020/21 was presented to the IGC in April 2021 and approved by the P&RC in May 2021. It concluded that appropriate governance arrangements were in place throughout the year and that assurances had been provided to the P&RC on the work undertaken and progressed during the year. Internal audit A30/21 provided moderate assurance on the security of e-Health related mobile devices such as laptops and tablets, including the arrangements for the requisitioning, receipt, labelling, storage and disposal of such equipment.

Action Point Reference 6 Risk & Assurance reporting	
Finding:	
Currently, risk reporting to Standing Committees covers only those risks where the risk score has changed and, as a result, detailed risk reports on the IG and the IT Infrastructure strategic risks have not yet been reported to the P&RC. A programme of 'deep dive' risk reporting has commenced and will include all strategic risks. We have been informed that a strategic risk for Cyber resilience will be introduced from quarter 2 of 2021/22 and the status of the existing strategic IT infrastructure will be reviewed.	
Audit Recommendation:	
As a number of strategic risks are aligned to the P&RC, a programme of prioritised reporting should be agreed to ensure adequate and prioritised reporting on all risks aligned to the committee, including IG and cyber security.	
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 forward look programme of prioritised reporting on strategic risks aligned to the Performance & Resources Committee will be agreed.	
Action by:	**Date of expected completion:**
Performance Manager with support from Corporate Risk Manager and relevant risk leads	**November 2021**

Key Performance Indicators – Performance against Service Specification

	Planning	Target	2019/20	2020/21
1	Strategic/Annual Plan presented to Audit & Risk Committee by April 30th		Draft presented 16 June 2020	Draft circulated 9 June 2021
2	Annual Internal Audit Report presented to Audit & Risk Committee by June		Yes	Yes
3	Audit assignment plans for planned audits issued to the responsible Director at least 2 weeks before commencement of audit	75%	100%	100%
4	Draft reports issued by target date	75%	81%	53%
5	Responses received from client within timescale defined in reporting protocol	75%	81%	80%
6	Final reports presented to target Audit & Risk Committee	75%	84%	78%
7	Number of days delivered against plan	100% at year-end	91%	93%
8	Number of audits delivered to planned number of days (within 10%)	75%	74%	71%
9	Skill mix	50%	72%	71%
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:

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