NHS Fife Audit & Risk Committee

Thu 14 March 2024, 14:00 - 16:00

MS Teams

Agenda

14:00 - 14:00
0 min

1. Apologies for Absence

Alastair Grant

14:00 - 14:00
0 min

2. Declaration of Members' Interests

Alastair Grant

14:00 - 14:00
0 min

3. Minutes of Previous Meeting held on Wednesday 13 December 2023

Enclosed *Alastair Grant*

Item 3 - Audit & Risk Committee Minutes (unconfirmed) 20231213.pdf (7 pages)

14:00 - 14:10
10 min

4. Matters Arising / Action List

Enclosed *Alastair Grant*

Item 4 - Audit & Risk Committee Action List 20240314.pdf (1 pages)

14:10 - 14:20
10 min

5. EXTERNAL AUDIT

5.1. Patients' Private Funds - Audit Planning Memorandum

Enclosed *Kevin Booth / Alan Mitchell, Thomson Cooper*

Item 5.1 - Patients' Private Fund Planning Memo 2024.pdf (26 pages)

14:20 - 14:35
15 min

6. ANNUAL ACCOUNTS

6.1. Initial Annual Accounts Preparation Timeline

Enclosed *Kevin Booth*

Item 6.1 - SBAR Initial Annual Accounts Preparation Timeline.pdf (3 pages)
Item 6.1 - Appendix 1 Draft 2023-24 Annual Accounts Timetable.pdf (1 pages)

6.2. External Auditors Annual Accounts Progress Update

Enclosed *Chris Brown*

Item 6.2 - External Auditors Annual Accounts Progress Update.pdf (11 pages)

14:35 - 15:05

7. INTERNAL AUDIT

30 min

7.1. Internal Audit Progress Report

Enclosed *Barry Hudson*

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

7.2. Internal Audit – Follow Up Report on Audit Recommendations

Enclosed *Andy Brown*

- Item 7.2 - SBAR Internal Audit – Follow Up Report on Audit Recommendations 2022-23.pdf (16 pages)

7.3. Internal Audit Framework

Enclosed *Jocelyn Lyall*

- Item 7.3 - SBAR Internal Audit Framework.pdf (4 pages)
- Item 7.3 - Appendix A Internal Audit Framework Tracked Changes.pdf (29 pages)
- Item 7.3 - Appendix B Internal Audit Framework Clean Version.pdf (26 pages)

7.4. Business Continuity Arrangements Internal Audit Report

Enclosed *Joy Tomlinson*

- Item 7.4 - SBAR Business Continuity Arrangements Internal Audit Report.pdf (5 pages)
- Item 7.4 - Appendix 1 Business Continuity Findings Report.pdf (17 pages)

15:05 - 15:20
15 min

8. RISK

8.1. Corporate Risk Register

Enclosed *Maxine Michie / Pauline Anne Cumming*

- Item 8.1 - SBAR Corporate Risk Register.pdf (7 pages)
- Item 8.1 - Appendix 1 NHS Fife Corporate Risk Register as at 5 March 2024.pdf (20 pages)
- Item 8.1 - Appendix 2 Assurance Principles.pdf (1 pages)

8.2. Risks & Opportunities Group Progress Report

Enclosed *Pauline Anne Cumming*

- Item 8.2 - SBAR Risks & Opportunities Group Progress Report.pdf (4 pages)

15:20 - 15:50
30 min

9. GOVERNANCE MATTERS

9.1. Audit & Risk Committee Self-Assessment Report 2023/24

Enclosed *Dr Gillian MacIntosh*

- Item 9.1 - SBAR Audit & Risk Committee Self-Assessment Report 2023-24.pdf (13 pages)

9.2. Annual Review of Audit & Risk Committee Terms of Reference

Enclosed *Dr Gillian MacIntosh*

- Item 9.2 - Annual Review of Audit & Risk Committee Terms of Reference + appendix.pdf (11 pages)

9.3. Losses & Special Payments Quarter 3

Enclosed *Kevin Booth*

- Item 9.3 - SBAR Losses & Special Payments Quarter 3.pdf (3 pages)

Item 9.3 - Appendix 1 Losses & Special Payments Quarter 3.pdf (1 pages)

9.4. Waiver of Competitive Tenders Quarter 3

Enclosed *Kevin Booth*

Item 9.4 - SBAR Waiver of Competitive Tenders Quarter 3.pdf (3 pages)

9.5. Final Annual Workplan 2024/25

Enclosed *Dr Gillian MacIntosh*

Item 9.5 - Final A&R Annual Workplan 2024-25.pdf (4 pages)

15:50 - 16:00
10 min

10. FOR ASSURANCE

10.1. Audit Scotland Technical Bulletin 2023/4

Enclosed *Kevin Booth*

Item 10.1 - SBAR Audit Scotland Technical Bulletin 2023-4.pdf (3 pages)
Item 10.1 - Appendix 1 Audit Scotland Technical Bulletin 2023-4.pdf (23 pages)

10.2. NHS in Scotland 2023 Audit Scotland Report

Enclosed *Kevin Booth*

Item 10.2 - NHS in Scotland 2023 Audit Scotland Report.pdf (59 pages)

10.3. Delivery of Annual Workplan 2023/24

Enclosed *Dr Gillian MacIntosh*

Item 10.3 - Delivery of Annual Workplan 2023-24.pdf (5 pages)

16:00 - 16:00
0 min

11. ESCALATION OF ISSUES TO NHS FIFE BOARD

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

Verbal *Alastair Grant*

16:00 - 16:00
0 min

12. ANY OTHER BUSINESS

16:00 - 16:00
0 min

13. DATE OF NEXT MEETING - THURSDAY 16 MAY 2024 FROM 2PM - 4PM VIA MS TEAMS

Fife NHS Board

Unconfirmed

MINUTE OF THE AUDIT & RISK COMMITTEE MEETING HELD ON WEDNESDAY 13 DECEMBER 2023 AT 1.30PM VIA MS TEAMS

Present:
Alastair Grant, Non-Executive Member (Chair)
Cllr Graeme Downie, Non-Executive Member *(from item 5.4)*
Anne Haston, Non-Executive Member
Kirstie MacDonald, Non-Executive Member

In Attendance:
Kevin Booth, Head of Financial Services & Procurement
Andy Brown, Principal Auditor Manager
Chris Brown, Head of Public Sector Audit (UK), Azets
Pauline Cumming, Risk Manager
Andrew Ferguson, Senior Audit Manager, Azets
Alistair Graham, Associate Director of Digital & Information *(item 5.3 only)*
Barry Hudson, Regional Audit Manager
Amy Hughes, Senior, Azets
Jocelyn Lyall, Chief Internal Auditor
Dr Gillian MacIntosh, Head of Corporate Governance & Board Secretary
Margo McGurk, Director of Finance & Strategy
Hazel Thomson, Board Committee Support Officer (Minutes)

Chair's Opening Remarks

The Chair welcomed everyone to the meeting.

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

1. Apologies for Absence

Apologies were received from member Aileen Lawrie (Non-Executive Member) and attendee Carol Potter (Chief Executive).

2. Declaration of Members' Interests

There were no declarations of interest made by members.

3. Minute of the last Meeting held on 31 August 2023

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

4. Action List / Matters Arising

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

5. RISK

5.1 October 2023 Risk Management Development Session Outputs

The Director of Finance & Strategy presented the paper which sets out the key aspects of the discussion.

It was noted that there was a positive response in relation to the improvements made to risk management reporting and the introduction of the deep dives. It was noted that the Risk & Opportunities Group will be exploring further enhancements.

It was acknowledged that the Committee explored their risk management responsibilities and agreed to enhance that through requesting updates from the other Committees on their discussion on the corporate risk register to further support this.

It was acknowledged that an excellent presentation was provided from the Associate Director of Digital & Information in terms of further developing the dashboard.

The Director of Finance & Strategy stated that a number of actions from the session will be added to the Committee action list.

Action: Director of Finance & Strategy/Board Committee Support Officer

The Committee **approved** the note of the development session.

5.2 Corporate Risk Register

The Director of Finance & Strategy advised that the report was presented to the full NHS Fife Board at the November 2023 meeting for scrutiny.

It was reported that since the last report the strategic risk profile is unchanged, no risks have been closed, and two potential new corporate risks have been identified relating to the Preparation for the Implementation of the Health and Care (Staffing) (Scotland) Act 2019, and Future Biological Threats including Pandemics, which will be added to the Corporate Risk Register for the next iteration.

A Haston, Non-Executive Member, requested an update on risk 9 – quality & safety. The Director of Finance & Strategy advised that the Chief Executive had commissioned an external review around triangulation of risks in this area and the purpose of the review was to explore if further management reporting around quality & safety was required, to provide greater assurance. It was advised that the previous Chief Internal Auditor has been commissioned to take this review forward.

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

5.3 Risk & Opportunities Group Progress Report

The Associate Director of Digital & Information confirmed updates on elements of the risk management improvement programme, particularly around the work of the presentation of the corporate risk register, the role of the deep dive and supporting further improvement in the operational risk management, which will be provided in due course.

A Haston, Non-Executive Member and the Chief Internal Auditor both expressed support for the ongoing work.

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

5.4 Risk Management Policy Update

The Director of Finance & Strategy reported that the Risk Management Framework was approved at the September 2023 Board meeting. It was noted that there had been an outstanding action to update the Risk Management Policy and the Director of Finance & Strategy explained that once the previous Policy had been revised, there was considerable duplication and overlap with the content of the Framework.

Committee attendees commented that there was strong support from the Risk & Opportunities Group to expand the Framework document to capture essential content from the Policy, as detailed in the paper. It was also noted that this would prevent multiple sources of the same guidance, and that it could be managed within the Risk Management Team to ensure the Framework remains current.

A Haston, Non-Executive Member, questioned if there was a benefit of having two separate documents. In response, the Director of Finance & Strategy explained that the Framework now contained all new or additional content, which will enable easier engagement and guidance for staff.

The Committee took **assurance** from the update and **approved** the proposal within.

6. INTERNAL AUDIT

6.1 Delivering Excellence in Internal Audit

The Chief Internal Auditor presented on Delivering Excellence in Internal Audit and was thanked for an informative presentation.

6.2 Internal Audit Progress Report

The Regional Auditor Manager advised that the paper provides assurance on progress againt the current internal audit plan. It was highlighted that there have been delays in finalising audits due to staff absences. It was further highlighted that the 2023/24 some revisions to the plan will be shared with the Committee members in January 2024.

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

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

The Principal Auditor Manager provided a summary of the paper. It was advised that there are currently six actions that are older than one year, and extended review dates have been agreed with the appropriate officers; the detail is provided within appendix C. It was noted that extensions are routinely reviewed to consider how likely it is that actions will be implemented by the revised implementation date.

Members considered the content of appendix D – Recommendations less than 1 year and agreed to receive updates only on recommendations less than one year old that have a fundamental or significant priority, with the caveat that they could be signposted to the information, if required.

The Committee took **assurance** from the status of Internal Audit recommendations recorded within the AFU system.

6.4 Internal Controls Evaluation (ICE) Report 2023/24

The Chief Internal Auditor advised that a full review of all areas of governance has been carried out, which supports identifying any potential issues that may impact the governance statement. It was noted that the ICE report sits alongside the annual report and year end audits report.

It was advised that the report is positive with a real focus on improvement. The main challenges and improvement themes from the report included delivering financial sustainability; a requirement for broader strategic reform; realistic workforce plans; and a need to work closely with partners to address capacity and flow issues.

Key developments were highlighted, including the Population Health & Wellbeing Strategy and the continuing development of the Integrated Performance & Quality Improvement Report.

The Chief Internal Auditor advised that positive engagement continues with responsible officers, in terms of the actions, and that the position on all the previous years' recommendations is provided within the report. An overview was provided on progress on a number of key recommendations.

Following a question from A Haston, Non-Executive Member, the Director of Finance & Strategy provided clarity in relation to the table of assurances and financial sustainability action plan.

Following a query from G Downie, Non-Executive Member, the Director of Finance & Strategy confirmed that scenarios have been prepared in advance of the December SG budget statement, that discussions take place with other NHS Scotland Health Boards, and that the pressure areas are similar across the boards.

The Committee took **assurance** from the Internal Control Evaluation report.

7. EXTERNAL AUDIT

7.1 Annual Audit Plan 2023/24

A Hughes, Azets, spoke to the External Audit Annual Audit Plan. She highlighted the significant risks of material misstatement to the financial statements and provided an overview of these risks. An independence threat was also disclosed, and an explanation was provided on the safeguards in place to mitigate ahead of the assignment.

It was reported that the timelines set out within the paper will ensure that the Scottish Government deadline date for approval of the accounts, of 30 June 2024, will be met.

It was agreed that Azets will hold a training session for Committee members on their responsibilities for the Annual Accounts. The timeline for the session will be factored into the Committee workplan.

Action: C Brown, Azets/Board Committee Support Officer

The Committee **approved** the External Audit Annual Audit Plan.

8. GOVERNANCE MATTERS

8.1 National Fraud Initiative Assignment 2023 Participation

The Head of Financial Services & Procurement explained the process to raise awareness of board participation. It was noted that whilst there were no significant findings to report from NHS Fife there were a number of minor outcomes and a summary of these was provided to support the committees understanding of the process.

A Haston, Non-Executive Member, queried where the payroll-to-payroll multiple employment investigation sits and was advised that these matches are investigated by the Financial Services Team.

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

8.2 Losses & Special Payments Quarter 2

The Head of Financial Services & Procurement advised that the report is provided to give assurance that losses and special payments continue to be tightly controlled in quarter 2. It was reported that there were 229 losses in the quarter, which is significantly higher than the previous quarter, however, the cost was notably down, primarily due to the significant reduction in clinical negligence payments.

Additional assurance was provided that any findings identified through the analytical review, which is carried out by the Financial Services Team, are forward to the next quarter to assist with the identification of any trends and associated risks that may be developing.

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

8.3 Procurement Tender Waivers Quarter 2

The Head of Financial Services & Procurement reported that in quarter 2 the Procurement Team awarded five contracts of £50,000 or above. Of these contracts, one was subject to a waiver of competitive tender. A brief summary of the justification was presented and assurance was provided that the process was correctly followed as detailed in the Financial Operating Procedures.

The Committee took **assurance** that the procurement process for the waiver of competitive tenders was correctly applied in the period.

8.4 Financial Operating Procedures Review 2023

The Head of Financial Services & Procurement reported that the 2023 review has concluded as planned. He advised that the Financial Operating Procedures form part of the internal controls system.

Confirmation was provided that key individuals across NHS Fife were consulted during the review to ensure that appropriate expertise was utilised. A number of key sections were highlighted having had significant amendments. The patient private funds management section in particular had been considerably revised and it was noted that there was an internal audit assignment carried out in conjunction, and work is ongoing to ensure that those involved in patient funds management at ward level are aware of the changes in current practice that need to be followed. It was also highlighted that a deeper dive has been carried out on the Patient and Public Expenses Payment Policy, and a new section has been added to cover leases to ensure that there is a revised control to align with the adoption of IFRS16.

It was advised that the next review is scheduled for 2025, and an interim update will be provided if any significant changes come to light.

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

8.5 Review of Draft Annual Workplan 2024/25

The Director of Finance & Strategy advised that the draft workplan sets out the priorities for the Committee for 2024/25 and this will be regularly reviewed to ensure that it remains current.

The Committee **approved** the proposed Annual Workplan 2024/25.

9. FOR ASSURANCE

9.1 Audit Scotland Technical Bulletin 2023/3

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

9.2 Delivery of Annual Workplan 2023/24

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

10. ESCALATION OF ISSUES TO NHS FIFE BOARD

There were no issues to highlight to the Board.

11. ANY OTHER BUSINESS

There was no other business.

12. DATE OF NEXT MEETING

The next meeting will take place on **Thursday 14 March 2024** from 2pm – 4.30pm via MS Teams.

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

AUDIT & RISK COMMITTEE – ACTION LIST
Meeting Date: Thursday 14 March 2024

NHS Fife

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	TIMESCALE	COMMENTS / PROGRESS	RAG
1.	31/08/23	**National Risk Management System**	Exploratory discussions are ongoing at a national level around procurement of risk management systems. Currently, the local preference is for Datix Cloud IQ. The outcome of national discussions is awaited.	**PC**	An update will be brought back to the Committee on developments as the business case is finalised.	17/03/22 - A business case is being developed in April 2022 for NHS Fife, and the preferred upgrade package is Datix Cloud IQ. A verbal update was provided at the September 2022 meeting.	In progress/ on hold
2.	13/12/23	**October 2023 Risk Management Development Session Outputs**	To add specific actions from the session to the Committee action list.	**MM/HT**	May 2024		
3.	13/12/23	**Annual Audit Plan 2023/24 – Annual Accounts**	A training session for Committee members on their responsibilities for the Annual Accounts to be factored into the Committee workplan.	**CB/HT**	March 2024	Complete.	Closed

Fife Health Board Patients' Private Funds Audit Planning Memorandum

To the Board

Audit of Accounts

Year Ended 31 March 2024

Introduction

Purpose and Scope

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

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

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

In recent years, there have been a number of developments in the auditing and financial reporting framework, particularly in relation to charities. These are set out in the separate charity Appendix. If you wish to discuss further the impact of these developments on Fife Health Charity we would be pleased to do so.

This report is addressed to the Board of Fife Health Board Patients' Private Funds and is intended for internal use only for the purpose of planning and discussing the audit of the financial statements for the year ended 31 March 2024. This report may not be reproduced in whole or in part without the prior, written consent of Thomson Cooper.

Background to Appointment

General

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

Independence

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

Staff Independence

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

Money Laundering Regulations

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

Quality

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

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

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

Background to Appointment (continued)

Ethical Standards

Part 3 of the Revised Ethical Standard 2019 issued by the Financial Reporting Council looks at 'Long Association with Engagements'. Where partners and staff in senior positions have a long association, a familiarity threat to integrity and objectivity of that person may exist. In order to safeguard against such threats, the firm is required to apply appropriate safeguards. These safeguards could include rotating the audit partner by appointing another partner with no previous involvement as a Responsible Individual (RI) with the entity, rotating senior members of the audit team, involving an additional partner who has not previously been a member of the engagement team to advise or arranging an engagement quality review of the audit.

Subject to board approval, it is suggested Alan Mitchell will be retained as the RI and Fiona Haro, another RI within the firm, will undertake a concurring review.

Alan Mitchell has been the Responsible Individual (RI) for 11 years, however over this time the composition of the Board of Trustees has changed and the audit manager in charge of the audit fieldwork has changed. The RI is involved in the direction of the audit and supervises all work conducted, however the RI does not perform any of the audit fieldwork. All audit work is carried out by a qualified accountant.

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

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Thomson Cooper Audit Approach

General

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

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

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

Effective planning facilitates:

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

Detailed Audit Procedures

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

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

Relationship with Internal Audit

Introduction

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

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

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

International Standard on Auditing 610

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

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

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

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

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

Staffing

Partner in Charge of Assignment

The audit engagement partner is Alan Mitchell. This is Alan's 11th year as lead. In accordance with Section 3 of the Ethical Standard, safeguards are in place to ensure objectivity and independence is not impaired.

Details of the safeguards in place are set out on page 3.

Alan will sign the Audit Report as Senior Statutory Auditor on behalf of Thomson Cooper.

Support Partners

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

Other Staff

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

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

The senior staff member this year is Lauren Halford, a qualified Accountant.

Audit Risks

Introduction

Audit risk comprises three elements:

- Inherent risk
- Control risk
- Detection risk

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

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

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

The list is not exhaustive and has been prepared based upon our previous experience prior to the commencement of the detailed planning work for the audit for the year ended 31 March 2024.

The Board remain ultimately responsible for the integrity of the financial statements and risk management in the widest context. Thomson Cooper, as external auditor, are responsible for providing the Board of Fife Health Board Patients' Private Funds reasonable assurance that the accounts are free from material misstatement and that the accounts give a true and fair view of the state of the affairs of Fife Health Board Patients' Private Funds at 31 March 2024. While the audit work performed may involve consideration of such issues as the impact of failure of IT equipment for example, the work performed will be limited to considering the extent to which the breach might impact upon the financial statements. Hence risks of this nature have been excluded from those listed below.

Audit Risks (continued)

Security of Patients Funds

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

Compliance with Agreed Operating Procedures

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

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

Management Override

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

Fraud

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

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

Audit Risks (continued)

Fraud (continued)

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

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

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

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

Materiality

Concept and definition

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

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

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

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

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

Calculation and determination

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

We determine materiality in order to:

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

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

Materiality (continued)

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

Reassessment of materiality

We will reconsider materiality if, during the course of our audit engagement, we become aware of facts and circumstances that would have caused us to make a different determination of planning materiality if we had been aware of those facts and circumstances when we made our initial determination.

Further, when we have performed all our substantive tests and are ready to evaluate the results of those tests, including any misstatements we detected, we will reconsider whether materiality, in combination with the nature, timing and extent of our auditing procedures, provided a sufficient audit scope. If we conclude that our audit scope was sufficient, we will use materiality to evaluate whether uncorrected misstatements, individually or in aggregate, are material.

Unadjusted errors

In accordance with auditing standards, we will communicate to the Board all unadjusted items identified during our audit, other than those which we believe are "clearly trivial".

Clearly trivial is defined as matters which will be of a wholly different (smaller) order of magnitude than the materiality thresholds used in the audit, and will be matters that are clearly inconsequential, whether taken individually or in aggregate.

Auditing standards do not place numeric limits on the meaning of 'clearly trivial', however, we consider the 'clearly trivial' limit to be less than 1% of materiality.

We will obtain written representations from the Board confirming that after considering all these unadjusted items, both individually and in aggregate, no adjustments are required.

There are a number of areas where we would strongly recommend or request any misstatements identified during the audit process being adjusted. These include:

- misstatements that we believe were intentionally made to achieve targeted earnings or similar goals;
- clear cut-off errors whose correction would cause non-compliance with loan covenants, management compensation agreements, other contractual obligations or governmental regulations that we consider are significant; and
- other misstatements that we believe are material or clearly wrong.

Reporting of Audit Findings

Communication

As external auditor, we have direct access to the Board should the need arise. Audit findings will be communicated orally at the meeting of the Board at which the annual accounts are reviewed.

In addition, on completion of the audit field work an Audit Completion Memorandum will be prepared summarising the main audit findings which will be addressed to the Board for their responses.

Audit Adjustments

Any misstatements identified as a result of the audit work performed, which have not already been adjusted, will be reported to the Board. If, after discussion, there remain any material unadjusted misstatements written representation from the Board may be sought setting out the reasons for non-adjustment.

Misstatements which have been found, but adjusted, will only be brought to the attention of the Board where it is believed that an awareness is required for the Board to be able to fulfil their governance responsibilities or where adjustments indicate significant weaknesses in the system of internal controls.

Audit Timetable

We have assumed that "those charged with governance" are the Board of Trustees. ISA (UK) 260 "Communication of audit matters with those charged with governance", requires auditors to plan the form and timing of communications with those charged with governance.

The audit process is made up of three stages: planning, fieldwork and completion. The planned timing of the audit process is as follows:

- Pre Year End Planning Meeting with Client
- 17 January 2024
- Issue Audit Planning Memorandum
- 4 March2024
- Issue Bank Confirmation Letter
- March 2024
- Planning Meeting with client
- WC 8 April 2024
- Draft Accounts to be received
- 22 April 2024
- Audit Staff Planning Meeting
- 29 April 2024
- Audit Fieldwork commences
- 6 May 2024
- Audit Clearance Meeting
- WC 27 May 2024
- Board Meeting
- 20 June 2024
- Deadline for Accounts Signing
- 30 June 2024

Fee Proposal

We have set out below our fee proposal (excluding VAT and necessary disbursements) for 31 March 2024.

We request that management prepare schedules to support the figures included in the financial statements in order to operate a cost effective audit service. Our fee estimates are based on the following assumptions:

- Internal financial controls can be relied upon where planned;
- Working papers which support the accounts will be of the highest standard;
- You will inform us on a timely basis of any significant developments or emerging risks;
- You will provide requested information within agreed upon timescales; and
- There are no protracted conclusions to the audit process.

	Proposed 2024	Actual 2023
	£	£
Billing Timetable		
Billed after audit fieldwork	2,500	2,150
Billed on signing of accounts	1,150	1,000
	3,650	3,150

The above fees are exclusive of VAT and expenses.

Appendix 1 – Engagement Letter

An electronic copy of our newly issued Engagement Letter is as follows:

CF15B.1537854.KC

-

24 March 2021

The Trustees
Fife Health Board Patients' Private Fund
Evans Business Centre
Mitchelston Industrial Estate
Mitchelston Drive
Kirkcaldy
Fife
KY1 3NB

Dear Trustees

We are pleased to continue the instruction to act as your advisers and are writing to confirm the terms of our appointment.

The purpose of this letter together with the attached terms and conditions is to set out our terms for carrying out the work and to clarify our respective responsibilities.

We are bound by the ethical guidelines of the Institute of Chartered Accountants Scotland and accept instructions to act for you on the basis that we will act in accordance with those guidelines.

1. Engagement letter

1.1 Thank you for engaging us as your advisers. Alan Mitchell will be your main point of contact and will have primary responsibility for this assignment. This letter and the attached schedule(s) of services together with this firm's standard terms and conditions set out the basis on which we will act.

2. Who we are acting for

2.1 For the avoidance of doubt Margo McGurk is acting as nominated first point of contact. Any change to the nominated person should be notified to us in writing and will not be effective until acknowledged by us in writing.

3. Period of engagement

3.1 This engagement will start from the date this letter is signed. It replaces all previous engagements that we have had with you.

4. Our responsibility to you

4.1 We have set out the agreed scope and objectives of your instructions within this letter of engagement. Any subsequent changes will be discussed with you and where appropriate a new letter of engagement will be agreed. We shall proceed on the basis of the instructions we have received from you and will rely on you to tell us as soon as possible if anything occurs which renders any information previously given to us as incorrect or inaccurate. We shall not be responsible for any failure to advise or comment on any matter which falls outside the specific scope of your instructions. We cannot accept any responsibility for any event, loss or situation unless it is one against which it is the expressed purpose of these instructions to provide protection.

5. Your responsibility to us

5.1 The advice that we give can only be as good as the information upon which it is based. Insofar as that information is provided by you, or by third parties with your permission, your responsibility arises as soon as possible if any circumstances or facts alter as any alteration may have a significant impact on the advice given. If the circumstances change therefore or your needs alter, advise us of the alteration as soon as possible in writing.

6. Services

6.1 Attached is the schedule of services listed below which records the work we are instructed to carry out. This also states your and our responsibilities in relation to the work to be carried out.

Schedules

Unincorporated Charity Audit (April 2015 version 2)

6.2 You may request that we provide other services from time to time. We will issue a separate schedule of service or, if necessary, a new letter of engagement and scope of work to be performed accordingly.

6.3 Because rules and regulations frequently change you must ask us to confirm any advice already given if a transaction is delayed or a similar transaction is to be undertaken.

7. Fees

7.1 Our fees will be charged in accordance with our standard terms and conditions. Please review these to ensure you understand the basis of our charges and our payment terms.

8. Limitation of liability

8.1 You have agreed that our liability as auditors to the company will be limited in accordance with sections 532 to 538 of the Companies Act 2006. The terms of this agreement are in our standard terms and conditions which are attached to this engagement letter.

8.2 We specifically draw your attention to paragraph 23 of our standard terms and conditions which sets out the basis on which we limit our liability to you and to others. You should read this in conjunction with paragraph 11 of our standard terms and conditions which excludes liability to third parties.

8.3 There are no Third Parties that we have agreed should be entitled to rely on the work done pursuant to this engagement letter.

9. Your agreement

9.1 Once it has been agreed, this letter will remain effective until it is replaced.

9.2 We shall be grateful if you could confirm your agreement to the terms of this letter, the schedule of services and the standard terms and conditions by signing the enclosed copy and returning it to us immediately.

9.3 If this letter and schedule of services is not in accordance with your understanding of the scope of our engagement or your circumstances have changed, please let us know.

Yours sincerely

Thomson Cooper

Acceptance

We confirm that we have read and understood the contents of this letter, schedules and related terms and conditions and agree that it accurately reflects our fair understanding of the services that we require you to undertake.

Signed ..... Date .....

For and on behalf of
Fife Health Board Patients' Private Fund

SCHEDULE OF SERVICES

This schedule should be read in conjunction with the engagement letter and the standard terms and conditions.

UNINCORPORATED CHARITY AUDIT

1. Your responsibilities as trustees of the charity

1.1 In agreeing to these engagement terms, you acknowledge your responsibilities and confirm that you understand them.

1.2 As trustees of the charity you are responsible for:

a) ensuring that adequate accounting records are maintained which disclose the charity's financial position with reasonable accuracy at any time;

b) preparing financial statements for each financial year that:

i) give a true and fair view of the charity's state of affairs at the end of the financial year and of its incoming resources and application of resources for that year; and

ii) are in accordance with the Charities and Trustee Investment (Scotland) Act 2005 and regulations thereunder;

c) preparing an annual report on the activities of the charity during the year that complies with the requirements of the relevant regulations.

1.3 In preparing the financial statements (or arranging for them to be prepared) you are required to:

a) select suitable accounting policies and then apply them consistently;

b) make judgements and estimates that are reasonable and prudent;

c) prepare the financial statements on the going concern basis unless it is inappropriate to assume that the charity will continue in business; and

d) have regard to applicable accounting standards and the relevant statement of recommended practice.

1.4 You are responsible for such internal controls as you consider necessary to enable the preparation of the financial statements that are free from material misstatement, whether due to fraud or error.

1.5 Under the Charities Accounts (Scotland) Regulations 2006 (as amended) and the Charities SORP you are required to report as to whether you have given consideration to the major risks to which the charity is exposed, and to the systems designed to manage those risks. We are not required to audit this statement, or to form an opinion on the effectiveness of the risk management and control procedures.

1.6 You are responsible for safeguarding the assets of the charity and to ensure their proper application, and hence for taking reasonable steps to prevent and detect fraud and other irregularities.

1.7 You are responsible for ensuring that the charity complies with laws and regulations that apply to its activities, and for preventing non-compliance and detecting any that occurs.

1.8 You undertake to make available to us, as and when required, all the charity's accounting records and related financial information, including minutes of management and members' meetings that we need to do our work. You will disclose to us all relevant information in full. In particular, you agree to provide:

a) access to all information of which management is aware that is relevant to the preparation of the financial statements such as records, documentation and other matters;

b) additional information that we may request from management for the purpose of the audit; and

c) unrestricted access to persons within the entity from whom we determine it necessary to obtain audit evidence.

1.9 If audited financial information is published, which includes a report by us or is otherwise connected to us, on the charity's website or by other electronic means, you must inform us of the electronic publication and obtain our consent before it occurs and ensure that it presents the financial information and auditor's report properly. We have the right to withhold consent to the electronic publication of our report or the financial statements if they are to be published in an inappropriate manner.

1.10 You must set up controls to prevent or detect quickly any changes to electronically published information. We are not responsible for reviewing these controls nor for keeping the information under review after it is first published. You are responsible for the maintenance and integrity of electronically published information and we accept no responsibility for changes made to audited information after it is first posted.

1.11 You are responsible for establishing and controlling any process for electronically distributing Annual Reports and other financial information to members and/or supporters of the charity and to the Office of the Scottish Charity Regulator (OSCR).

1.12 You are responsible for filing the charity's financial statements and an annual report for the financial year complying in its form and content, as well as other relevant documentation, with OSCR in accordance with their requirements, unless otherwise agreed.

1.13 The audited financial statements and annual report are required to be delivered to OSCR within nine months of the end of the charity's financial year end and it is the trustees' responsibility to ensure that this deadline is met.

2. Our responsibilities as auditor

2.1 We have a statutory responsibility to report to you whether, in our opinion, the financial statements give a true and fair view of the state of affairs of the charity at the end of the financial year and of its incoming resources and application of resources in that year and whether they have been properly prepared in accordance with the Charities and Trustee Investment (Scotland) Act 2005 and regulations thereunder. In deciding this, we must consider the following matters, and report on any that we are not satisfied with:

a) whether the charity has kept proper accounting records;

b) whether the charity's balance sheet and statement of financial activities are in agreement with the accounting records and returns;

c) whether we have obtained all the information and explanations which we consider necessary for the purposes of our audit; and

d) whether the information given in the annual report of the charity trustees is not consistent with that contained in the audited financial statements.

2.2 We may also need to deal with certain other matters, according to the circumstances, in our report such as any material concerns we may have relating to the financial effects of any non-compliance with relevant laws and regulations.

2.3 We have a professional responsibility to report if the financial statements do not significantly comply with applicable financial reporting standards or the relevant statement of recommended practice unless, in our opinion, the departure is justified in the circumstances. In deciding whether or not this is the case we consider:

a) whether the non-compliance is necessary for the financial statements to give a true and fair view; and

b) whether the non-compliance has been clearly disclosed.

2.4 Our professional responsibilities also include:

a) describing in our audit report the trustees' responsibilities for the financial statements if the financial statements or accompanying information do not include this information; and

b) considering whether other information in documents containing the audited financial statements is consistent with those financial statements.

2.5 In respect of the expected form and content of our report, we refer you to the most recent bulletin on auditor's reports published by the Auditing Practices Board at http://www.frc.org.uk/apb. The form and content of our report may need to be amended in the light of our findings.

2.6 We have a statutory duty to report to OSCR such matters (concerning the activities or affairs of the charity or any connected institution or body corporate) of which we become aware during the course of our audit which are (or are likely to be) of material significance to OSCR in the exercise of the powers of inquiry into, or acting for the protection of, charities. It is envisaged that the need to make such a report will arise only very rarely, in accordance with the guidance set out in International Standards on Auditing (UK & Ireland) 250 Section B "The Auditor's Right and Duty to Report to Regulators in the Financial Sector".

2.7 We will report solely to the charity's trustees, as a body. Our audit work will be undertaken so that we might state to the trustees those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the trustees, as a body, for our audit work, for this report, or for the opinion we have formed.

2.8 You should be aware that the charity's annual financial statements are for the specific purpose of reporting to the trustees [as well as to the members] at a particular point in time. They may therefore not be suitable for other purposes such as such as making decisions regarding borrowing or investing by you as trustees or by any other party.

3. Scope of audit

3.1 We will carry out our audit in accordance with the International Standards on Auditing (UK and Ireland) issued by the Auditing Practices Board. The audit will include such tests of transactions and of the existence, ownership and valuation of assets and liabilities as we consider necessary.

3.2 We shall obtain an understanding of the accounting and internal control systems to ensure they are adequate as a basis for the preparation of the financial statements and to establish whether the charity has kept proper accounting records. We will gather enough evidence to enable us to reach a reasonable conclusion.

3.3 You are responsible for safeguarding the charity's assets and for preventing and detecting fraud, error and non-compliance with law or regulations. We will plan our audit so that we can reasonably expect to detect significant misstatements in the financial statements or accounting records (including those resulting from fraud, error or non-compliance with law or regulations), but you cannot rely on us finding all such errors.

3.4 We shall not be treated as having notice, for the purposes of our audit responsibilities, of information provided to members of our firm other than those engaged on the audit.

3.5 Once we have issued our audit report we have no further responsibility in relation to the financial statements for that financial year.

3.6 We would appreciate receiving notice of and invitations to attend the meeting of the trustees at which the annual report and financial statements are to be approved.

3.7 To ensure that there is effective two-way communication between us and to comply with the requirements of Auditing Standards we will:

a) contact you prior to the audit to discuss any relevant matters and to agree any required action; and

b) contact you to discuss any matters arising from the audit and to confirm any agreed action.

4. Reporting to the Trustees and Management

4.1 The nature and extent of our procedures will vary according to our assessment of the charity's accounting system and, where we wish to place reliance on it, the internal control system, and may cover any aspect of the charity's operations that we consider appropriate. Our audit is not designed to identify all significant weaknesses in the charity's systems but, if such weaknesses come to our notice during the course of our audit which we think should be brought to your attention, we shall report them to you. Any such report may not be provided to third parties without our prior written consent. Such consent will be granted only on the basis that such reports are not prepared with the interests of anyone other than the charity in mind and that we accept no duty or responsibility to any other party as concerns the reports.

5. Representations by management/trustees

5.1 As part of our normal audit procedures, we may request written confirmation of oral representations which we have received during the course of the audit on matters having a material effect on the financial statements.

6. Documents issued with the financial statements

6.1 In order to assist us with the examination of your financial statements, we shall request sight of all documents or statements, including the trustees' report, which are due to be issued with the financial statements. If it is proposed that any documents or statement which refer to our name, other than the audited financial statements, are to be circulated to third parties, please consult us before they are issued.

7. Irregularities, including fraud

7.1 The responsibility for the prevention and detection of fraud, error and non-compliance with law or regulations rests with yourselves. However, we shall endeavour to plan our audit so that we have a reasonable expectation of detecting material misstatements in the financial statements or accounting records (including those resulting from fraud, error or non-compliance with law or regulations), but our examination should not be relied upon to disclose all such material misstatements or frauds, errors or instances of non-compliance as may exist.

8. Provision of Service Regulations

8.1 Details of our audit registration can be viewed at www.auditregister.org.uk under reference number 0538.

24 March 2021

Thomson Cooper

Appendix 2 – Hospitals Visited

Hospital	Gross Receipts	2015	2016	2017	2018	2019	2020	2021	2022	2023	Proposed 2024
Adamson	-										
Levenmouth	63	✓				✓	✓				
Lynebank	87,295		✓		✓	✓		✓	✓		✓
Queen Margaret *	9,017		✓					✓			✓
St Andrews	-										
Stratheden	113,109	✓		✓	✓		✓		✓	✓	
Whyteman's Brae	8,369			✓						✓	

* Excludes "QM Acute" of £44,160

Gross Receipts are based on the figures from the accounts for the year ended 31 March 2023.

Note : Queen Margaret will also be visited to review and test the art catalogue

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**14 March 2024**
Title:	**Annual Accounts Preparation Timeline**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Kevin Booth, Head of Financial Services & Procurement**

1 Purpose

This is presented for:

- Assurance

This report relates to a:

- Government policy/directive
- Legal requirement

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

- Effective

2 Report summary

2.1 Situation

As part of the objectives of the Audit & Risk Committee in supporting the Accountable Officer and NHS Fife Board in meeting their assurance needs, the committee is required to review and recommend approval of the Audited Annual Accounts to the Board.

This paper is provided as an update to the committee on the progress of the Annual Accounts process and any concerns identified with regards to the anticipated timeframe to completion on the 30th June 2024.

2.2 Background

At the previous Audit and Risk Committee on the 13th December 2023, Azets, the Boards External Auditors presented the NHS Fife Annual Audit Plan 2023/24. The timelines contained within this plan were formed following discussions with the Head of Financial Services & Procurement and the Director of Finance and Strategy.

In order to support the External Auditors assignment and with the objective of requiring to have the Annual Accounts approved by the Board and presented to the Scottish

Government by 30th June 2024 an internal timetable is normally produced to manage components and ensure key milestones are understood and met across the finance team.

2.3 Assessment

The attached timetable (Appendix 1) was prepared by the Head of Financial Services and Procurement and was agreed with the Deputy Director of Finance. The timetable provides conformation of all key components, when they are to be concluded by and who the accountable individual is within the Finance Directorate.

The timetable was shared with the External Auditors for their awareness on 29th February and regular progress updates will be provided to them during the Annual Accounts process and until such time that the draft Annual Accounts are provided to them (Monday 6th May 2025).

A staged approach to the provision of the draft Annual Accounts has again been agreed with the External Auditors to allow them to progress with different elements as they are completed and ahead of them being incorporated into the final draft.

Key dates including the agreement of Year End Balances from the Health & Social Care Partnership, the Draft Accounts for the Patients Private funds and the Health Charity have been communicated to applicable external parties to ensure they align with their own processes.

2.3.1 Quality, Patient and Value-Based Health & Care

N/A

2.3.2 Workforce

The Finance staff's required input for the Annual Accounts process is communicated to them at the internal planning stage. In order to support the External Audit progress, the finance team will prioritise supporting Azets reviews wherever possible.

2.3.3 Financial

The Annual Accounts process is the key part of the Boards disclosure of its Financial Performance for the year 2023/24.

2.3.4 Risk Assessment/Management

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

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

Developments towards the Boards Anchor Institution ambitions will be incorporated into the Annual Accounts.

2.3.6 Climate Emergency and Sustainability Impact

Developments towards the Boards response to the climate emergency and its sustainability impact will be incorporated into the Annual Accounts.

2.3.7 Communication, involvement, engagement and consultation

The Head of Financial Services & Procurement has produced an internal timetable to ensure that all steps in the Annual Accounts process have been considered and are completed within the appropriate timeframe. Weekly meetings are held with Azets to inform progress and ensure timely resolution of any active matters arising.

2.3.8 Route to the Meeting

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

2.4 Recommendation

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

3 List of appendices

- **Appendix 1 –** NHSF Internal Annual Accounts Timetable 2023/24

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

NHS Fife

Annual Accounts Timetable 2023/24

Task	Owner	Day	Target Date
Distribute approved Templates & clarify Working Papers responsibility	KB	Friday	08/03/2024
Distribute Annual Accounts Manual & Capital accounting Manual	KB	Friday	08/03/2024
NHS Scotland bodies - Final date for purchase invoice authorisation and PECOS receipting, for payment by 24th March	**AMH**	**Wednesday 3pm**	**20/03/2024**
Final Inter account cash transfer (Endowment - Exchequer)	IP	Wednesday	20/03/2024
Final date for payments to Scottish NHS Scotland bodies without agreement of the recipient	AMH	Friday	22/03/2024
Final date for purchase invoice authorisation and PECOS receipting, for payment by 31st March	**All**	**Wednesday 3pm**	**27/03/2024**
Final creditors payment before 31 March (BACS file produced)	AMH/IH	Thursday	28/03/2024
Final date for sales invoices to NHS Scotland bodies to be included in SFR30 balances agreed	**IH**	**Thursday**	**28/03/2024**
Final creditors payment before 31 March credited to bank accounts	AMH/IH	Tuesday	02/04/2024
Purchase ledger close (month 12)	AMH/Zendesk	Sunday 8pm	31/03/2024
Registered Invoices Excel Report run	Ledger Control	Tuesday 9am	02/04/2024
Petty Cash Certificates returned	IH/AW	Wednesday	03/04/2024
Date first creditor payment after 31 Mar credited to bank accounts	AMH/IH	Friday	05/04/2024
Clinical/medical negligence provision	RM	Thursday	04/04/2024
Injury benefit / Early Retirement provision	KB	Thursday	04/04/2024
Upload Year End Stock Entries to eFin	**IH**	**Thursday**	**04/04/2024**
Registered Invoices year end coded & uploaded to eFin	**IH**	**Friday 9am**	**05/04/2024**
Financial Accounts ledger entries complete	**Fin A/c's**	**Thursday 5pm**	**04/04/2024**
Sales ledger close (month 12)	**IH/Zendesk**	**Friday**	**05/04/2024**
Return of Draft Front End Narrative sections	KB	Friday	05/04/2024
Front End Narrative to DOF for Review	KB	Monday	08/04/2024
Remuneration Report data reports from Payroll	TC/DK	Monday	05/04/2024
Capital entries complete	**TG & GM**	**Wednesday**	**10/04/2024**
Financial Management ledger entries complete	**FM**	**Wednesday**	**10/04/2024**
Primary Care entries complete	**CS**	**Wednesday**	**10/04/2024**
Final date for notifying other NHS Bodies of amounts to be charged in current Financial Year	FM	Monday	15/04/2024
Front End Narrative submitted to Auditors	**KB**	**Monday**	**15/04/2024**
Control account reconciliations complete	Ledger Control	Tuesday	16/04/2024
Primary Care control accounts reconciled	IH	Tuesday	16/04/2024
Agree and obtain reassurance from Fife Health & Social Care IJB on balances for consolidation	RR	Monday	25/04/2024
Remuneration Report complete	KB	Tuesday	16/04/2024
Remuneration Report to DOF/Chief Executive for review	KB	Wednesday	17/04/2024
Agreement of Earmarked Reserves & Direction Letter	AH/RR	Tuesday	25/04/2024
Finalise FPR Return cashflow	IH/KB	Friday	19/04/2024
General ledger close (month 12)	**Zendesk**	**Monday**	**22/04/2024**
Agree Debtors, creditors, income and expenditure balances with NHS Scotland bodies for SFR30	**IH**	**Friday**	**19/04/2024**
Analysis of debtors & creditors	IH	Wednesday	24/04/2024
Remuneration Report issued to Auditors	**KB**	**Monday**	**22/04/2024**
FPR Return to SGHSCD (Month 12)	RR	Monday (Noon)	22/04/2024
Revaluation figures processed in eFin	TG & GM	Thursday	25/04/2024
All working papers & draft Notes to be completed and available in AA folder	All	Thursday	25/04/2024
Working papers ready for auditors, confirmed to KB	**All**	**Friday**	**26/04/2024**
General ledger close (month 13)	**Zendesk**	**Monday 4pm**	**29/04/2024**
Draft Charity Accounts/Patient Funds Accounts complete	**IP/IH/KB**	**Monday**	**25/04/2024**
Annual Accounts Excel Template to DOF/Chief Executive for review	**KB**	**Friday**	**03/05/2024**
FPR Return to SGHSCD (Month 13)	RR	Monday (Noon)	06/05/2024
Draft accounts (Excel Template/Word Document) issued to Auditors	**KB**	**Monday**	**06/05/2024**

NHS Fife

Interim progress report

Year ended 31 March 2024

March 2024

Contents

Your key team members

Chris Brown
Engagement Lead
Chris.Brown@azets.co.uk

Andrew Ferguson
Engagement Manager
Andrew.Ferguson@azets.co.uk

Amy Hughes
Engagement Assistant Manager
Amy.Hughes@azets.co.uk

Caitlin Mackenzie
Senior
Caitlin.Mackenzie@azets.co.uk

Introduction

Adding value through the audit

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

Purpose

This paper provides the Audit and Risk Committee with a report on:

- Progress made to date with the external audit and whether it is on track
- Any emerging issues or findings which may impact the final accounts audit.

Responsibilities of the Board and the auditor

Board responsibilities

The Board has responsibility for:

- Preparing financial statements which give a true and fair view, in accordance with the applicable financial reporting framework and relevant legislation;
- Maintaining proper accounting records and preparing working papers to an acceptable professional standard that support the financial statements;
- Ensuring the regularity of transactions, by putting in place systems of internal control to ensure that they are in accordance with the appropriate authority; and
- Preparing and publishing, along with the financial statements, an annual governance statement, management commentary and a remuneration report in accordance with prescribed requirements.

Our requirements

In our audit plan, we set out the following requirements to enable us to deliver the audit in line with the agreed fee and timetable:

- Draft financial statements to be produced to a good quality by the agreed deadlines;
- Good quality working papers at the same time as the draft financial statements;
- Availability of staff during the period of the audit;
- Prompt and sufficient responses to audit queries to minimise delays.

Summary of audit progress

We have finalised our planning and our audit plan was presented to the Audit and Risk Committee on 13 December 2023.

Engagement with management has been good and we have received responses to a range of enquiries and requests, enabling us to progress our planning and interim work. Where information has been received, we have not at this stage identified any adverse findings to report to you.

We have planned and carried out an interim audit in February 2024 and have updated our understanding of NHS Fife's systems via walkthrough tests and discussions with members of the finance team. We also held discussions to develop our understanding of significant risk areas and to assist us in determining a testing approach to these areas, particularly the PFI refinancing in December 2023 and revaluations of property, plant and equipment (PPE).

The key information we have requested but not yet received relates to a walkthrough and system note for the implementation of IFRS 16 for PFI. We have agreed to carry out our walkthrough and system note work closer to the fieldwork stage, due to delayed central guidance and revised model being issued in February 2024.

Audit work plan tracker

KEY:

RED: Information required significantly delayed and statutory deadline may not be met / significant issue identified as finding

AMBER: Information required is delayed / issue identified

GREEN: Information required received and audit on track / no significant adverse findings or issues identified

Planned activity	Progress	Issues, impact and actions	Progress	Findings
Income and Receivables Walkthrough	We arranged meetings with the finance team to walkthrough the income and receivables process and document our understanding of this.	No issues noted at this point. We have one point to follow up on regarding customer set up.	Complete	No issues noted
Expenditure and Payables Walkthrough and System Notes (General)	We arranged meetings with the finance and procurement teams to walkthrough the general expenditure and payables process and document our understanding of this.	No issues noted at this point.	Complete	No issues noted
Expenditure and Payables Walkthrough and System Notes (Pharmacy)	We visited the Victoria Hospital and held discussions with the finance and pharmacy teams to walkthrough the pharmacy expenditure and payables process and document our understanding of this.	No issues noted, we have completed our discussions.	Complete	No issues noted
Payroll System Notes	We have received updated system notes on the payroll process and have documented our understanding of this.	No issues noted, information has been received.	Complete	No issues noted
Fixed Assets System Notes	We have received updated system notes on the fixed assets process and have documented our understanding of this.	No issues noted, information has been received.	Complete	No issues noted
PPE Revaluations Walkthrough and System Notes	We arranged a meeting with the capital team to walkthrough the PPE revaluations process and document our understanding of this.	No issues noted, we have completed our meetings and received the follow up documents requested.	Complete	No issues noted
IFRS 16 Implementation for PFI Walkthrough and System Notes	We have agreed to carry out our walkthrough and system notes work closer to the fieldwork stage, due to delayed central guidance and revised model being issued in February 2024.	This is in line with our expectations due to this being the first year of implementation of IFRS 16 for PFI.	Start Delayed	TBC

Audit work plan tracker

Planned activity	Progress	Issues, impact and actions	Progress	Findings
Bank and Cash System Notes	We have received updated system notes on the bank and cash process and have documented our understanding of this.	No issues noted, information has been received.	Complete	No issues noted
Leases System Notes	We arranged a meeting with the capital team to discuss the leases process and document our understanding of this.	No issues noted, we have completed our meetings.	Complete	No issues noted
Provisions System Notes and Walkthrough	We arranged a meeting with the estates team to walkthrough the provisions process and document our understanding of this.	No issues noted, we have completed our meetings and received the follow up documents requested.	Complete	No issues noted
Related Party Transactions System Notes	We have received updated system notes on the related party transactions process and have documented our understanding of this.	No issues noted, information has been received.	Complete	No issues noted
Journals Walkthrough	We arranged meetings with the financial services and financial management teams to walkthrough the journals process and document our understanding of this.	No issues noted, we have completed our meetings and received the follow up documents requested.	Complete	No issues noted
Nominal Ledger System Notes	We have received updated system notes on the nominal ledger process and have documented our understanding of this.	No issues noted, information has been received.	Complete	No issues noted

Audit work plan tracker

Planned activity	Progress	Issues, impact and actions	Progress	Findings
PFI Refinancing Discussions	We arranged a meeting with the estates and finance team to discuss the PFI refinancing in December 2023. We have gained an understanding of how this was carried out and the impact this will have on future budgets. Work still has to be undertaken by the finance team on updating the accounting model and this will be shared with us once it has been finalised.	No issues noted, work is still ongoing and we will undertake further work at the fieldwork stage of the audit to ensure this is appropriately reflected in the accounts.	Interim work complete, to be followed up at final audit	No issues noted at this point
Intangible Asset Discussions	We were invited to a meeting with the capital and finance team to discuss the two potential intangible asset additions being brought in to bridge the gap in the existing systems. The NHS Fife Digital team have provided us with more information to further our understanding of how this should be accounted for.	Work is still ongoing to understand the assets purchased and proposed accounting treatment by management, bringing forward judgements from the final fieldwork stage of the audit. No conclusions have been reached at this point, however as this was not originally in our interim work plan, this has been assessed as green progress.	In progress	No issues noted at this point
Starters and Leavers Payroll Testing	We requested a listing of starters and leavers covering the year to date (P1-10). This is to support our substantive testing to be completed on payroll expenditure, and bring forward testing out of the final fieldwork stage into the interim period.	Listing has been received. We will pick a sample and test this in further detail.	In progress	No issues noted at this point

Audit work plan tracker

Planned activity	Progress	Issues, impact and actions	Progress	Findings
Wider Scope Areas	Meetings have been held with the relevant contacts to discuss the following areas: **Financial Management** • Work done to date in reducing reliance on agency staff and associated costs. **Vision, Leadership and Governance** • Details of the implementation plans to support delivery of the Population Health and Wellbeing Strategy and progress made to date including how progress is measured. • Details of changes in Board members during the year. • Evidence of Board induction sessions/ development sessions during the year for new Board members and the new Chair. • Work over plans to implement Second Edition of Blueprint for Good Governance. • Details of changes to Governance arrangements in the year. • Details of any risk management /reporting framework changes during the year. **Use of Resources to Improve Outcomes** • Details of any amendments made or proposed to NHS Fife's performance framework.	No issues noted, we have completed our discussions.	Complete	No issues noted

Progression of the Audit

Summary of work to be undertaken between now and final audit

We will continue to follow up on the starters and leavers testing, with the aim of having the testing for M1-10 completed by the start of the final audit fieldwork.

Discussions are ongoing regarding the potential capitalisation of the intangible asset and we will continue to discuss and work with management to understand their proposed accounting treatment on this matter.

When there is a process for the implementation of IFRS 16 for PFI, notably the issue of central guidance and templates, we will hold a meeting to discuss, document and walkthrough our understanding of this to process.

We have now set up weekly catch-up meetings beginning now until the end of June with management to enable us to discuss any outstanding information or arising challenges or concerns. We have discussed provisional dates for receiving information for the final audit alongside managements year end accounts production timetable and we will work towards these to enable us to carry out the audit as efficiently as possible.

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NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**14 March 2024**
Title:	**Internal Audit Progress Report**
Responsible Executive/Non-Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Barry Hudson, Regional Audit Manager /**
	Jocelyn Lyall, Chief Internal Auditor

1 Purpose

This is presented for:

- Assurance
- Discussion

This report relates to a:

- Local policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this report is to:

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

2.2 Background

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

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

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

2.3 Assessment

We have previously reported audit days not delivered due to sickness absence and delays in staff recruitment. FTF is currently fully staffed, and this has allowed us to continue to progress the Fife Audit Plan since our December 2023 progress report to the Audit and Risk Committee.

However, in February 2024 two qualified Principal Auditors working predominantly in the Fife and Forth Valley teams submitted their resignations. The recruitment process has commenced, and it is anticipated that it will take a minimum of four months to have replacement staff in post. Overall, it is likely that this reduction in resource will impact on delivery across FTF and on routine audit work within the Fife Audit Plan.

Year-end work will be prioritised, building on audit work already completed for the Internal Control Evaluation (ICE), and sufficient audit work will be completed to allow the Chief Internal Auditor to provide the necessary assurances prior to the signing of the annual accounts.

The Fife Audit Plan for 2023/24 has been revised to prioritise those audits which are of most significance and adjusted to reflect available resource. Audit and Risk Committee members were sent a revised 2023/24 Audit Plan on 26 February 2024, and this was electronically approved by the members. Reviews not completed as part of the 2023/24 Audit Plan will be risk assessed for inclusion in the 2024/25 Audit Plan.

Progress on implementation of agreed actions within our audit reports is monitored through the Audit Follow-Up System. The Audit Follow-Up system is maintained by Internal Audit and regular update reports are presented to the Audit and Risk Committee and Executive Directors Group.

An update on the External Quality Assessment was to be provided to the Audit and Risk Committee at its meeting on 14 March 2024 following agreement of the process by the FTF Partnership Board on 20 February 2024. However, the FTF Partnership Board was cancelled as key members including the Chair could not attend and the next scheduled meeting is due to take place on 2 May 2024. The agreed External Quality Assessment process will therefore be reported to the May 2024 Audit and Risk Committee.

2.3.1 Quality/ Patient Care

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

2.3.2 Workforce

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

2.3.3 Financial

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

2.3.4 Risk Assessment/Management

The process to produce the Annual Internal Audit Plan considers inherent and control risk for all aspects of the Internal 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. Legislative requirements are a core consideration in planning all internal audit reviews.

As detailed in the assessment section, the requirement to recruit to two vacant Principal Auditor posts is likely to impact on delivery across FTF and NHS Fife Audit Plans.

The risk 'Compliance with Internal Audit Framework' is recorded on the FTF risk register and is described as:

'There is a risk that due to the cumulative effect of resource challenges and complexity of audits with generally higher risks and control issues, internal audit may not comply fully with the Internal Audit Framework, comprising the Audit Charter and the Specification for Internal Audit Services'.

This includes:

- Compliance with Public Sector Internal Audit Standards
- Compliance with the Service Specification, specifically:
  - Delivery of the agreed annual internal audit plan
  - Provision of assurance throughout the year
  - Achievement of quality and performance measures
  - Provision of an opinion to the Chief Executive as Accountable Officer for yearend assurance.

This risk is scored as 'Moderate' and 12 controls have been identified to mitigate the risk.

2.3.5 Equality and Diversity, including health inequalities

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

2.3.6 Other impacts

N/A

2.3.7 Communication, involvement, engagement and consultation

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

2.3.8 Route to the Meeting

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

2.4 Recommendation

The Audit and Risk Committee is asked to:

- **Discuss** and take **assurance** on the progress on the delivery of the Internal Audit Plan(s)
- **Note** an update will be provided on the External Quality Assessment to the May 2024 Audit and Risk Committee

- **Note** the approval of the revised 2023/24 Internal Audit Plan

3 List of appendices

The following appendices are included with this report:

Appendix A – Internal Audit Progress Report highlighting:

- Finalised Internal Audit reports
- Internal Audit reports issued in draft at the time of submission of papers for the Audit and Risk Committee
- Internal Audit Work in Progress and Planned
- A summary of Internal Audit Reports issued since the last Audit and Risk Committee.

FTF Internal Audit Service

Internal Audit Progress Report

Introduction

This report presents the progress of internal audit activity to 1 March 2024.

Internal Audit Activity

The following audit products, with the audit opinion shown, have been issued since the last Audit and Risk Committee meeting on 13 December 2023. Each review has been categorised within one of the five strands of corporate governance. A summary of each report is included for information within the 'Summary of Audit findings' section.

NHS Fife Completed Audit Work

Audit 2022/23 and 2023/24	Opinion on Assurance	Recommendations	Draft issued	Finalised
Corporate Governance				
B13/23 Resilience and Business Continuity	Limited Assurance	3 Significant 2 Moderate	4 December 2023	19 February 2024
B14/23 Strategic Planning	Reasonable Assurance	1 Merits Attention	8 December 2023	9 January 2024
Financial Governance				
B24B/24 Endowments – Review of Health Charity Draft Constitution	N/A	N/A	18 December 2023	19 December 2023

Fife IJB Completed Audit Work

Audit 2022/23 and 2023/24	Opinion on Assurance	Recommendations	Draft issued	Finalised
F05/23 Workforce Planning	Reasonable Assurance	4 Moderate	26 October 2023	8 January 2024

NHS Fife Draft Reports Issued

	Draft issued
B17/23 Workforce Planning • Exit meeting held on 23 February 2024 to discuss report. Further meeting required with CIA and Workforce colleagues to finalise the report.	11 December 2023
B24/24 Patients Funds	5 March 2024

Fife IJB Draft Reports Issued

	Draft issued
F06/24 Fife IJB – Resilience and Business Continuity Arrangements	26 February 2024

NHS Fife Work in Progress and Planned:

Audit 2022/23 and 2023/24		Status	Target Audit and Risk Committee
Year End Summary Reports to the May 2024 Audit and Risk Committee			
B01/24	Audit Risk Assessment & Operational Planning	Y/E Report	May 2024
B02/24	Audit Management & Liaison with Directors	Y/E Report	May 2024
B03/24	Liaison with External Auditors	Y/E Report	May 2024
B04/24	Audit and Risk Committee	Y/E Report	May 2024
B05/24	Clearance of Prior Year	Y/E Report	May 2024
B09/24	Audit Follow Up	Y/E Report	May 2024
B10/24	Attendance and input / provision of advice at Standing Committees and other Groups.	Y/E Report	May 2024
B11/24	Assurance Mapping	Y/E Report	May 2024
B14/24	Risk Management	Y/E Report	May 2024
Remaining Audits from revised 2023/24 Internal Audit Plan			
B12/24	Implementation of the Governance Blueprint	Planning	May 2024
B15/24	Environmental Management	Planning	May 2024
B20/24 (incorporating B16/23)	Medicines Management • Prior year assignment combined with current year	WIP	May 2024

B23/24 (incorporating B20/23)	Financial Process Compliance • Prior year assignment combined with current year • Fieldwork will be completed with draft report to be issued 12 March 2024	WIP	May 2024
B21/24	Efficiency, effectiveness and timeliness of retention and recruitment systems	Planning	May 2024

Fife IJB Work in Progress and Planned:

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

Summary of Audit Findings

This section provides a summary of the findings of internal audit reviews concluded since the previous Audit and Risk Committee meeting of December 2024 where a progress report was considered.

B13/23 – Resilience and Business Continuity

Limited Assurance report – see agenda item 7.4.

B14/23 – Strategic Planning

Audit opinion - Reasonable Assurance report

Recommendations - One Moderate

The development of the Public Health and Wellbeing Strategy (PHWS) was informed by a review of the previous Clinical Strategy 2016-2021, the remobilisation plans, enabling strategies, engagement with members of Fife NHS Board, staff and the wider community and a public health needs assessment.

Risks relating to successful delivery of the strategy have been identified and are monitored by the Public Health and Wellbeing Committee and Fife NHS Board.

Given the financial sustainability and workforce challenges being faced by all NHS Boards in Scotland, these risks to the delivery of the PHWS are actively being considered as a key focus of monitoring implementation.

While the Scottish Government has set very challenging national objectives, NHS Fife needs to be mindful that its own strategic objectives must be deliverable within acceptable risk tolerances. The PHWS recognises the financial and workforce pressures but, as a high-level strategy, it does not provide detailed information on how these will be addressed. As NHS Fife progresses through the implementation stage, clarity around how the strategy will be delivered within the financial and workforce constraints should begin to emerge, as well as an understanding of any elements of the strategy which might not be achievable within its lifespan. The mid-year update on the PHWS provided to the PHWC in November 2023 is the first example of this.

B24B/24 Endowments - Review of the Fife Health Charity Draft Constitution

The Charity Director requested a review of the Fife Health Charity draft constitution.

Conclusion – the draft constitution for the Fife Health Charity was reviewed against guidance and best practice and a comparison to similar documents used across the FTF charity clients was completed. Internal audit confirmed compliance with guidance and no material issues or additions were reported back to the Charity Director.

F05/23 Fife IJB Workforce Planning

Audit opinion - Reasonable Assurance report

Recommendations - Four Moderate

Our review of the HSCP Workforce Strategy & Plan 2022-25 highlighted the following themes:

- The HSCP Workforce Strategy & Plan 2022-25 broadly complies with the Scottish Government (SG) requirements, except that there is not sufficient granular information for analysis/ description of the establishment gap between the projected future workforce need and current staffing in terms of overall numbers. This was a key internal audit recommendation and work necessary to address this has been included in the HSCP Workforce Strategy & Plan 2022-25 Short-Term and Medium-Term Action Plans.
- We were pleased to evidence the inclusive working relationship and collaboration between the HSCP Organisational Development team, NHS Fife, Fife Council, the independent and the third sector. In line with the DL(2022)09, a Workforce Strategy Group was set up for stakeholders with representatives from the whole Partnership, including the NHS Fife Workforce team, Fife Council colleagues and HSCP Service Managers.
- Whilst the HSCP Workforce Strategy & Plan 2022-25 has Action Plans to help alleviate challenges and external pressures, the Strategic Workforce risk states that *'it is unlikely the risk will reduce until more of the workforce action plans have been completed, it will be monitored closely over the next few months.*'
- The Strategic Risk Register was last considered at the March 2023 Finance, Performance & Scrutiny (FP&S) Committee and is presented to the Committee every six months. We would anticipate that the Deep dive review of the Workforce risk at the March 2024 FP&S will provide oversight and an update on the effectiveness of the mitigating controls on reducing the risk score.
- The update to the May 2023 SLT on the Year One Action Plan showed significant progress on actions.
- While the Workforce Plan reporting process is clearly described within the Workforce Strategy and Plan for 2022-25, reporting arrangements in future iterations would be strengthened through more formal regular reporting (currently annual) to ensure oversight of progress and early warning of any barriers to achievement by the IJB or delegated Committee.

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**14 March 2024**
Title:	**Internal Audit – Follow Up Report on Audit Recommendations**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Report Author:	**Barry Hudson, Regional Audit Manager/ Andy Brown, Principal Auditor**

1 Purpose

This is presented for:

- Assurance
- Discussion
- Decision

This report relates to the:

- Audit Follow up Protocol

This aligns to the following NHSScotland quality ambition:

- Effective

2 Report summary

2.1 Situation

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

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

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

2.2 Background

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

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

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

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

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

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

2.3 Assessment

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

The table below shows the status of all remaining internal audit recommendations, other than ICE and Annual Report recommendations, at 29 February 2024, with comparable figures from the last Audit Follow-Up (AFU) report at 30 November 2023 (Ext = Extended, O/S = Outstanding & NYD = Not Yet Due).

	Feb 2024			**Nov 2023**		
Remaining Actions	**7**			**14**		
	Ext	O/S	NYD	Ext	O/S	NYD
Recommendations more than 1 year (*Appendix C)*	6	0	0	6	0	0
Recommendations less than 1 year	0	0	1	6	0	2

The table below shows the status of all remaining ICE and Annual Report recommendations at 29 February 2024, with actions from the 2023/24 ICE (B08/24) now included, and shows good progress having since 30 November 2023 with no extended target implementation dates.

	Feb 2024			Nov 2023		
Remaining Actions	**10**			**9**		
	Ext	O/S	NYD	Ext	O/S	NYD
Recommendations more than 1 year (*Appendix C)*	0	0	0	0	0	0
Recommendations less than 1 year	0	0	10	2	0	7

Progress summary

The following reports have been removed from the follow-up process since the last follow-up report was presented:

Report Removed	**Reason**
B18-23 Whistleblowing	All actions completed and validated.
B21-23 Patients' Funds	All actions completed and validated.
B08/23 ICE 2022/23	All actions completed and validated or superseded by other reports.

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

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

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

AFU Report Content

Appendices C and D provide detailed information on progress with all remaining recommendations that have had their target implementation date extended. Appendix C includes those that are **more** than a year old and Appendix D includes those that have a fundamental or significant priority and are **less** than a year old.

2.3.1 Quality, Patient and Value-Based Health & Care

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

2.3.2 Workforce

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

2.3.3 Financial

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

2.3.4 Risk Assessment/Management

The process to produce the Annual Internal Audit Plan considers inherent and control risk for all aspects of the Internal 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. Legislative requirements are a core consideration in planning all internal audit reviews.

The requirement to recruit to two vacant Principal Auditor posts is likely to impact on delivery across FTF and NHS Fife Audit Plans.

The risk 'Compliance with Internal Audit Framework' is recorded on the FTF risk register and is described as:

'*There is a risk that due to the cumulative effect of resource challenges and complexity of audits with generally higher risks and control issues, internal audit may not comply fully with the Internal Audit Framework, comprising the Audit Charter and the Specification for Internal Audit Services*'.

This includes:

- Compliance with Public Sector Internal Audit Standards
- Compliance with the Service Specification, specifically:
  - Delivery of the agreed annual internal audit plan
  - Provision of assurance throughout the year
  - Achievement of quality and performance measures
  - Provision of an opinion to the Chief Executive as Accountable Officer for yearend assurance.

This risk is scored as 'Moderate' and 12 controls have been identified to mitigate the risk.

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

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

2.3.6 Climate Emergency & Sustainability Impact

Not applicable

2.3.7 Communication, involvement, engagement and consultation

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

2.3.8 Route to the Meeting

Not applicable

2.4 Recommendation

The Audit and Risk Committee is asked to:-

- Take **assurance** and **consider** the status of Internal Audit recommendations recorded within the AFU system.

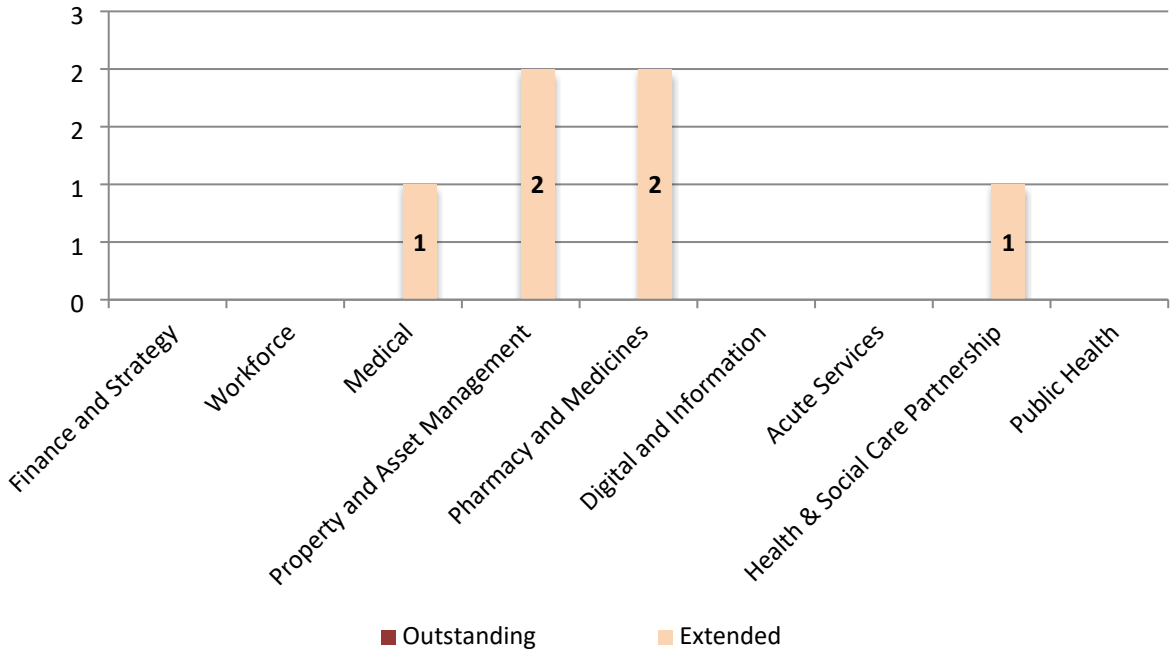
3. List of appendices

The following appendices are included with this report:

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

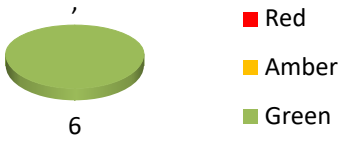
Recommendations More Than 1 Year

Outstanding and Extended by Directorate

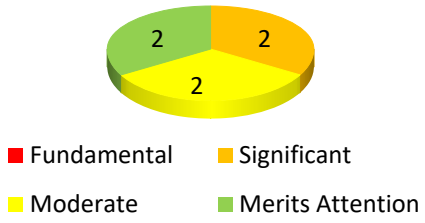


Extended Recommendations RAG Status and Priority

RAG Status



Priority



Recommendations Less Than 1 Year

There are no remaining actions with extended target implementation dates that are less than 1 year from the date of publication.

Internal Audit Reports with Remaining Actions	Date of Issue	Total Recs.	Complete	Superseded	Remaining		Extended	Outstanding	Not Yet Due		Not Validated
2020/21											
B13/21 Risk Management Strategy	Sep 21	5	4	0	1		1	0	0		-
B19/21 Clinical Governance Strategy and Assurance	Sep-21	2	1	0	1		1	0	0		-
B21/21 Medical Equipment and Devices	Nov-21	4	2	0	2		2	0	0		-
2020/21 Totals		**11**	**7**	**0**	**4**		**4**	**0**	**0**		**0**
2021/22											
B16/22 Prescription Stationery Security	May-22	11	9	0	2		2	0	0		-
2021/22 Totals		**11**	**9**	**0**	**2**		**2**	**0**	**0**		**0**
2022/23											
B14/23 Strategic Planning - Development	Jan-24	1	0	0	1		0	0	1		-
2022/23 Totals		**1**	**0**	**0**	**1**		**0**	**0**	**1**		**0**
Overall Totals (Actions from reports where recommendations remain unaddressed)		**23**	**16**	**0**	**7**		**6**	**0**	**1**		**0**

Previous ICE and Annual Reports with Remaining Actions	Date of Issue	Total Recs.	Complete	Superseded	Remaining		Extended	Outstanding	Not Yet Due		Not Validated
2023/24											
B06/24 Annual Report – 2022-23	Jun-23	11	5	0	6		0	0	6		-
B08/24 ICE – 2023-24	Dec-23	6	2	0	4		0	0	4		
2023/24 Totals		**17**	**7**		**10**		**0**	**0**	**10**		**-**
Overall Totals (Actions from reports where recommendations remain unaddressed)		**17**	**7**		**10**		**0**	**0**	**10**		**-**

Report	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
2020/21 - Extended							
B13/21 Risk Management Strategy	3	S	Now that there is clarity around responsibility for operations, an Integration Joint Board (IJB) Risk Management Strategy should be produced and formally agreed with the parties as soon as possible and incorporated into the NHS Fife Framework. More detailed aspects of the risk management arrangements between NHS Fife and Fife IJB should be included in GP/R7 - Risk Register and Risk Assessment policy.	**Director of Health & Social Care**	~~31 Mar 22~~ ~~30 Sep 22~~ ~~31 Dec 22~~ ~~31 Aug 23~~ ~~31 Dec 23~~ 30 Sep 24		The remaining part of this action is for the NHS Fife Risk Appetite to be reviewed taking into account the risk appetite of the IJB and this will be undertaken by 30 September 2024 as part of the overall review of NHS Fife's Risk Appetite.
B19/21 Clinical Governance Strategy and Assurance	1	S	Revision of Clinical and Care Governance Strategy addressing recommendations made in Internal Audit report B15/17 & B18/18 – Clinical Governance Strategy & Assurance and related governance improvements.	Associate Director of Quality and Clinical Governance **Medical Director**	~~31 Jan 22~~ ~~31 May 22~~ ~~31 Oct 22~~ ~~31 Jul 23~~ 31 Mar 24		The recommendation from this report has many component parts 1a to 1h. **The following elements are still to be addressed**: 1g – *Reflection on why some CGC sub-groups/committees are required to provide annual assurance before CGC concludes on its own annual assurance report/statement and others don't and for changes to assurance requirements to be made accordingly and reflected in the CGC workplan.* - The reason for the difference has been explained to internal audit and will be included in the SBAR for the presentation of subgroup/committee annual assurance statements for 2023/24.
B21/21 Medical Equipment and Devices	1	M A	Updates required to both the GP/E4 – Medical Equipment Management Policy (including related appendices) and E14.1 - Equipment Procurement Operational Policy and these require to be authorised by the Capital Equipment Management Group (CEMG).	Head of Estates **Director of Property and Asset Management**	~~31 Jan 22~~ ~~31 Jul 22~~ ~~30 Jun 23~~ ~~31 Oct 23~~ 31 Mar 24		The Medical Equipment Management Policy (GP/E4) and related procedure GP/E4 have been updated and approved with a review date of 1 September 2025 and both are published on Stafflink. The E14 suite of policies have been reviewed and revised and are awaiting approval from the General Policies Group. These will then be published on Stafflink as components of the overarching policy (GP/E4).

Report	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
	3	M A	Evidence of new Equipment Request Forms (ERFs) being completed correctly with the added sections fully populated. CEMG membership to be updated to formally include a representative from Digital and Information (D&I).	Head of Estates **Director of Property and Asset Management**	~~31 Jan 22~~ ~~31 Jul 22~~ 30 Sep 23 31 Mar 24		A new Equipment Request Form (ERF) was introduced but a check by Internal Audit found that the forms were not being completed fully. Further changes have been made to the form and it is included in the revised E14 suite of policies referred to above that are pending approval from the General Policies Group. A representative from D&I is now a member of the CEMG.
20/21 Extended	**4**						
2021/22 - Extended							
B16/22 Prescription Stationery Security	2a	M	Risk assessments of areas used in Pharmacy departments at VHK and QMH for the storage of Prescription Stationery.	Lead Pharmacist Medicine Governance and Medicines Supply Chain Manager **Director of Pharmacy & Medicines**	~~31 Oct 22~~ ~~30 Apr 23~~ ~~31 Oct 23~~ 29 Feb 24		Work has started to address the issues raised in the risk assessment but is not yet complete. Swipe access has been installed but is not yet activated but this is imminent.
	2b	M	Implementing a protocol for changing any combination locks remaining in use whenever anyone who knew the code leaves the service.	Lead Pharmacist Medicine Governance and Medicines Supply Chain Manager **Director of Pharmacy & Medicines**	~~31 Oct 22~~ ~~30 Apr 23~~ ~~31 Oct 23~~ 29 Feb 24		As per 2a above.
21/22 Extended	**2**						

Report	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
Total > 1 Year	6						

ANNUAL and ICE REPORTS Report	Rec Number	Priority	Brief Description	Responsible Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
There are no actions from Internal Audit Annual Reports or Internal Control Evaluation (ICE) Reports that have extended target implementation dates.							

Report	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
Year- Extended							
Only actions associated with recommendations that are considered Fundamental or Significant will be included in this section (ie actions that have extended implementation dates within 12 months from their publication) but these will be signposted from here. For this reporting cycle there are no such actions to report.							
Year Extended							
Total < 1 Year	**0**						

ANNUAL and ICE REPORTS Report	Rec Number	Priority	Brief Description	Responsible Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
Only actions associated with recommendations that are considered Fundamental or Significant will be included in this section (ie actions that have extended implementation dates within 12 months from their publication) but these will be signposted from here. For this reporting cycle there are no such actions to report.							
-							

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

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

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

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

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**14 March 2024**
Title:	**Internal Audit Framework**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Report Author:	**Jocelyn Lyall, Chief Internal Auditor**

1 Purpose

This report is presented for:

- Decision

This report relates to:

- Legal requirement
- Local policy

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

- Safe
- Effective

2 Report summary

2.1 Situation

Internal Audit Charter

Public Sector Internal Audit Standards (PSIAS) state:

"*The internal audit charter is a formal document that defines the internal audit activity's purpose, authority and responsibility. The internal audit charter establishes the internal audit activity's position within the organisation, including the nature of the chief audit executive's functional reporting relationship with the board; authorises access to records, personnel and physical properties relevant to the performance of engagements; and defines the scope of internal audit activities. Final approval of the internal audit charter resides with the board."*

In this context, the Board is represented by the Audit and Risk Committee which has delegated responsibility for audit matters.

Specification for Internal Audit Services

FTF Audit provides the Internal Audit service to NHS Fife as part of a shared service which is hosted by NHS Fife. A Partnership Board comprising the Directors of Finance for NHS Fife, Forth Valley and Tayside is chaired by the NHS Fife Director of Finance and Strategy.

FTF Clients include:

- NHS Tayside, NHS Fife, NHS Forth Valley as partners in the Consortium
- NHS Lanarkshire as a managed audit service
- Chief Internal Auditor function for Fife, Angus, Dundee and Falkirk IJBs

- Joint Chief Internal Auditor Function for North and South Lanarkshire IJBs

Each mainland Health Board has in place a Consortium Shared Services Agreement (SSA) for Internal Audit Services and a Specification for Internal Audit Services. The SSA was electronically approved by the FTF Partnership Board on 29 February 2024. The Director of Finance has the delegated responsibility to approve these agreements on behalf of NHS Fife.

The standard Internal Audit Framework brings together the FTF Audit Charter, Service Specification and Reporting Protocol.

The Internal Audit Framework has been revised to reduce duplication and to refresh the language within the document. A 'tracked' changes version of the master Internal Audit Framework is at appendix A and a 'changes accepted' version of the Framework is at Appendix B.

The FTF Partnership Board have the responsibility to approve the draft Internal Audit Framework prior to the presentation to the respective Audit and Risk Committees for their final approval and the Internal Audit Framework was electronically approved by the FTF Partnership Board on 29 February 2024.

2.2 Background

Internal Audit Framework

Public Sector Internal Audit Standards require each organisation to agree an Audit Charter that defines the purpose, authority, and responsibility of Internal Audit, whilst also clarifying the functional reporting relationships and accessibility provisions.

The Audit Charter is complementary to the relevant provisions included in the Board Standing Orders and Standing Financial Instructions, the FTF Service Specification, the Reporting Protocol, and the Consortium Shared Service Agreement.

The Service Specification sets out the responsibilities of FTF as Internal Auditors.

The Reporting Protocol describes the Internal Audit reporting process from planning through to the presentation of internal audit reports to Audit and Risk Committees.

2.3 Assessment

The documents as above provide the Audit and Risk Committee with the background and operational oversight of the Internal Audit function and allow the Audit and Risk Committee to meet the requirements of PSIAS.

2.3.1 Quality, Patient and Value-Based Health & Care

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

2.3.2 Workforce

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

2.3.3 Financial

Any financial implications will be highlighted and progressed appropriately if required.

2.3.4 Risk Assessment / Management

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

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

Any internal audit assignments which involve the review of policies and procedures will consider the way in which equality and diversity is incorporated into Board documentation.

2.3.6 Climate Emergency & Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

All elements of this framework have been updated by the Chief Internal Auditor with input from the FTF Management Team and were approved by the FTF Partnership board on 29 February 2024.

2.3.8 Route to the Meeting

- This framework has been updated by the Chief Internal Auditor.
- Approved by the FTF Partnership Board – 29 February 2024.

2.4 Recommendation

The Audit and Risk Committee is asked to:

- **Note** the NHS Fife Specification for Internal Audit Services
- **Decision** - Approve the Internal Audit Charter
- **Decision** - Approve the NHS Fife Internal Audit Reporting Protocol

3 List of appendices

The following appendices are included with this report:

- Appendix A - Internal Audit Framework – tracked changes.
- Appendix B - Internal Audit Framework – changes accepted.

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

Introduction

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

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

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

Purpose and responsibility

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

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

The Shared Services Agreement and associated Service Specification with FTF set out their specific responsibilities as ~~l~~internal A~~a~~uditors to NHS XXX.

Independence and Objectivity

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

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

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

Whilst maintaining effective liaison and communication with the organisation, as provided in this Charter, all internal audit activities shall remain free of untoward influence by any element in the

organisation, including matters of audit selection, scope, procedures, frequency, timing, or report content to permit maintenance of an independent and objective attitude necessary in rendering reports.

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

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

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

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

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

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

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

Authority and Accountability

Internal Audit derives its authority from the NHS Board, the Accountable Officer and Audit and Risk Committee and the relevant provisions included in the organisation's~~.~~ Code of Corporate Governance. ~~These authorities are established in Standing Orders and Standing Financial Instructions adopted by the Board.~~

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

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

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

~~In order to~~To facilitate its assessment of governance within the organisation, Internal Audit is granted access to attend meetings of the Board and any committee or sub-committee of the Board charged with aspects of governance. This includes access the minutes and papers of open and closed meeting sessions.

Relationships

The Chief Internal Auditor and Regional Audit Manager will ~~maintain functional~~ liaise~~on~~ with~~to~~ the Director of Finance (or a nominated deputy)~~and Strategy who has been nominated by the Accountable Officer~~ as the executive lead for internal audit.

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

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

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

~~The Audit and Risk Committee may determine that another Committee of the organisation is a more appropriate forum to receive and action individual audit reports. However,~~ The Audit and Risk Committee ~~will remain~~ is the final reporting line for all audit reports and where it is appropriate for a report to be shared with another Governance / Standing Committee, this will be included on the audit assignment plan.

Standards, Ethics, and Performance

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

Internal Audit will operate in accordance with the Shared Services Agreement (updated ~~2019~~2024) and associated performance standards agreed with the ~~Audit and Risk Committee~~Partnership Board. The ~~Shared Services Agreement~~Service Specification includes a number of Key Performance Indicators ~~and we have agreed with the Audit and Risk Committee that these will~~ to be reported to ~~each~~ Audit and Risk Committee meeting as part of the Internal Audit Progress report and within the Annual Report.

Scope

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

- Reviewing the reliability and integrity of financial and operating information and the means used to identify measure, classify, and report such information;
- Reviewing the systems established to ensure compliance with ~~those~~ policies, plans, procedures, laws, and regulations ~~which could have a significant impact on operations, and reports on whether the organisation is in compliance~~;

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

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

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

Risk Management

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

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

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

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

Appropriate communication ~~is in place~~ with the risk management function will be maintained, ~~which~~ includinges provision of all audit reports and regular meetings with risk ~~management~~ managers.

Reporting arrangements including Key Performance Indicators

Arrangements for reporting and following up individual assignments are contained within the reporting and follow-up protocols approved by the Audit and Risk Committee.

The Specification states that '*The principal report to be produced by Internal Audit will be the Annual Audit Report for each audit year. This needs be prepared in time for submission to the Audit and Risk Committee not later than the target date specified in Appendix I in order to provide the assurance required in considering the Board's Annual Accounts.*

The Annual Audit Report should contain:

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

- ✧ *The Accountable Officer has implemented a governance framework in line with required guidance sufficient to discharge the responsibilities of this role;*
- ✧ *The Internal Audit plan has been delivered in line with PSIAS*

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

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

Assurances provided to parties outside the organisation;

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

Approach

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

Access and Confidentiality

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

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

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

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

Irregularities, Fraud & Corruption

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

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

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

Quality Assurance

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

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

Resolving Concerns

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

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

Review of the Internal Audit Charter

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

Date: February~~March~~ 2024~~3~~

Date of next review: February~~March~~ 2025~~4~~

Mission and values

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

WORKING TOGETHER TO PROVIDE ASSURANCE AND ADD VALUE

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

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

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

APPENDIX 2

Specification for Internal Audit Services

APPENDIX 2

CONTENTS

Page

1. Introduction

This document sets out a specification for the Internal Audit requirements of the Client. The specification is for a total Internal Audit Service to the Client organisation over the period 1 April 202419 to 31 March 20274.

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

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

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

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

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

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

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

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

2. Internal Audit Responsibilities

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

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

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

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

- the organisation's objectives are achieved
- there is economical and efficient use of resources

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

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

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

3. Internal Audit Standards

~~3.1 Public Sector Internal Audit Standards (PSIAS)~~

3.~~1~~2 FTF shall comply with PSIAS and report on its compliance to the Audit and Risk Committee as part of the Annual Internal Audit Report. FTF shall maintain a system to ensure compliance with ~~Public Sector Internal Audit Standards~~PSIASPSIAS and shall adhere to an agreed timetable for undertaking and reporting external quality assessment~~s~~ / validated self-assessment. ~~and reporting on a formal mid-point self-assessment against the Standards~~.

4. Planning

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

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

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

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

4.5 The Annual Internal Audit Plan will be kept under review and any required amendments in response to emerging risks or other factors will be discussed with the Director of Finance before approval by the Audit and Risk Committee.

Strategic Audit Plan

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

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

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

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

Annual Audit Plan

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

Audit Assignment Plans

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

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

5. Managing Audit Work

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

5.2 The Chief Internal Auditor will also be responsible for monitoring the contract and will therefore be the Agreement Control Officer performing the additional quality, performance measurement and liaison activities. The Chief Internal Auditor shall be available to meet with the Director of Finance whenever required and at least bi-annually to discuss the service.

5.3 The Regional Audit Manager will be expected to be available to attend meetings with the Director of Finance at least monthly and as required, to discuss the progress of individual projects. The Regional Audit Manager will be the Internal Audit point of contact for any other bodies, internal or external, such as the external auditor.

5.4 The Audit and Risk Committee and Director of Finance must endeavour to ensure management's perspective of internal audit is positive and that a participative approach is adopted. Therefore FTF will be expected to actively involve and keep auditees informed during all stages of audit assignments. This is particularly crucial during the testing and evaluation stages when it would be more appropriate to inform management of the emerging findings where these are significant rather than wait and produce the findings in a report at a later date. The circumstances where this approach would be appropriate would be:

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

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

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

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

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

6. Reporting

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

6.2 The aim of every internal report should be to:

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

6.3 In addition, Internal Audit should provide the Director of Finance and Audit and Risk Committee with regular reports on progress. ~~(see 6.9 below)~~

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

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

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

Individual Audit Project Reporting

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

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

Annual Audit Reporting

6.8 The principal reports to be produced by Internal Audit will be the Internal Control Evaluation (ICE) and the Annual Internal Audit Report for each audit year. The ICE is normally presented to the January Audit and Risk Committee and the Annual Internal Audit Report needs be prepared in time for submission to the Audit and Risk Committee not later than the target date

specified in Appendix I following the end of the audit period. The Annual Internal Audit Report should contain:

- An opinion on whether:
  - Based on the work undertaken, there were adequate and effective internal controls in place throughout the year
  - The Accountable Officer has implemented a governance framework in line with required guidance sufficient to discharge the responsibilities of this role
- The Internal Audit plan has been delivered in line with PSIAS
- analysis of any changes in control requirements during the year
- comment on the key elements of the control environment
- summary of performance against this service specification
- progress in delivering the Quality Assurance Improvement Programme.

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

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

Progress reporting

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

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

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

Progress reports will also be presented to each Audit and Risk Committee in a format agreed with the Client.

7. Quality Control and Quality Measurements

7.1 The Chief Internal Auditor will be held accountable by the Audit and Risk Committee for performance and is therefore responsible for ensuring quality standards are defined, agreed, monitored and reported. These aspects of quality should be enshrined in the Performance Measures, shown in Appendix 1 and reported within the Annual Internal Audit Report.

7.2 The Chief Internal Auditor shall continuously review the performance of each region and use this review to inform the bi-annual discussion with the Client Director of Finance.

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

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

Client Satisfaction Survey

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

7.6 In addition, the Chief Internal Auditor will seek to ascertain the views of the Audit and Risk Committee and Board Members in relation to the quality of the service. This will be achieved through discussion with the Director of Finance, and through the offer of availability for meetings with the Audit and Risk Committee Chair and Board Chair.

8. Liaison with External Audit

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

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

9. Best Value Reviews

9.1 The Scottish Public Finance Manual states that responsibility for Best Vale rests with the Accountable Officer. It is the responsibility of the Internal Auditor, as part of the general review of systems of internal control, to review, appraise and report to management the extent to which the organisation's assets and interests are accounted for and safeguarded against losses of all kinds arising from fraud and other offences, waste, extravagance and inefficient administration, poor value for money or other cause. This will include review of the Best Value Framework, undertaken as part of the Annual Report fieldwork.

9.2 Identification of cost savings will be a consideration in every audit.

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

10. Suspected Criminal Offences

10.1 CEL (2013)11, an update of CEL (2008) 03 “Strategy to Combat Financial Crime in NHS Scotland” sets out further requirements on Boards and the requirements of the Bribery Act (2010) that need to be met. Whilst the key messages from CEL 11 (2013) remain relevant, the introduction of the Counter Fraud Strategy 2023-26 and the Counter Fraud Standards will assess how effectively Health Boards tackle fraud, bribery and corruption. ~~the annual list of activities required by NHS Boards was revised in a Dear Colleague letter of 1 July 2015 from the Director of Finance, eHealth and Analytics in the Scottish Government Health and Social Care Directorate (SGHSCD) which places an increased emphasis on delivering agreed outcomes and putting the customer at the heart of NHS Scotland Counter Fraud Services (CFS) work.~~

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

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

11. Freedom of Information

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

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

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

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

12. Staffing

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

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

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

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

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

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

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

Chief Internal Auditor:	member of CCAB Institute or CMIIA with experience equivalent to at least five years post-qualification experience and three years audit experience
Qualified:	member of a CCAB Institute, the Institute of Internal Auditors or an alternative qualification agreed with the Director of Finance

including specialist support e.g. computer audit (ITAC etc.) and Risk Management.

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

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

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

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

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

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

Appendix I

INTERNAL AUDIT SPECIFICATION

PERFORMANCE MEASURES

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

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

Appendix II

INTERNAL AUDIT SPECIFICATION

INTERNAL AUDIT REPORTING PROTOCOL & FLOWCHART

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

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

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

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

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

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

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

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

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

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

11. The recommendations will be added to the AFU System by Internal Audit and progress on implementation of appropriate action reported to the Audit and Risk Committee.

12. All final audit reports may be presented to the Executive Directors Group / Executive

Leadership Team, relevant Standing Committee and, where appropriate, the XXX IJB Audit and Risk Committee.

Dispute resolution

13. In the event of a failure to receive a timely response from the Responsible Director in relation to a draft report or assignment plan, or to reach agreement on a fundamental recommendation, the matter will be referred to the Director of Finance ~~and Strategy~~ and, if necessary, to the Chief Executive.

Assignment Milestone	Stage	Processes involved	Responsibilities	Response time
	Annual Audit Plan agreed	Formulated from Strategic Audit Plan for agreement by Audit & Risk Committee	Regional Audit Manager/ Chief Internal Auditor with Director of Finance ~~and Strategy~~	
1	Assignment Plan agreed	Terms of reference for the assignment agreed with Responsible Director and / or Responding Officer.	Regional Audit Manager with Responding Officer/ Responsible Director.	within 2 weeks of issue
2	Fieldwork commenced	Audit team conduct audit assignment in accordance with Assignment Plan	Principal/Auditor with co-operation of client operational staff	
3	Fieldwork completed	Audit findings evaluated and summary of findings discussed and agreed with appropriate staff, including the Responding Officer. If the audit findings relate to the work of any other department or have an impact on any other departments, an appropriate senior officer from within that area will be consulted on the summary of findings. Draft report prepared for review.	Principal/Auditor in discussion with operational staff prior to Audit Manager review	within 1 week of fieldwork end
4	Draft report issued to Directorate	Audit report issued to Directorate in draft for review and consideration of action plans. If audit findings relate to the work of any other department or have an impact on any other departments, an appropriate senior officer from within that area should be consulted on the report content.	Regional Audit Manager with Principal/ Auditor to Responding Officer/ Responsible Director.	within 2 weeks of fieldwork end
5	Directorate response	Formal response required from Directorate to include completed time bound action plan matrix.	Responding Officer with agreement of Responsible Director	within 2 weeks of draft report release

Assignment Milestone	Stage	Processes involved	Responsibilities	Response time
6	Report issued to Director of Finance and Strategy	Audit report reviewed for clearance.	Regional Audit Manager	within 1 week of Directorate response
			Director of Finance ~~and Strategy~~/ Responding Officer/ Responsible Director	within 1 week of receiving report
7	Final Report released	Report issued in full to relevant officers and External Auditor.	Regional Audit Manager/FTF Office Manager to Director of Finance and Strategy, Responding Officer & Chief Executive	within 1 week of Director of Finance ~~and Strategy~~ clearance

Flowchart

Stage	Explanation	Timeframe
Assignment Plan	Assignment Plan issued to relevant Client Director by Principal Auditor/Auditor. When agreed, the assignment plan is issued to the Director of Finance and Strategy.	For return within 2 weeks
Fieldwork	Fieldwork carried out by Principal Auditor/Auditor according to the Annual Internal Audit Plan. On completion of fieldwork the summary of findings is discussed and agreed with the appropriate staff. A draft report will be prepared and file review undertaken.	File Review for completion within 1 week
Issue of Draft Report to Directorate	The draft report will be issued to the Responding Officer for factual accuracy check and management responses.	For return within 2 weeks
Directorate Response	Management responses are received and incorporated within the report.	Within 1 Week
Report to CE and Director of Finance	Report is issued to Director of Finance and Strategy for review, comment and approval.	For return within 1 Week
CE / Director of Finance Responses	The responses from the Director of Finance and Strategy will be incorporated into the report.	Within 1 ~~w~~Week
Report finalised and issued	The Office Manager will finalise and issue the report to the relevant Client Director and Officers.	By the end of the next day
Recom-mendations added to AFU	The recommendations will be added to the AFU System by the AFU Coordinator and progress reported to the Audit & Risk Committee.	On receipt of report

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

Appendix III

INTERNAL AUDIT SPECIFICATION

FOLLOW-UP OF AGREED INTERNAL AUDIT RECOMMENDATIONS – HYPERLINK / TO LOCAL POLICY

NHS XXX

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

1. INTRODUCTION

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

2. MANAGEMENT FOLLOW-UP ON INTERNAL AUDIT REPORTS

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

allow consideration of any long outstanding responses, repeated extensions to due by dates, actions not completed and those which did not fully address the identified control weakness, either because of the content or the accuracy of the response.

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

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

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

3. ~~FOLLOW-UP OF EXTERNAL AUDIT REPORTS~~

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

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

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

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

Appendix IV

INTERNAL AUDIT SPECIFICATION
AUDIT SERVICE

STAFFING SKILL MIX

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

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

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

Appendix V

INTERNAL AUDIT SPECIFICATION
AUDIT SERVICE

~~PUBLIC SECTOR INTERNAL AUDIT STANDARDS~~PSIAS

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

FTF Audit Charter

Introduction

Public Sector Internal Audit Standards (PSIAS) require each organisation to agree an Audit Charter which is annually updated following approval by the Board, in this case through the Audit and Risk Committee. This Charter is complementary to the relevant provisions included in the organisation's Code of Corporate Governance and the Shared Service Agreement and Service Specification with FTF Audit (SSA).

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

- Board means the Board of NHS Tayside with responsibility to direct and oversee the activities and management of the organisation. The Board has delegated authority to the Audit and Risk Committee in terms of providing a reporting interface with internal audit activity; and
- Senior Management means the Chief Executive as the designated Accountable Officer for NHS Tayside. Interface with internal audit activity is through the Director of Finance.
- FTF are the Internal Auditors for NHS Tayside.

Purpose and responsibility

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

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

The Shared Services Agreement and associated Service Specification with FTF set out their specific responsibilities as Internal Auditors to NHS Tayside.

Independence and Objectivity

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

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

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

Whilst maintaining effective liaison and communication with the organisation, as provided in this Charter, all internal audit activities shall remain free of untoward influence by any element in the organisation, including matters of audit selection, scope, procedures, frequency, timing, or report

content to permit maintenance of an independent and objective attitude necessary in rendering reports.

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

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

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

FTF have controls in place to ensure compliance with the relevant aspects of the PSIAS and the wider requirement to conform with NHSScotland standards of conduct regulations.

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

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

The Specification also sets out the required qualified skill-mix as well as specifying the responsibility of FTF to ensure staff are suitably trained with appropriate skills, recorded in a Personal Development Plan and where relevant fulfilling professional continual professional development requirements

Authority and Accountability

Internal Audit derives its authority from the NHS Board, the Accountable Officer and Audit and Risk Committee and the relevant provisions included in the organisation's Code of Corporate Governance.

The Chief Internal Auditor leads FTF and assigns a Regional Audit Manager to NHS Tayside. For line management (e.g. individual performance) and professional quality purposes (e.g. compliance with the PSIAS), the Regional Audit Managers report to the Chief Internal Auditor.

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

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

To facilitate its assessment of governance within the organisation, Internal Audit is granted access to attend meetings of the Board and any committee or sub-committee of the Board charged with aspects of governance. This includes access the minutes and papers of open and closed meeting sessions.

Relationships

The Chief Internal Auditor and Regional Audit Manager will liaise with the Director of Finance (or a nominated deputy) as the executive lead for internal audit.

Internal Audit will work closely with NHS Tayside Executive Leadership Team in planning its work programme. Audit work will be planned in conjunction with management, particularly in respect of the timing of audit work.

Internal Audit will meet regularly with the external auditor to consult on audit plans, discuss matters of mutual interest, discuss common understanding of audit techniques, method and terminology, and to seek opportunities for co-operation in the conduct of audit work.

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

The Audit and Risk Committee is the final reporting line for all audit reports and where it is appropriate for a report to be shared with another Governance / Standing Committee, this will be included on the audit assignment plan.

Standards, Ethics, and Performance

Internal Audit must comply with the Core Principles for the Professional Practice of Internal Auditing, the Code of Ethics, the Standards and the Institute of Internal Auditors Definition of Internal Auditing.

Internal Audit will operate in accordance with the Shared Services Agreement (updated 2024) and associated performance standards agreed with the Partnership Board. The Service Specification includes a number of Key Performance Indicators to be reported to Audit and Risk Committee meeting as part of the Internal Audit Progress report and within the Annual Report.

Scope

Internal Audit evaluates the adequacy and effectiveness of the organisation's governance, risk management arrangements, system of internal control, and the quality of performance. It includes but is not limited to:

- Reviewing the reliability and integrity of financial and operating information and the means used to identify measure, classify, and report such information;
- Reviewing the systems established to ensure compliance with policies, plans, procedures, laws, and regulations;
- Reviewing the means of safeguarding assets and, as appropriate, verifying the existence of such assets;
- Reviewing and appraising the economy and efficiency with which resources are employed, this may include benchmarking and sharing of best practice;
- Reviewing operations or programmes to ascertain whether results are consistent with the organisation's objectives and goals and whether the operations or programmes are being carried out as planned;
- Reviewing specific operations at the request of the Audit and Risk Committee or management;
- Monitoring and evaluating the effectiveness of the organisation's risk management arrangements and the overall system of assurance (see below);
- Ensuring effective co-ordination, as appropriate, with external auditors; and
- Reviewing the Annual Governance Statement prepared by senior management.

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

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

Risk Management

Internal Audit will liaise with both the Audit and Risk Committee and senior management to discuss the alignment of audit priorities to strategic and emerging risks.

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

Through specific audits, internal audit will also review the risk management systems, associated controls, assurance processes and functions, and test the operation of controls.

Appropriate communication with the risk management function will be maintained, including provision of all audit reports and regular meetings with risk managers.

Reporting arrangements including Key Performance Indicators

Arrangements for reporting and following up individual assignments are contained within the reporting and follow-up protocols approved by the Audit and Risk Committee.

The Specification states that '*The principal report to be produced by Internal Audit will be the Annual Audit Report for each audit year. This needs be prepared in time for submission to the Audit and Risk Committee not later than the target date specified in Appendix I in order to provide the assurance required in considering the Board's Annual Accounts.*

The Annual Audit Report should contain:

- *An opinion on whether:*
    - ✧ *Based on the work undertaken, there were adequate and effective internal controls in place throughout the year;*
    - ✧ *The Accountable Officer has implemented a governance framework in line with required guidance sufficient to discharge the responsibilities of this role;*
    - ✧ *The Internal Audit plan has been delivered in line with PSIAS*
- *analysis of any changes in control requirements during the year.*
- *comment on the key elements of the control environment.*
- *summary of performance against this service specification.*
- *progress in delivering the Quality Assurance Improvement Programme.*

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

Assurances provided to parties outside the organisation;

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

Approach

To ensure delivery of its scope and objectives in accordance with the Charter, Internal Audit has produced a suite of working practice documents.

Access and Confidentiality

Internal Audit shall have the authority to access all the organisation's information, documents, records, assets, personnel and premises that it considers necessary to fulfil its role. This shall extend to the

resources of third parties that provide services on behalf of the organisation. NHS Tayside's Standing Financial Instructions state that '*The Chief Internal Auditor is entitled without necessarily giving prior notice to require and receive:*

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

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

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

Irregularities, Fraud & Corruption

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

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

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

Quality Assurance

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

The Chief Internal Auditor has established a quality assurance programme designed to give assurance through internal and external review that the work of Internal Audit is compliant with the PSIAS and to achieve its objectives. A commentary on compliance against PSIAS will be provided in the Annual Internal Audit Report.

Resolving Concerns

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

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

Review of the Internal Audit Charter

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

Date: February 2024

Date of next review: February 2025

Mission and values

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

WORKING TOGETHER TO PROVIDE ASSURANCE AND ADD VALUE

We achieve this by following the PSIAS:

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

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

APPENDIX 2

Specification for Internal Audit Services

APPENDIX 2

CONTENTS

Page

1. Introduction

This document sets out a specification for the Internal Audit requirements of the Client. The specification is for a total Internal Audit Service to the Client organisation over the period 1 April 2024 to 31 March 2027.

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

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

1.3 It is the duty of FTF to provide the Internal Audit Service to a standard that is acceptable to the Director of Finance and the Audit and Risk Committee, and that is

1.4 FTF and its staff will maintain confidentiality and shall not disclose, except as required by law, to any person other than a person authorised by the Client, any information acquired by FTF staff in connection with the provision of the Internal Audit Service concerning:

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

1.5 Subject to the availability of resources, FTF and its staff shall co-operate and respond to reasonable requests or give support in situations.

1.6 FTF shall comply with the PSIAS.

2. Internal Audit Responsibilities

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

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

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

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

- ✧ the organisation's objectives are achieved
- ✧ there is economical and efficient use of resources
- ✧ risks are adequately and effectively identified, recorded and managed
- ✧ there is compliance with established policies, procedures, laws and regulations
- ✧ assets belonging or entrusted to the organisation are properly controlled and safeguarded from losses of all kinds, including those arising from fraud, irregularity or corruption
- ✧ there is integrity and reliability of information and data provided to management including that used in decision making

- ✧ the organisation's interests are protected with regard to any contractual arrangements entered into
- ✧ the controls over information technology applications and installations are sufficient in quality and comply with recommended standards.

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

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

3. Internal Audit Standards

3.1 FTF shall comply with PSIAS and report on its compliance to the Audit and Risk Committee as part of the Annual Internal Audit Report. FTF shall maintain a system to ensure compliance with PSIASPSIAS and shall adhere to an agreed timetable for undertaking and reporting external quality assessment / validated self-assessment.

4. Planning

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

4.2 Internal Audit shall then prepare a strategic and annual audit plan based on the Strategic Risk Register and independent assurances available from other sources. In order to ensure coverage of all key controls. Internal Audit will undertake a risk assessment, of the organisation and the NHS control framework.

4.3 Audit plans will then be prepared by FTF, agreed with the Director of Finance prior to submission to the Senior Management Team and to the Audit and Risk Committee for approval. The approved plan will be shared with external audit.

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

4.5 The Annual Internal Audit Plan will be kept under review and any required amendments in response to emerging risks or other factors will be discussed with the Director of Finance before approval by the Audit and Risk Committee.

Strategic Audit Plan

4.5 The Strategic Audit Plan should cover the period agreed by the Director of Finance and Audit and Risk Committee. The plan should usually incorporate a rotation of audit emphasis to form a cyclical approach.

There are a number of areas within the audit universe which need to be reviewed annually. These may include:

- ✧ Core Financial systems
- ✧ Reviews targeting high risk fraud/probity areas through proactive CFS liaison
- ✧ Management of significant projects
- ✧ Post-transaction Monitoring

The Strategic and Annual Plans will be presented by the Chief Internal Auditor for formal approval by the Audit and Risk Committee by 30 June. The Strategic Plan should be updated annually to inform the Annual Audit Plan.

Annual Audit Plan

4.6 The Chief Internal Auditor will submit to the Audit and Risk Committee an Annual Audit Plan, which should reflect the audit coverage identified in the Strategic Audit Plan. The Annual Audit Plan should set out the planned scope of audit work and should identify the critical areas to be covered and resources required in each project.

Audit Assignment Plans

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

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

5. Managing Audit Work

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

5.2 The Chief Internal Auditor will also be responsible for monitoring the contract and will therefore be the Agreement Control Officer performing the additional quality, performance measurement and liaison activities. The Chief Internal Auditor shall be available to meet with the Director of Finance whenever required and at least bi-annually to discuss the service.

5.3 The Regional Audit Manager will be expected to be available to attend meetings with the Director of Finance at least monthly and as required, to discuss the progress of individual projects. The Regional Audit Manager will be the Internal Audit point of contact for any other bodies, internal or external, such as the external auditor.

5.4 The Audit and Risk Committee and Director of Finance must endeavour to ensure management's perspective of internal audit is positive and that a participative approach is adopted. Therefore, FTF will be expected to actively involve and keep auditees informed during all stages of audit assignments. This is particularly crucial during the testing and evaluation stages when it would be more appropriate to inform management of the emerging findings where these are significant rather than wait and produce the findings in a report at a later date. The circumstances where this approach would be appropriate would be:

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

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

5.5 The Chief Internal Auditor is responsible for delivering an economic and efficient quality audit and ensuring that the internal audit service is delivered according to the terms of this specification. The Chief Internal Auditor's responsibility broadly encompasses the following areas:

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

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

6. Reporting

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

6.2 The aim of every internal report should be to:

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

6.3 In addition, Internal Audit should provide the Director of Finance and Audit and Risk Committee with regular reports on progress.

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

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

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

Individual Audit Project Reporting

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

Annual Audit Reporting

6.8 The principal reports to be produced by Internal Audit will be the Internal Control Evaluation (ICE) and the Annual Internal Audit Report for each audit year. The ICE is normally presented to the January Audit and Risk Committee and the Annual Internal Audit Report needs be prepared in time for submission to the Audit and Risk Committee not later than the target date specified in Appendix I following the end of the audit period. The Annual Internal Audit Report should contain:

- ✧ An opinion on whether:
  - ✧ Based on the work undertaken, there were adequate and effective internal controls in place throughout the year
  - ✧ The Accountable Officer has implemented a governance framework in line with required guidance sufficient to discharge the responsibilities of this role
- ✧ The Internal Audit plan has been delivered in line with PSIAS
- ✧ analysis of any changes in control requirements during the year
- ✧ comment on the key elements of the control environment
- ✧ summary of performance against this service specification
- ✧ progress in delivering the Quality Assurance Improvement Programme.

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

Progress reporting

6.9 The Director of Finance will receive regular progress reports, together with the FTF Balanced Scorecard specific to the client detailing progress against the agreed Annual Audit Plan together with notification of any significant breaches of the timescales within the approved reporting protocol. Progress reports will also be presented to each Audit and Risk Committee in a format agreed with the Client.

7. Quality Control and Quality Measurements

7.1 The Chief Internal Auditor will be held accountable by the Audit and Risk Committee for performance and is therefore responsible for ensuring quality standards are defined, agreed, monitored and reported. These aspects of quality should be enshrined in the Performance Measures, shown in Appendix I and reported within the Annual Internal Audit Report.

7.2 The Chief Internal Auditor shall continuously review the performance of each region and use this review to inform the bi-annual discussion with the Client Director of Finance.

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

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

Client Satisfaction Survey

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

7.6 In addition, the Chief Internal Auditor will seek to ascertain the views of the Audit and Risk Committee and Board Members in relation to the quality of the service. This will be achieved through discussion with the Director of Finance, and through the offer of availability for meetings with the Audit and Risk Committee Chair and Board Chair.

8. Liaison with External Audit

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

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

9. Best Value Reviews

9.1 The Scottish Public Finance Manual states that responsibility for Best Vale rests with the Accountable Officer. It is the responsibility of the Internal Auditor, as part of the general review of systems of internal control, to review, appraise and report to management the extent to which the organisation's assets and interests are accounted for and safeguarded against losses of all kinds arising from fraud and other offences, waste, extravagance and inefficient administration, poor value for money or other cause. This will include review of the Best Value Framework, undertaken as part of the Annual Report fieldwork.

9.2 Identification of cost savings will be a consideration in every audit.

10. Suspected Criminal Offences

10.1 CEL (2013)11, an update of CEL (2008) 03 “Strategy to Combat Financial Crime in NHS Scotland” sets out further requirements on Boards and the requirements of the Bribery Act (2010) that need to be met. Whilst the key messages from CEL 11 (2013) remain relevant, the introduction of the Counter Fraud Strategy 2023-26 and the Counter Fraud Standards will assess how effectively Health Boards tackle fraud, bribery and corruption.

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

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

11. Freedom of Information

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

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

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

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

12. Staffing

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

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

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

- ✧ all relevant provisions of this specification
- ✧ all relevant rules, procedures and standards of the organisation
- ✧ security
- ✧ patient confidentiality and relevant aspects of Information Governance

12.4 The Chief Internal Auditor should co-ordinate and keep under review the continuing training requirements of all staff and report on these as part of the Balanced Scorecard.

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

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

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

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

12.6 FTF shall maintain the skill mix of staff outlined in Appendix IV. Performance against this specified skill mix should be reported within the Annual Internal Audit Report.

12.7 FTF shall be required to keep records detailing actual time spent on each audit and the name and qualification of staff. Only time spent working exclusively on the performance of the services and associated travelling time shall be chargeable.

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

- ✧ there are sufficient staff employed at the appropriate levels to fulfil the terms of the Shared Service Agreement

Appendix I

INTERNAL AUDIT SPECIFICATION

PERFORMANCE MEASURES

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

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

Appendix II

INTERNAL AUDIT SPECIFICATION

INTERNAL AUDIT REPORTING PROTOCOL & FLOWCHART

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

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

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

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

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

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

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

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

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

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

11. The recommendations will be added to the AFU System by Internal Audit and progress on implementation of appropriate action reported to the Audit and Risk Committee.

12. All final audit reports may be presented to the Executive Leadership Team, relevant Standing Committee and, where appropriate, the Tayside IJB Audit and Risk Committees (Angus, Dundee City and Perth & Kinross).

Dispute resolution

13. In the event of a failure to receive a timely response from the Responsible Director in relation to a draft report or assignment plan, or to reach agreement on a fundamental recommendation, the matter will be referred to the Director of Finance and, if necessary, to the Chief Executive.

Assignment Milestone	Stage	Processes involved	Responsibilities	Response time
	Annual Audit Plan agreed	Formulated from Strategic Audit Plan for agreement by Audit & Risk Committee	Regional Audit Manager/ Chief Internal Auditor with Director of Finance	
1	Assignment Plan agreed	Terms of reference for the assignment agreed with Responsible Director and / or Responding Officer.	Regional Audit Manager with Responding Officer/ Responsible Director.	within 2 weeks of issue
2	Fieldwork commenced	Audit team conduct audit assignment in accordance with Assignment Plan	Principal/Auditor with co-operation of client operational staff	
3	Fieldwork completed	Audit findings evaluated and summary of findings discussed and agreed with appropriate staff, including the Responding Officer. If the audit findings relate to the work of any other department or have an impact on any other departments, an appropriate senior officer from within that area will be consulted on the summary of findings. Draft report prepared for review.	Principal/Auditor in discussion with operational staff prior to Audit Manager review	within 1 week of fieldwork end
4	Draft report issued to Directorate	Audit report issued to Directorate in draft for review and consideration of action plans. If audit findings relate to the work of any other department or have an impact on any other departments, an appropriate senior officer from within that area should be consulted on the report content.	Regional Audit Manager with Principal/ Auditor to Responding Officer/ Responsible Director.	within 2 weeks of fieldwork end
5	Directorate response	Formal response required from Directorate to include completed time bound action plan matrix.	Responding Officer with agreement of Responsible Director	within 2 weeks of draft report release

Assignment Milestone	Stage	Processes involved	Responsibilities	Response time
6	Report issued to Director of Finance and Strategy	Audit report reviewed for clearance.	Regional Audit Manager	within 1 week of Directorate response
			Director of Finance / Responding Officer/ Responsible Director	within 1 week of receiving report
7	Final Report released	Report issued in full to relevant officers and External Auditor.	Regional Audit Manager/FTF Office Manager to Director of Finance and Strategy, Responding Officer & Chief Executive	within 1 week of Director of Finance clearance

Flowchart

Stage	Explanation	Timeframe
Assignment Plan	Assignment Plan issued to relevant Client Director by Principal Auditor/Auditor. When agreed, the assignment plan is issued to the Director of Finance and Strategy.	For return within 2 weeks
Fieldwork	Fieldwork carried out by Principal Auditor/Auditor according to the Annual Internal Audit Plan. On completion of fieldwork the summary of findings is discussed and agreed with the appropriate staff. A draft report will be prepared and file review undertaken.	File Review for completion within 1 week
Issue of Draft Report to Directorate	The draft report will be issued to the Responding Officer for factual accuracy check and management responses.	For return within 2 weeks
Directorate Response	Management responses are received and incorporated within the report.	Within 1 Week
Report to CE and Director of Finance	Report is issued to Director of Finance and Strategy for review, comment and approval.	For return within 1 Week
CE / Director of Finance Responses	The responses from the Director of Finance and Strategy will be incorporated into the report.	Within 1 week
Report finalised and issued	The Office Manager will finalise and issue the report to the relevant Client Director and Officers.	By the end of the next day
Recom-mendations added to AFU	The recommendations will be added to the AFU System by the AFU Coordinator and progress reported to the Audit & Risk Committee.	On receipt of report

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

Appendix III

INTERNAL AUDIT SPECIFICATION

FOLLOW-UP OF AGREED INTERNAL AUDIT RECOMMENDATIONS – HYPERLINK / TO LOCAL POLICY

Appendix IV

INTERNAL AUDIT SPECIFICATION
AUDIT SERVICE

STAFFING SKILL MIX

For the purpose of paragraph 12.7, it is expected that at least 50% of the internal audit work shall be undertaken by qualified staff.

Appendix V

INTERNAL AUDIT SPECIFICATION
AUDIT SERVICE

PSIAS

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

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**14 March 2024**
Title:	**Business Continuity Arrangements Internal Audit Report**
Responsible Executive:	**Joy Tomlinson, Director of Public Health**
Report Author:	**Susan Cameron, Head of Resilience**

1 Purpose

This report is presented for:

- Discussion
- Decision

This report relates to:

- Legal requirement – Civil Contingencies Act 2004. Business Continuity Planning (BCP)
- Emerging issue

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

- Safe

2 Report summary

2.1 Situation

The purpose of this report is to provide committee members with an overview of the key findings and agreed actions in response to the Business Continuity Internal Audit Report B13/23 (**Appendix 1**).

The audit opinion within the report is one of limited assurance and contains five recommendations alongside agreed actions. This paper provides an overview of work to update and refresh business continuity planning across Fife and the additional actions which have been agreed in response to the audit report.

2.2 Background

NHS Fife is classified as a Category 1 responder, which carries specific responsibilities set out in "*The Civil Contingencies Act (CCA) 2004*" and "*The Civil Contingencies Act 2004 (Contingency Planning) (Scotland) Regulations 2005*". This legislation includes the requirement for Business Continuity arrangements to be in place.

Business continuity arrangements were identified as an audit topic in recognition of the importance of forward planning and following recommendations from Interim Internal Audit report B23/22. This earlier report did not result in an audit opinion as a full review could not

be undertaken due to vacancies and within the Resilience team and operational pressures as a consequence of the COVID19 pandemic.

The Interim Internal Audit B23/22 highlighted the following areas for action:

- Confirmation that local business continuity planning assurance has taken place, incorporating learning
- Formal approval of Major Incident plan
- Confirmation that necessary governance arrangements are in place

All of the actions agreed within the previous Interim Internal Audit report have been completed and this has been evidenced with Internal Audit and reported to EDG and Clinical Governance Committee.

The summary table below sets out the recommendations and evidenced which has been received and agreed with Internal Audit relating to the previous report B23/22:

Requested	**Status Evidence**
Evidence of Business Continuity (BC) Plans having been reviewed in accordance with relevant guidance	• Master BC Ledger centrally held. • Testing and Exercising Programme. • Quarterly EPRR Whole systems Assurance Reporting to Resilience forum & EDG. • Supportive Site visits. • Resilience Team Huddles. • Datix Business impact assessment risk profile status & Dashboard.
Finalised Major Incident Operational Plan with scheduled review date	• Major Incident Framework guidance & action cards ratified 10/8/2023 review in 12 months (10/8/2024). • Action Cards implemented for BC Planning. • 21 Emergency Department action cards reviewed & updated. • HAZMAT Scenario Test to planning undertaken 25/8/22.
Resilience Assurance Reporting mechanisms	• Quarterly EPRR Whole systems Assurance Reporting to Resilience forum & EDG. • Annual Statement of Assurance. • Business Continuity Management Systems datix risk profiling. • Stakeholder consultation via S bars to SLT & H&SCP SLT meeting groups.

The new Internal Audit report B13/23 was commissioned to support the work established last year to strengthen Business Continuity and provide new areas of focus. During 2023 a review of the adequacy of Business Continuity Planning (BCP) arrangements for NHS Fife and Fife Health & Social Care Partnership (HSCP) was taken forward. Initial testing of a sample of BCPs completed by the Resilience team identified that not all sections of BCPs were completed, including those on training and testing.

In 2020 a new process of assurance was put in place within NHS Fife but there was limited opportunity to test this due to the pressures associated with the pandemic.

The existing NHS Fife 'Assurance of Resilience Capabilities' procedure was discussed with the Acute Senior Leadership Team who acknowledged that the Assurance of Resilience Capabilities procedure was difficult to implement It was agreed that a revised governance and assurance process for Business Continuity assurance should be developed.

Work has progressed with both Acute services and Health and Social Care Partnership to ensure plans are held across all service areas. The number of areas identified as requiring BCPs to be in place has expanded from 75 to 146 over the last year. In November 2023, a new strategic Business Continuity Management Systems approach launched across NHS Fife. The system uses Datix and it allows managers to see the plans for areas they have responsibility for. The system is administered and monitored by the resilience team.

BCP training is provided by the resilience team to ensure ongoing support for plan owners and managers. A short Business Continuity survey was undertaken in July 2022. When asked specifically to type of support needed, 43% of management responses mentioned BCPs. 75% of managers said that BCPs were useful during the pandemic, and 49% said they would value additional support from the Business Continuity team. Testing and exercising of plans with service area managers commenced in March 2023 which is providing direct feedback to the quality of planning – the aspiration is that this will continue to build and improve the quality of local BCP in situ.

2.3 Assessment

The Internal Audit report B13/23 (**Appendix 1**) provides an overall audit opinion of limited assurance. The report considers both strategic and operational areas of BCP and notes the ongoing work to strengthen individual plans, the new monitoring system now in place as well as highlighting areas which require further actions. Section 1 of the report describes the key findings from the review. The wider work which has progressed since the first audit report is covered in points 8, to 11 on page three of the report.

In addition, the Internal Audit review examined 8 individual BCPs in detail. This review found that business impact assessments had been completed in all cases and risk assessments in the majority of these. However, the review highlights that key sections were not complete and final sign-off was missing from some plans.

Risk overview

The audit recommends review of the overarching risk relating to Business Continuity and Emergency Planning which is managed by the Public Health Assurance Committee. The existing risk combines a description of the implications of a failure to plan for emergency planning and Business Continuity planning. This risk description covered the period of the pandemic at a time when planning capacity was significantly constrained. The risk will be reviewed and it is anticipated that a new specific risk for BCP will assist with implementation of management actions.

Reminder of individual plan holder's responsibilities

Information has been gathered from managers about the process of Business Continuity assurance. This has been used to inform new assurance changes where monthly summary assurance reports have commenced to be proactively provided to plan managers for their monitoring. The advantage of this approach is that the checking process is now proactive & spread over a more manageable time period for all involved. An improvement plan will be brought to the Resilience Forum and EDG by the end of June 2024.

Review of Business Continuity templates and procedures

Over the last year significant planning changes have been progressed with new supportive BCP action card templates which are available on Blink and a revised business impact analysis assessment form to better aid digital systems considerations.

Tailored BCP training is provided by resilience to ensure ongoing support and during January 2023 to February 2024 a total of 69 staff attended the training. Testing and exercising of plans with service area managers commenced in March 2023 which is providing direct feedback to the quality of planning – this however will take time to phase in across all service areas. Internal audit sampled 8 /146 plans where their feedback indicates there are still significant planning & assurance risk. A considerable degree of work will still be required from managers across services to enable assurance (See Appendix 1: B13/23 Findings Report), however there has already been very positive engagement and this can be seen in the number of updated plans over the winter months.

Updating Business Continuity Policy

This will be updated and aligned with other resilience policies and will also be informed by the recently refreshed National Strategic Guidance for business continuity.

The internal audit findings and recommendations will build on the work which has already been progressed across the organisation. The findings are accepted, noting that it was only possible to sample a small number of plans during the review. While the report at present is one of limited assurance, there is now much greater visibility of Business Continuity and positive engagement with individual service areas. It is anticipated that progress will continue over the coming year and the areas of agreed action will be completed within the timescales set out in Section 2 of the report.

2.3.1 Quality / Patient Care

BCP documents provide support for staff in the event of any internal incident & strengthens the ability of NHS Fife as an organisation to protect its patients & wider workforce from any unforeseen events.

2.3.2 Workforce

NHS Fife has a legal requirement to ensure adequate information, instruction & training has been provided to its workforce to ensure planning for preparedness.

2.3.3 Financial

Internal Business Continuity incidents have the potential to rapidly cause financial impact. Investment in planning for preparedness reduces overall incident recovery costs. Expanded use of Datix does not require additional IT expenditure.

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

BCP and testing supports incident recovery which may include a degree of environmental impact.

2.3.5 Route to the Meeting

This paper is brought directly to the Audit & Risk committee to provide informed awareness.

- 20/2/24 - final B13/23 audit report issued
- 28/2/24 - B13/23 Audit feedback was shared with all identified BC plan owners
- 29/2/24 - verbal update to EDG for awareness

2.4 Recommendation

Discussion – For examining and considering any wider implication.

The Audit and Risk Committee is asked to **consider** the findings of the Business Continuity Arrangements Internal Audit B13/23 Report and to **endorse** the action plan set out within Section 2 of the report.

The following appendices are included with this report:

- Appendix 1 – B13/23 Findings Report

Report Contact
Susan Cameron
Head of Resilience
Email susan.cameron10@nhs.scot

FTF Internal Audit Service

Business Continuity Arrangements

Report No. B13/23

Issued To: **Carol Potter, Chief Executive**
Margo McGurk, Director of Finance & Strategy

Dr Joy Tomlinson, Director of Public Health
Susan Cameron, Head of Resilience

Nicky Connor, Director of Health & Social Care]
Gillian MacIntosh, Head of Corporate Governance/Board Secretary
Hazel Thomson, Board Committee Support Officer

Clinical Governance Committee
Audit and Risk Committee
External Audit
Audit Follow Up

Contents

Draft Report Issued	29 November 2023
Management Responses Received	***13 December 2023***
Target Audit & Risk Committee Date	13 December 2023
Final Report Issued	**19 February 2024**

CONTEXT AND SCOPE

1. NHS Fife is a Category 1 Responder under the Civil Contingencies Act (2004) and associated regulations (2005). This is further defined in Scottish Government guidance 'Preparing Scotland' as: "Category 1 Responders are organisations that provide vital services in an emergency. They include emergency services, local authorities, health boards and the Scottish Government".

2. NHS Resilience Scotland published complimentary guidance in 2013, 'Preparing for Emergencies, Guidance for Health Boards in Scotland'. NHS Standards for Organisational Resilience (2nd edition) was published in May 2018.

3. Internal audit B23/22 – Resilience Interim Report concluded that key controls were not functioning as required and highlighted immediate concerns over governance and internal control arrangements for resilience. The recommendations within that report are now being implemented by management and are monitored by Internal Audit as part of the audit follow-up process. The Director of Public Health requested further internal audit work to review departmental arrangements for preparation of Business Continuity Plans (BCPs), to complement the implementation of recommendations from report B23/22. This report details the action taken to improve the key controls over business continuity planning arrangements since report B23/22 was issued on 19 April 2022.

4. NHS Fife's Strategic Resilience Forum (RF) terms of reference state that NHS Fife's duties under the Civil Contingencies Act (2004) include putting in place BCPs and a related training and exercising programme. For a sample of wards and departments across the Directorates this audit assessed whether in line with the remit of the Strategic RF:

   - Business Continuity planning arrangements within prioritised services and functions are updated and tested in accordance with relevant guidance, and where appropriate they incorporate learning and required changes arising from Covid-19 and Brexit.

5. Recognising the challenges wards have faced following the pandemic and the recent number of cases of flu, consideration was given to:

   - Whether lessons learnt from those experiences could benefit from a change to BCP procedures or the provision of additional training.
   - If BCPs exist, but are out of date, or if informal Business Continuity arrangements are in place where BCPs do not exist.
   - What barriers exist, preventing wards and departments maintaining up to date BCPs.

AUDIT OPINION

6. The Audit Opinion of the level of assurance is as follows:

Level of Assurance		System Adequacy	Controls
Limited Assurance		Significant gaps, weaknesses or non-compliance were identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the area audited.	Controls are applied but with some significant lapses.

7. A description of all definitions of assurance and assessment of risks are given in Section 4 of this report.

Overall Arrangements

8. While there is no separate strategic risk for business continuity, risk ID 518 within the Public Health Directorate risk register covers resilience arrangements, including BCP, and was reviewed by the Head of Resilience in August 2023. As the EDG had agreed the introduction of the new Business Continuity Management System (BCMS), it was judged appropriate for the risk to remain as moderate. When this risk is next reviewed the findings from this report should be considered when assessing the risk score, with it being increased and escalated as required.

9. Following the restructure and strengthening of the Resilience Team in 2022, the team is progressing a review of the adequacy of BCP arrangements for NHS Fife and Fife Health & Social Care Partnership (HSCP). Review of BC reporting arrangements has been completed with additional information on completeness of BCPs to be included in future reporting to the RF.

10. Initial testing of a sample of BCPs completed by the Resilience team and reported to the EDG in January 2023 identified that not all sections of BCPs were completed, including those on training and testing. Further efforts by the Resilience Team to obtain assurance on the completeness of BCPs from the responsible leads was unsuccessful, with the majority of leads not responding.

11. In response to the known issues with completeness of BCPs and to enable more effective monitoring, the new BCMS which uses the DATIX system, has been introduced by the Resilience Team and will be used as the basis for providing updates on BCPs to the RF on an ongoing basis. It will provide, on a dashboard basis, up to date information on every ward and department that requires a BCP. Further consideration will be given to the effectiveness of the dashboard as part of the Audit Follow-Up process when Internal Audit monitor recommendations made in this report.

12. Our audit findings confirmed that for the wards tested, BCP arrangements were not adequate. Successful implementation of the BCMS is essential and should drive improvement. However, the Resilience Team should continue to communicate the importance of business continuity planning and robust support from senior management will be vital in successfully achieving improvement.

13. Wards and departments have ownership of their BCP and it is not the responsibility of the Resilience Team to review every BCP in detail. Authorisation of each BCP by the relevant senior management lead is required to confirm they are fully functional therefore represents a key control. Authorisation of BCPs should therefore be monitored and reported as a Key Performance Indicator (KPI) and the Resilience Team should remind authorising managers of their responsibilities, should BCPs not be reviewed and authorised.

14. In preparing a BCP, initial steps include completion of a Business Impact Assessment (BIA) to establish the most critical factors affecting ongoing continuity of service, such as staffing and equipment; followed by a Risk Assessment (RA) to consider the likelihood of the risks associated with eight different scenarios occurring, such as fire. Depending on the outcome of these initial assessments the most critical aspects are taken forward for inclusion within the BCP.

15. Internal audit analysis of a sample of eight plans concluded that BIAs were completed in all instances and RAs in the vast majority. Staffing shortages was the most reported reason for non-completion. As with BCPs, several of the BIAs and RAs in the sample were not signed by an authorising manager, with key sections not completed in full. The sections not completed included the training of staff, testing of BCPs and noting the actions put in place as a result of the BC analysis to counter the impact of any incident that might arise. No explanation was provided in the BCPs as to why the blank sections had not been completed. Reporting on BIAs and RAs should be included within the new BCMS dashboard.

Business Continuity Plans – Database

16. The Resilience Team maintain a database to monitor and report on wards and departments required to have BCPs. The most recent position at November 2023 is detailed below:

Business Continuity Plans	**No. of NHS Fife BCPs**	**%**
Up to date	46	32%
Overdue Review	75	51%
Not Dated	25	17%
Total	**146**	**100%**

17. We would highlight that 68% of overdue BCPs were more than six months out of date. It is not possible to tell if the 'not dated' BCPs are overdue, but as updated BCPs were not submitted to the Resilience Team, that is likely to be applicable to a number of them.

Ward and Departmental Testing

18. Our review of eight wards and departments focussed on the completion of BCPs and areas not completed within the BCP document. This did not include consideration of the completeness of the list of prioritised services deemed to require a BCP. A summary of the results from our sample is as follows:

- 75% had no evidence that BCPs had been tested (6/8).
- 87% had no records available to confirm that training had been completed (7/8).
- 62% of completed BCPs were not authorised i.e., confirmed as fully functional by a senior manager (5/8).
- 50% of BCPs reviewed were overdue for review, two dating back to 2021 (4/8).

19. Therefore, our testing did not provide assurance that up to date and fully documented BCPs were in place for the areas reviewed. Our testing and the data held in the BCP database indicates that non completion of BCPs continues to be an issue across the wider organisation. The issues identified in this audit, along with action to address them should be reported and escalated as required. We recommend that the resilience risk (ID518) is reviewed and updated to ensure the risk reflects all required elements, current controls and required controls / actions.

20. Management leads for the BCPs reviewed by Internal Audit explained that the most common barrier that prevents wards and departments from maintaining fully up to date BCPs is the overall pressure currently placed on NHS services.

21. While discussions with management indicate that informal business continuity arrangements exist, when training or testing requirements are reviewed and it is concluded that neither is required, an explanation as to why that is the case should be provided. This also applies to the use of action cards. This would formally record the decision and inform the authorising manager of the reason for that assessment for their consideration, before authorising the BCP review as complete. Amending the BCP template to include the requirement to include such detail would enable BCPs to further explain the reasoning behind such decisions and evidence that all appropriate scenarios had been considered.

Detailed Testing Findings

Continuity Incidents – Initial Actions

22. Management consulted during our sample testing of wards and departments informed us that actions in response to a continuity incident would be initially escalated to senior management for resolving on a Directorate basis, rather than at ward or department level. This escalation process was detailed in all the BCPs reviewed.

23. Although an immediate response to an incident can be initiated through the escalation process, the consequence of certain sections of BCPs not being completed could have a detrimental impact on providing an effective response to an incident, for example noting the actions put in place as a result of the BC analysis to counter the impact of any incident that might arise.

Daily Continuity of Services – Impact on BCPs

24. Ward and departmental management indicated that there are informal arrangements to support the daily continuity of all services, but that these arrangements are not recorded within the existing BCP template framework. One example is through the daily safety huddle meeting, attended by all relevant wards and departments, to consider the continuity of services. One of the most frequently arising continuity issues, staffing shortages, is dealt with at these meetings and can involve a pooling of resources across all services. Not recording such arrangements in BCPs may impact the BCP process for a ward/department.

Feedback from Wards/Departments on Procedures and Templates

25. Feedback from management at wards/departments sampled was that a revision of the format of BC planning templates would be beneficial to make preparation less time consuming. In our opinion the current format of the BCP template enables a full review of BC arrangements to be completed, but the template does require a considerable amount of detail to be recorded if fully completed. In view of the number of sections not completed within the sample reviewed, and that this is likely to be similar across the organisation, consideration should be given to revising the template. This could be achieved by some of the current sections e.g., action cards and training, being included as appendices for use if required, with an explanation provided in the body of the plan explaining the reason for their use or non-use for sign off by the authorising manager.

26. A further revision to the BCP template could be made by including actions that apply to all wards and departments within the original templates as a standard continuity measure e.g., the daily safety huddle arrangements and incidents where a common response would be appropriate, such as water shortages. For the latter example, Estates could approve the process that should be followed by all wards and departments. This situation is also likely to apply to other scenarios and would save time in completing BCPs.

Business Continuity Plans – Action Cards

27. Details of continuity arrangements are required to be recorded on action cards, but none of the wards and departments in our sample used action cards, with it being explained that continuity incidents would be resolved through managements own initial assessment of the situation and immediate action based on their training and then escalation to senior management for consideration on a collective basis. The use of action cards was therefore not deemed necessary by wards and departments, but this was not noted on any of the BCPs reviewed.

Business Continuity Plans – Training

28. The Business Continuity (BC) Policy, which was due for update in May 2023, requires that "*Each directorate is responsible for ensuring that staff receives training appropriate to the Business Continuity requirements of specific departments*".

29. Only one of the eight areas sampled could provide evidence of staff training being completed. Management from several wards informed us that at all times there would be an appropriately qualified member of staff in charge of the ward or department, who, as part of their training to advance to their qualified position, would have covered continuity of service arrangements; and as part of their daily responsibilities, would be fully aware any immediate action to take and be aware of the escalation procedures to follow. Based on our sample testing, we cannot therefore provide any assurance that staff have been appropriately trained in Business Continuity Planning.

Business Continuity Plans – Testing

30. For our sample there was no evidence of any testing of BCPs. It is a requirement of the Business Continuity Policy that plans are '*tested when changes within the department occur or on an annual basis as a minimum*'.

31. Management informed us that knowledge of the procedures to be followed when an incident arises and the immediate escalation process for resolution are known to staff as part of their daily responsibilities. Based on that and the immediate escalation of incidents to senior management for consideration and resolution, it was explained that further individual testing was therefore not required. Internal Audit is of the opinion that this approach does not provide a robust control, and the requirements of the Business Continuity Policy in relation to testing should be followed.

Business Continuity Plans – Senior Management sign-off

32. Only 38% of the sample of BCPs reviewed (3/8) was authorised by senior management as required and for training and testing sections were blank for the majority of our sample. Not authorising BCPs or doing so when a number of important sections are blank, does not provide any assurance that properly prepared and full functional BCPs exist.

Covid 19

33. As reported to the December 2022 RF meeting, feedback from a survey completed by the Resilience team into the usefulness of BCPs during the Covid-19 pandemic recorded that 43% of respondents requested support in ensuring their BCPs were adequate should there be such an occurrence in future. From our review of eight BCPs, only one department had completed a detailed risk assessment of the impact of Covid-19 on the BCP and updated it accordingly. The Resilience Team survey feedback and Internal Audit's testing indicates that it cannot be confirmed that all BCPs have been updated to take account of the lessons learned from the Covid-19 pandemic. Action should be taken to confirm that all BCPs have been updated for the lessons learned from Covid-19 pandemic and that be reported to the RF once completed.

ACTION

34. 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

35. 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:	
Risk ID 518 within the Public Health Directorate Risk register covers resilience arrangements, including BCP. The risk was 'moderate' when last reviewed in August 2023. This score was based on the action being taken to introduce the new BCMS, as agreed by the EDG.	
Audit Recommendation:	
When Risk ID 518 is next reviewed the findings from this report should be reviewed and reflected in the risk score, with consideration given by the risk owner as to whether this risk should be increased to a high score with notification of this escalation to EDG for their attention.	
Assessment of Risk:	
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.**
Management Response/Action:	
Risk ID 518 describes the risk that NHS Fife may be unable to respond to a major emergency, service failure or serious public health incident and simultaneously provide care due to a lack of planning. This risk has been actively managed and the position has improved significantly within the last year as the new Incident Management Framework and related plans have been developed. The audit has identified gaps in key controls relating to business continuity. To address these gaps a new risk will be considered for business continuity planning, its description and ownership being discussed with senior management from the Acute Directorate and the H&SCP. The findings of this report will be considered when assessing its initial risk score and updates on it will be reported to the Public Health Assurance Committee on an ongoing basis as part of quarterly reporting on resilience arrangements.	
Action by:	**Date of expected completion:**
Head of Resilience	**31 March 2024**

Action Point Reference 2

Finding:

Our review of a sample of BCPs noted that:

- At end of November 2023 the database of BCPs recorded that 32% were up to date, with the remainder being overdue a review, or not dated. It is unclear if BCPs that are not dated are overdue.
- 68% of overdue BCPs were overdue by more than six months.
- 62% of the sample of BCPs reviewed by Internal Audit had not been authorised by a senior manager i.e. confirmed as complete and fully functional.
- The authorised BCPs reviewed by internal audit had sections that had not been completed and no explanation was provided as to why training and testing was not required.

The introduction of the BCMS is designed to drive improvement and improve monitoring and reporting on BCPs, with the current data and internal audit testing indicating inadequate completion of plans in this area at present.

Audit Recommendation:

All areas should be reminded of their responsibility for maintaining BCPs. The wards and departments without an up to date plan should be actively supported to do so within an agreed timeframe and any barriers to completion should be escalated to EDG, so that action can be taken to provide clear focus and culture change from the top of the organisation. An improvement action plan should be put in place and progress should be reported and monitored. Thereafter, the RF should monitor progress in updating BCPs as part of quarterly resilience reporting. Updating of BCPs to incorporate the lessons learned from the Covid-19 pandemic and reporting on such should be incorporated into this process.

The reminder should also advise senior managers who authorise the BCPs of the importance of their role in ensuring fully functional BCPs and that it is a requirement for them to authorise BCP completeness. To ensure authorisation can be monitored on an ongoing basis this information should be recorded in the BCMS dashboard, for follow-up if it is not being completed.

Assessment of Risk:

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.**

Management Response/Action:

We agree that an improvement plan will be beneficial for business continuity planning. Training is widely available in short sessions for staff and we will continue to refine and develop this to meet the needs of staff.

This will support teams to develop confidence in their BCP's and also the added value that they bring. Action has already been initiated to remind managers of their responsibility for maintaining BCPs via the provision of enhanced reporting on BCPs via the BCMS dashboard.

In addition, DATIX is to be used to collate data on all NHS Fife BCPs, including their authorisation. Once these actions have been fully completed, BCP owners will be able to access dashboard information detailing the status of their BCPs. Further reports will also be provided to General Managers on a quarterly basis detailing the completeness of BCPs for each Directorate. The EDG will be updated on completion of these actions as part of the quarterly resilience update reporting. The RF will be updated on the completeness of BCPs at each of its meetings. Further planned reporting in 2024 includes an annual report on BC planning to the Clinical Governance Committee (CGC)	
Action by:	**Date of expected completion:**
Head of Resilience	**31 October 2024**

Action Point Reference 3	
Finding:	
The remit of the Clinical Governance Committee (CGC) includes receiving assurance reports from the Resilience Forum. The CGC will also be provided with this audit report.	
Audit Recommendation:	
To ensure the CGC receives appropriate assurance on robustness of BCP, the RF's Annual Statement of Assurance to the Committee should provide an update specifically cross-referenced to the current status of the action taken relating to each recommendation in this report.	
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:	
Agreed, this will be completed as part of the RFs assurance statement for 2024.	
Action by:	**Date of expected completion:**
Head of Resilience	**31 May 2024**

Action Point Reference 4

Finding:

The existing BCP procedures and templates are not being used to fully record the BCP arrangements in place within wards and departments. In addition, several sections are commonly not being completed, with no explanation provided. Evidence of fully functional BCPs does not therefore exist.

Audit Recommendation:

The format of the BCP template should be reviewed to enable business continuity arrangements to be fully detailed and to more easily evidence that a fully functional BCP is in place. This should include consideration of documenting on a standardised basis within the template any procedures that involve common actions to be followed by all wards and departments, so that:

- Action taken on a more informal basis is included, such as a description of the escalation process and the safety huddle. This could also help identify any risks not covered by these arrangements that need to be separately considered.
- A description is included of the procedures to be followed for resolution of issues that are completed by another department e.g., water supply problems. The description would be a common approach for all wards and departments to follow rather than individual responses having to be determined by each.
- The BCP template provides more question-and-answer sections requiring wards to explain why no training, testing or supporting action cards are required thereby ensuring the BCP demonstrates that a full assessment has been completed and can be signed off by the authorising manager.

The above review should also include consideration of the associated BIA and RA templates on a similar basis.

Assessment of Risk:

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.

Management Response/Action:

Several actions have already been initiated and rolled out to enable ward and departmental BCP arrangements to be fully detailed. This includes standardised action cards (August 2023) specifying the escalation process and steps to be followed by all wards and departments for specific continuity incidents such as water supply problems.

BIA and RA templates have been reviewed and the BCP template is in the process of being updated. Its revision will consider the changes suggested above. Once that is finalised an exercise will be completed to determine if the revised BCP is adequate, with any further revisions being completed thereafter.

Staff will be kept informed of these updates via the Resilience Workforce Briefing.

Action by:	Date of expected completion:
Head of Resilience	**31 October 2024**

Action Point Reference 5	
Finding:	
The NHS Fife Corporate Business Continuity Policy was due for review in May 2023 and is therefore overdue. The findings of this audit confirm that such a review is necessary to ensure the policy appropriately details the operational and governance procedures that should be followed by those responsible for preparing BCPs.	
Audit Recommendation:	
To ensure it fully details the current operational and governance procedures relating to business continuity arrangements, a review of the NHS Fife Corporate Business Continuity Policy should be completed in conjunction with the other reviews recommended above. Thereafter, notification of its subsequent issue should be used to highlight any changes to the procedures, emphasise the importance and responsibility of all wards and departments designated as requiring a BCP, to keep them up to date.	
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 NHS Fife Corporate Business Continuity Policy and the other existing resilience policies are not fully aligned to each other, nor do they fully explain the existing BCP arrangements. They are therefore all going to be reviewed, with the intention of creating one overarching BC policy, which will be aligned to the National Strategic Guidance on resilience.	
Action by:	**Date of expected completion:**
Head of Resilience	**31 October 2024**

Section 3 Definition of Assurance and Recommendation Priorities

Definition of Assurance

To assist management in assessing the overall opinion of the area under review, we have assessed the system adequacy and control application, and categorised the opinion based on the following criteria:

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

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 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.**	**Three**
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.**	**None**

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**14 March 2024**
Title:	**Corporate Risk Register**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Pauline Cumming, Risk Manager**

1 Purpose

This report is presented for:

- Assurance

This report relates to:

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

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This paper provides an update on the Corporate Risk Register since the last report to the Committee on 13 December 2023.

Members are invited to:

- review the corporate risks as at 5 March 2024 set out at Appendix No.1;
- consider the information against the Assurance Principles at Appendix No.2;
- conclude and comment on the assurance derived from the report.

2.2 Background

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

- relevance

- proportionality
- reliability
- sufficiency

2.3 Assessment

NHS Fife Strategic Risk Profile

The Strategic Risk Profile as at 29/02/24 is provided at Table 1 below.

Table 1: Strategic Risk Profile

Strategic Priority	Total Risks	Current Strategic Risk Profile				Risk Movement	Risk Appetite
To improve health and wellbeing	4	2	2	-	-	◄►	High
To improve the quality of health and care services	6	4	2	-	-	▲	Moderate
To improve staff experience and wellbeing	2	2	-	-	-	◄►	Moderate
To deliver value and sustainability	6	4	2	-	-	◄►	Moderate
Total	**18**	**12**	**6**	**0**	**0**		

Summary Statement on Risk Profile

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

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

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

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

Since the last report to this Committee, the key changes are:

- One Corporate Risk has been closed - Risk 3 Covid -19 Pandemic
- One risk has reduced its risk rating and level - Risk 9 - Quality & Safety and is now within its risk appetite
- One new Corporate risk has been added to the Register - Risk 19 - Preparation for the Implementation of the Health and Care (Staffing) (Scotland) Act 2019
- The risk level breakdown is 12 high (n13) and 6 (n5) moderate level risks

KEY UPDATES

Closed Risk

Risk 3 - COVID - 19 Pandemic

At the meeting of the Clinical Governance Committee (CGC) on 12 January 2024, the Director of Public Health provided a report and a deep dive review which showed that the Covid-19 risk had achieved and surpassed its risk target and that there had been a period of stability in reviews of the risk over several months. It was recommended that the risk should close on the Corporate Risk Register and oversight should transfer to the Public Health Assurance Committee. The Committee took assurance on the deep dive and agreed on the recommendation. This has been actioned.

Active Risks

Risk 2 - Health Inequalities

At the meeting of the Public Health and Wellbeing Committee (PHWC) on 15 January 2024, the Director of Public Health presented a deep dive review of the Health Inequalities risk. This included a recommendation to increase the risk target rating and level from Moderate 10 to High 15. It was felt that the previous target of 10 was unrealistic, given slippage in the development of an action plan and associated evaluation framework. The Committee took assurance that there is robust oversight and management of this risk, and agreed with the recommended increase in the target risk rating and level. Members are advised that the Director of Public Health has changed the target date from 31 March 2024 to 31 May 2024; this will allow the next update to reflect review of the risk by the Public Health Assurance Committee scheduled for April 2024.

Risk 4 - Optimal Clinical Outcomes

As previously reported to members, following discussion at the Clinical Governance Committee (CGC) on 5 May 2023 and the Committee's Development Session on 23 October 2023, it was agreed that an updated deep dive on Optimal Clinical Outcomes should be carried out. The updated deep dive was discussed and accepted at EDG on 15 February 2024, and presented to the CGC on 1 March 2024. It has been agreed there should now be further discussion through the Risks and Opportunities Group (ROG) on whether it is appropriate to close the risk and develop a revised risk or risks.

Risk 9 - Quality and Safety

As previously reported to this Committee, following the deep dive review reported in July 2023, the Clinical Governance Committee (CGC) requested that the risk be revisited with a view to reducing the current risk score, given the governance arrangements in place, and the number of completed mitigations. A risk review was carried out which indicated the potential to reduce the risk level from high to moderate. Subsequently, it was agreed that the risk level should remain at high pending a review of governance arrangements.

Members are advised that it is now possible to confirm the adequacy and effectiveness of the relevant governance arrangements. An update to this effect was provided to the CGC on 1 March 2024. This confirmed that the current risk rating and level have reduced from High 15 to Moderate 12 which brings the risk within its risk appetite of Moderate. Additionally, the risk target has been reduced from Moderate 10 to Low 6.

Risk 10 - Primary Care Services

Following discussion of the Primary Care Services risk at the Public Health and Wellbeing Committee (PHWC) meeting on 15 January 2024, the Director of Health & Social Care agreed to review the timeline for achieving the target reduction in risk level from High 16 to Moderate 12. As the Primary Care Strategy is a 3 year programme, it is unlikely that the score will reduce much before 2025. In light of this, the timeline has been changed from 31/03/2024 to 31/03/2025.

Risk 13 - Delivery of a balanced in-year financial position

Further to agreement at the meeting of the Finance, Performance & Resources Committee (F, P&R) on 16 January 2024, the risk has been reviewed and mitigations have been updated. A potential increase to the current risk rating, and changes to the target rating and timescale still require to be discussed at the Executive Directors Group (EDG). Any developments will be presented to the next meeting of the F, P&R Committee on 7 May 2024.

Risk 14 - Delivery of recurring financial balance over the medium term

As agreed at the F, P&R Committee in January 2024, the risk was reviewed and mitigations updated. Possible increases to the current and target risk ratings still require to be discussed at EDG. The target timescale will also be reviewed. An update will be presented to the F,P&R Committee meeting in May 2024.

Risk 17- Cyber Resilience

A deep dive review of the Cyber Resilience risk was presented to the Clinical Governance Committee (CGC) on 12 January 2024. This articulated the actions being undertaken to mitigate the risk of the organisation being overcome by targeted and sustained cyber-attacks, which could impact the ability to deliver a full health service. It was noted that there are aspects outwith NHS Fife's control, such as cloud services, which are hosted by other Health Boards and National Services Scotland (NSS), and it was advised that improvement work is being undertaken with those parties. It was also noted that there are challenges in terms of recruitment and retention into digital roles. The CGC took assurance from the deep dive.

Risk 19 - Preparation for the Implementation of the Health and Care (Staffing) (Scotland) Act 2019

At its meeting on 28 November 2023, the Board approved the addition to the Corporate Risk Register of the above risk.

An update on the risk to the Staff Governance Committee (SGC) meeting on 6 March 2024, will indicate that the current actions to prepare for the implementation of the Act

from April 2024 are progressing well. However, Scottish Government feedback on the Board's Quarter 2 Return submission is still awaited and this in turn may lead to reconsideration of priorities. The scale back of the implementation of eRostering and the associated SafeCare module within the Board will also have an impact in terms of future reporting requirements.

Risk Descriptions

Risk 11 - Workforce Planning and Delivery
Following discussion at recent Operational and Strategic Workforce Planning meetings and at previous Staff Governance Committee (SGC) meetings, there will be a proposal to the meeting of the SGC on 6 March 2024 that the existing risk description requires to be amended to more accurately reflect the specific nature of the workforce challenges facing the Board.

The proposed change is as follows:

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

To: *"There is a risk that the current supply of a trained workforce is insufficient to meet the anticipated Whole System capacity challenges, or the aspirations set out within the Population Health & Wellbeing Strategy, which may impact on service delivery".*

The on-going national shortages of trained staff are well documented and can only be mitigated in part by workforce planning. In addition, this risk may be subject to further change given the current Reform, Transform, Perform focus. These matters will be considered under the Workforce Planning agenda item at the aforementioned SGC.

Details of all risks are contained within Appendix No. 1.

Potential New Corporate Risks

Pandemic Preparedness/Biological Threat
Further to the last report to this Committee, members are advised that preparation of a report and a deep dive review on the above risk is underway. Submission to the Clinical Governance Committee (CGC) was deferred from 1 March 2024 until the meeting on 3 May 2024. In the interim, the items will be progressed through the Public Health Assurance Committee, and the Executive Directors Group (EDG) in March/April. This will allow EDG to consider if they are supportive of the new risk being included on the Corporate Risk Register, and also to which committee it is best aligned.

Capital Funding - Service Sustainability
At the Finance, Performance & Resources Committee (F, P&R) in January 2024, it was agreed that a corporate risk should be developed to reflect how services can be sustained without additional capital funding. Members are advised that work is underway to develop

this risk which will be progressed through the Financial Capital Investment Group (FCIG) and the EDG during March/April 2024. This will allow EDG to consider if the new risk should be included on the Corporate Risk Register, and if so, to which committee it is best aligned. An update will be provided to the F, P&R Committee meeting on 7 May 2024.

Risk Deep Dive Reviews

Deep dive reviews continue to be a key element of our assurance arrangements. Fourteen of the current Corporate Risks have undergone at least one deep dive.

The exceptions are:

- Risk 6 - Whole System Capacity
- Risks 11 and 12 - Workforce Planning & Delivery, and Staff Health and Wellbeing - deep dives reviews have been carried out on related topics of significance
- Risk 19 - Preparation for the Implementation of the Health and Care (Staffing) (Scotland) Act 2019 - The risk was recently added to the Corporate Risk Register.

The requirement for a deep dive will continue to be determined through routes including EDG and the ROG. As recommended to this Committee on 13 December 2023, decisions will be informed by intelligence within operational teams, as well as consideration of trigger factors such as the creation of a new corporate risk, materially deteriorating risks, or the proposed de-escalation / closure of a corporate risk. The refreshed approach will be implemented during Quarter 2, 2024 - 2025.

The ROG will continue to support the further development of deep dive reviews to enhance understanding, inform strategic thinking and target and improve areas of risk.

Next Steps

The Corporate Risk Register will continue to evolve in response to feedback from this Committee and other stakeholders, including via Internal Audit recommendations.

2.3.1 Quality, Patient and Value-Based Health & Care

Effective management of risks to quality and patient care will support delivery of our strategic priorities. It is expected that the application of realistic medicine principles will ensure a more co - ordinated and holistic focus on patients' needs, and the outcomes and experiences that matter to them, and their families and carers.

2.3.2 Workforce

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

2.3.3 Financial

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

2.3.4 Risk Assessment / Management

Management and oversight of the corporate risks continues to be maintained, with risk reporting provided regularly to the relevant groups and committees.

The majority of risks remain above risk appetite, reflecting the ongoing level of delivery challenge across the services. The appetite status of the risks is as follows:

Above - 10
Within - 6
Below - 2

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

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

2.3.6 Climate Emergency & Sustainability Impact

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

2.3.7 Communication, involvement, engagement and consultation

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

2.3.8 Route to the Meeting

- Maxine Michie, Deputy Director of Finance on 5 March 2024

2.4 Recommendation

This report provides the latest position in relation to the management of corporate risks. Members are asked to take a **"reasonable" level of assurance** that, all actions, within the control of the organisation, are being taken to mitigate the risks as far as is possible to do so.

3 List of appendices

Appendix No.1 - NHS Fife Corporate Risk Register as at 5 March 2024
Appendix No. 2 - Assurance Principles

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

NHS Fife Corporate Risk Register as at 05/03/24

No	Strategic Priority and Risk Appetite	Risk Title and Description	Mitigation	Risk Appetite Status	Current Risk Level/ Rating	Target Risk level & rating by dd/mm/yy	Current Risk Level Trend	Risk Owner	Primary Committee
1	 HIGH	**Population Health and Wellbeing Strategy** There is a risk that the ambitions and delivery of the new organisational Strategy do not deliver the most effective health and wellbeing and clinical services for the population of Fife.	The strategy was approved by the NHS Fife Board in March 2023. This is in the context that the management of this specific risk will span a number of financial years. NHS Fife's 3-year Medium Term Plan was submitted to Scottish Government in July 2023 which flows from our strategy and is based on the same principles and values. An update on the deep dive review was provided to the PHWC in Sept 2023 which reported that structures and processes are being put in place to allow ongoing assessment on delivery of the strategy. Progress against delivery of the strategy has been documented in the PHW Strategy Mid Year Report approved in January 2024 by NHS Fife Board. The Annual Report 23/24 will describe progress made during 2023/24 against the strategy outcomes as well as the proposed actions for 2024/25. This will be aligned to the medium term financial plan.	Below	Mod 12	Mod 12 by 31/03/24	◀▶	Chief Executive	Public Health & Wellbeing (PHWC)
2	 HIGH	**Health Inequalities** There is a risk that if NHS Fife does not develop and implement an effective strategic approach to contribute to reducing health inequalities and their causes, health and wellbeing outcomes will continue to be poorer, and lives cut	Public Health and Wellbeing Committee established, with the aim of providing assurance that NHS Fife is fully engaged in supporting wider population health and wellbeing for the local population. The Population Health and Wellbeing	Within	High 20	High 15 by 31/05/24	◀▶	Director of Public Health	Public Health & Wellbeing (PHWC)

		short in the most deprived areas of Fife compared to the least deprived areas, representing huge disparities in health and wellbeing between Fife communities.	Strategy will identify actions which will contribute to reducing health inequalities; these will be set out in the delivery plan for the strategy. Consideration of Health Inequalities within all Board and Committee papers. Leadership and partnership working to influence policies to 'undo' the causes of health inequalities in Fife.						
4	 **HIGH**	**Policy obligations in relation to environmental management and climate change** There is a risk that if we do not put in place robust management arrangements and the necessary resources, we will not meet the requirements of the 'Policy for NHS Scotland on the Global Climate Emergency and Sustainable Development, Nov 2021.'	Robust governance arrangements remain in place including an Executive Lead and a Board Champion. Regional working group and representation on the National Board ongoing. Active participation in Plan 4 Fife continues. The NHS Fife Climate Emergency Report and Action Plan have been developed. These form part of the Annual Delivery Plan (ADP). The Action Plan includes mechanics and timescales. The Board's Climate Change Annual Report is being prepared for submission to PHWC in January 2024 and thereafter to Scottish Government (SG). Resource in the sustainability team has increased by 1 FTE via external funding initially for 12 months. The Head of Sustainability has been seconded from the Estates initially for 18 months to drive delivery of the Climate Emergency Action Plan. The deliverables associated with climate change, will be monitored	Below	Mod 12	Mod 10 by 01/04/2025	◄►	Director of Property & Asset Management	Public Health & Wellbeing (PHWC)

			through the Annual Delivery Plan.						
5	 **HIGH**	**Optimal Clinical Outcomes** There is a risk that recovering from the legacy impact of the ongoing pandemic, combined with the impact of the cost-of-living crisis on citizens, will increase the level of challenge in meeting the health and care needs of the population both in the immediate and medium-term.	The Board has agreed a suite of local improvement programmes, as detailed in the diagram below and related activities, to frame and plan our approach to meeting the challenges associated with this risk.  The governance arrangements supporting this work will inform the level of risk associated with delivering against these key programmes and reduce the level of risk over time: Delivery of the Population Health & Well-being Strategy Delivery of the Recovery and Renewal Priorities Plan4Fife 2021-2024 Update Embedding of Anchor Institution Principles Continue the work of the Integrated Planned Care Programme Board (Chaired by the Director of Acute Services). Continue the work of Integrated Unscheduled Care Project Board	Within	High 15	Mod 10 by 31/03/24	◄►	Medical Director	Clinical Governance (CGC)

			(chaired by the Medical Director) reporting to the Clinical Governance Committee three times per year. Continue the work of the Acute Cancer Services Delivery Group (chaired by the Director of Acute Services) reporting to the Cancer Governance and Strategy Group (chaired by the Medical Director). Continue to develop and implement Annual Delivery Plans for the Cancer Framework. Continue the work of the Primary Care Strategy Group Continue work on the Mental Health Redesign Programme Continue the work of the Scheduled Care Group Review the Scottish Government (SG) Value Based Health & Care. A Vision for Scotland, December 2022 document against our local plans. Continue escalation of issues through Senior Leadership Teams to Executive Director's Group then through to Clinical Governance Committee and other committees as appropriate Implement the Fife H&SCP Strategic Plan for Fife 2023-26 Implement the Cancer Framework Delivery Plan 2024/25 Ensure the NHS Fife Realistic Medicine/Value Based Health Care Delivery Plan aligns with the Scottish Government (SG) Value Based Health & Care. Action Plan 2023.						

6	 **MODERATE**	**Whole System Capacity** There is a risk that significant and sustained admission activity to acute services, combined with challenges in achieving timely discharge to downstream wards and/or provision of social care packages, that the management of Acute hospital capacity and flow will be severely compromised.	The combination of application of our OPEL process on a daily basis and the improvement work through our Integrated Unscheduled Care and Planned Care programmes provides the operational and strategic response to the challenges posed through this risk. A Whole System Winter Plan 23/24 has been produced as well as a report from the Whole System Winter Planning Workshop held in Sept 2023. This will include a response to surge and demand for an increase in capacity and flow through Acute, Community and Social Care. The System Flow Operational Group meets weekly with senior operational managers to review and plan capacity and flow across the Fife health and care system with escalation to the Integrated Unscheduled Care Board. Whole System Essential Flow Verification provides assurance that all patients identified as clinically fit or with a Planned Date of Discharge are reviewed daily. Weekly ASD Long Length of Stay (LoS) verification group to review and action LoS. Weekend verification group reviews the number of discharges and staffing ahead of weekend.	Above	High 20	Mod 9 by 30/04/24	◄►	Director of Acute Services	Finance, Performance & Resources (F,P&RC)

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

			cancer patients however routine long waiting times will increase. The governance arrangements supporting this work continue to inform the level of risk associated with delivering against these key programmes and mitigate the level of risk over time. Discussions continue with Scottish Government around the need for additional funding to help reduce the waiting times for long waiting routine patients. Planning for 2024/25 is underway in line with planning guidance letter received on 24/01/24. Confirmed funding 1M less than committed staff costs.						
8	 **MODERATE**	**Cancer Waiting Times (CWT)** There is a risk that due to increasing patient referrals and complex cancer pathways, NHS Fife will see further deterioration of Cancer Waiting Times 62-day performance, and 31 day performance, resulting in poor patient experience, impact on clinical outcomes and failure to achieve the Cancer Waiting Times Standards.	The prostate project group continues with actions identified to improve steps in the pathway. The nurse-led model went live in August 23. 159 patients have been seen in this clinic to date. There will be a focus to look at the waits to TP biopsy and post MDT part of the pathway. Fortnightly meetings with Scottish Government (SG) and quarterly monitoring of the Effective Cancer Management Framework continue. An update against actions on the Framework for Effective Cancer Management Submitted to SG. As of December 2023, Effective Breach Analysis guidance has been incorporated into the NHS Fife Wide Procedure for the Management of Patients Referred with a Suspicion or	Above	High 15	Mod 12 by 30/04/24	◄►	Director of Acute Services	Finance, Performance & Resources (F,P&RC)

			Diagnosed with Cancer was agreed at the NHS Fife policy group and widely circulated through StaffLink and to key stakeholders by email. Work has commenced to take forward the Regrading Framework which has now been published. Regrading is variable across services. A questionnaire sent to clinical teams is currently being reviewed. As of August 2023 Single Point of Contact Hub (SPOCH) has expanded their service to support initiation of the Optimal Lung Cancer Pathway and has integrated with the Rapid Cancer Diagnosis Service (RCDS) to support suspected cancer Colorectal referrals and the negative qFIT pathway. Evaluation of the (SPOCH) was completed in December 2023 and tabled at the Cancer Governance and Strategy Group in January. Work to support implementation of the Optimal Lung Cancer Pathway has seen a reduction in the wait for CT, CT reporting and to MDT. The Optimal Head & Neck Pathway has just been published. SG funding was agreed to support expedited CT/MRI and 24 hour turnaround reporting. The Cancer Framework and delivery plan has been launched and priorities for 2023 -24 are being implemented. The governance arrangements supporting this work will inform the level of risk associated with delivering against these key programmes and reduce the level of risk over time.						

			Cancer Waiting Times funding is expected to be provided on a recurring basis from 2024-25. Work is underway to prioritise bids to support improvement. ADP Actions for 2024/25 are under review.						
9	 **MODERATE**	**Quality & Safety** There is a risk that if our governance, arrangements are ineffective, we may be unable to recognise a risk to the quality of services provided, thereby being unable to provide adequate assurance and possible impact to the quality of care delivered to the population of Fife.	Effective governance is in place and operating through the Clinical Governance Oversight Group (CGOG) providing the mechanism for assurance and escalation of clinical governance (CG) issues to Clinical Governance Committee (CGC). There are also effective systems & processes to ensure oversight and monitoring of national & local strategy / framework / policy /audit implementation and impact.	Within	Moderate 12	Low 6 by 31/03/24	▲	Medical Director	Clinical Governance (CGC)
10	 **MODERATE**	**Primary Care Services** There is a risk that due to a combination of unmet need across health and social care as a result of the pandemic, increasing demand on services, workforce availability, funding challenges, adequate sufficient premises and overall resourcing of Primary Care services, it may not be possible to deliver sustainable quality services to the population of Fife for the short, medium and longer term.	A Primary Care Governance and Strategy Oversight Group (PCGSOG) is in place. A Primary Care Strategy was developed following a strategic needs analysis and wide stakeholder engagement. This was approved at IJB in July 2023 and is now moving to implementation. This is a 3 year strategy focused on recovery, quality and sustainability. Development of a Performance and Assurance Framework covering qualitative and quantitative performance will provide robust reporting, monitoring and oversight of implementation and impact of the Primary Care Strategy to committees quarterly. This is due by end of January 2024.**Completed** – this will go	Above	High 16	Mod 12 by 31/03/25	◄►	Director of Health & Social Care	Public Health & Wellbeing (PHWC)

			to the Primary Care Governance and Strategic Oversight Group for ratification. Following approval of the Performance and Assurance Framework an annual report will be presented to Committee / IJB. A Primary Care Improvement Plan (PCIP) is in place; subject to regular monitoring and reporting to General Medical Services (GMS) Board, Quality & Communities (Q&C) Committee, IJB and Scottish Government. A workshop took place in January 2023 to review and refresh the current PCIP to ensure it is contemporary and based on current position and known risks to ensure a realistic and feasible PCIP. This will be progressed via committees for approval by April 2024, following a further workshop to be convened by March 24. Local negotiations in relation to MOU2 transitionary payments are complete and agreement has been reached and implemented for 23/24. The review of leadership, management and governance structure which has been jointly commissioned by Deputy Medical Director (DMD) and Head of Service (HOS) for Primary & Preventative Care (P&PC) is now complete and is to be ratified by PCGSOG when it next convenes early 2024. Memorandum of Understanding 2 (MOU2) - in line with the direction of MOU2, the focus for the PCIP remains						

			to be delivery of a complete CTAC and Pharmacotherapy, This programme of work will be underpinned by the PCIP 2023-2024 with regular monitoring and oversight by the GMS groups and the governance structures of the IJB. This will be reviewed - April 2024. The PCIP 2023-2024 will focus on consistency, continuity of service and communication to develop a 52 week model of service delivery for the priorities of MOU2 and continue to sustain service delivery in line with the priorities of MOU including MSK, mental health practitioners, urgent care in hours and community link workers - March 2024. Pharmacotherapy and CTAC models for care continue to be shaped and developed. The anticipated date for completion is April 2024.						

19	 **MODERATE**	**Implementation of Health and Care (Staffing) (Scotland) Act 2019 [HCSA]** Taking account of ongoing preparatory work, there is a risk that the current supply and availability of trained workforce nationally, will influence the level of compliance with HCSA requirements. While the consequences of not meeting full compliance have not been specified, this could result in additional Board monitoring / measures.	NHS Fife Local HCSA Reference Group, with Fife wide, multi-disciplinary and staff representation, now well established. Frequency of meetings increased to monthly from September 2023. NHS Fife participating in nationally led Chapter Guidance testing and monthly national Chapter Testing Group meetings. Five SWOT Analyses have been presented so far both at local and national level, to share knowledge and increase awareness. Fortnightly Healthcare Improvement Scotland (HIS) / Scottish Government (SG) monitoring meetings in place with Head of Workforce Planning & Staff Wellbeing & N&M Workforce Lead. N&M Workforce Lead in post since March 2021, with SG funding provided. HCSA resources shared widely within NHS Fife. Active MS Teams Channel used to share information outwith meetings. Quarterly progress returns submitted to SG. Feedback informs local action plan. Regular updates provided to APF, EDG and SGC. Successful Board wide engagement event held with NHS Fife / Scottish Government / Healthcare Improvement Scotland on 30 November 2023. Planning underway for next event.	Within	Moderate 12	Mod 9 by 01/04/24	◄►	Director of Workforce	Staff Governance (SGC)
11	 **MODERATE**	**Workforce Planning and Delivery** There is a risk that if we do not implement effective strategic and operational workforce planning, we will not deliver the capacity and capability required to effectively deliver services.	Continued development of the workforce elements of the Annual Delivery Plan, Population Health & Wellbeing Strategy and Strategic Framework; alongside the Workforce Plan for 2022 to 2025 and aligned service based workforce plans.	Above	High 16	Mod 8 by 31/03/25	◄►	Director of Workforce	Staff Governance (SGC)

		Proposed revised description There is a risk that the current supply of a trained workforce is insufficient to meet the anticipated Whole System capacity challenges, or the aspirations set out within the Population Health & Wellbeing Strategy, which may impact on service delivery	Implementation of the Health & Social Care Workforce Strategy and Plan for 2022 to 2025 to support the Health & Social Care Strategic Plan for 2023 to 2026 and the integration agenda. Implementation of the NHS Fife Board Strategic and Corporate Objectives, particularly the “exemplar employer / employer of choice” and the associated values and behaviours and aligned to the ambitions of an Anchor Institution, e.g. Employability agenda / Modern Apprenticeships. Continued development of Service Level Workforce Plans, taking account of the 2024/2025 ADP submissions to establish the projected workforce gap between supply, demand, the financial envelope and identifying workforce and non workforce solutions services are progressing to mitigate workforce risks and balance service delivery. Quarterly Workforce Planning updates have been built into the governance cycle for 2024/2025. Consideration of impact of planned reduction in Agenda for Change staffs’ full time working week from 37.5 hours to 36 hours per week on workforce numbers and service capacity, with modelling being undertaken in line with National implementation plans. Progression of Bank and Agency Programme of Work and Nursing & Midwifery Workforce actions, to improve workforce sustainability, e.g. introduction of Assistant Practitioner roles and new Registrant recruitment. A successful mass recruitment event held on 1 June 2023, to support workforce sustainability, attracted over 350 applicants, with over 100 offers of						

			employment made. Candidates have undergone pre-employment checks with all candidates now confirmed and allocated to services, based on priority of need and skill mixed required. The Fife Care Academy held a recruitment event in November 2023 to support workforce sustainability. The event was attended by over 20 providers including NHS Fife nursing, Fife Council, independent and third sectors. A further event is planned for 21 February 2024, with 24 employers represented. The Care Academy Strategic Group is arranging tracking of all HSC learning activity to support mapping of course progression to inform future programme capacity. Local NHS Fife HCSA Reference Group is well established, with multi disciplinary, Board wide representation informing preparatory work for Act implementation in April 2024. Teams Channel created and supporting HCSA documentation shared within NHS Fife. Commencement of local guidance chapter testing to support the implementation of the Health and Care (Staffing) (Scotland) Act (2019) within NHS Fife. Five SWOT Analyses have been shared at the local Board Reference Group and with the National Testing Steering Group, to facilitate shared learning. Chapter Guidance testing will be completed by 31 March 2024. A HSCP reference group has also been established, with multi service representation including named CI registered managers. Sector leads from Third and Independent sector are included. A Teams channel and self-assessment tool have been created and						

			work on compiling the findings is advanced. Engagement sessions for the managers / supervisors are underway in two of the three services and a communication plan is being developed. The risk on the preparations for HCSA implementation has now been added to the Corporate Risk Register and is monitored via the NHS Fife HCSA Local Reference Group.						
12	 **MODERATE**	**Staff Health and Wellbeing** There is a risk that if due to a limited workforce supply and system pressure, we are unable to maintain the health and wellbeing of our existing staff we will fail to retain and develop a skilled and sustainable workforce to deliver services now and in the future.	Working in partnership with staff side and professional organisations across all sectors of NHS Fife to ensure staff health and wellbeing opportunities are maximised, to support attraction, development and retention of staff. The Staff Health & Wellbeing Framework for 2022 to 2025, setting out NHS Fife's ambitions, approaches and commitments to staff health and wellbeing, was published in December 2022 and complementary Action Plan for 2023 to 2025 now approved, in order to deliver these commitments. Consideration of staff support priorities for 2022-2025 being progressed via Staff Health & Wellbeing Group and other fora, aligned to Action Plan. Work progressing on Promoting Attendance improvement actions to support reductions in staff absence and wellbeing.	Above	High 16	Mod 8 by 31/03/25	◄►	Director of Workforce	Staff Governance (SGC)
13	 **MODERATE**	**Delivery of a balanced in-year financial position** There is a risk that due to the ongoing impact of the pandemic combined with the very challenging financial context both locally and nationally, the Board	During February 2024, all Boards received from the Scottish Government, a portion of UK consequentials funding to support a break even position. Despite this funding and the intensified measures and commitment to reduce	Above	High 16	Mod 12 by 31/03/24	◄►	Director of Finance & Strategy	Finance, Performance & Resources (F,P&RC)

		will not achieve its statutory financial revenue budget target in 2023/24 without further planned brokerage from Scottish Government.	costs and avoid any additional investment in our services, including implementation of the Reform, Transform, Perform (RTP) programme, a large deficit remains and it is highly likely that the Board will require significant financial brokerage from Scottish Government to break-even.						
14	 **MODERATE**	**Delivery of recurring financial balance over the medium-term** There is a risk that NHS Fife will not deliver the financial improvement and sustainability programme actions required to ensure sustainable financial balance over the medium-term.	Our financial improvement plan will be delivered through our Reform, Transform and Perform (RTP) Framework working collaboratively with our partners. Reform will necessitate immediate changes in our working practices across the organisation, Transform will focus on evolving our services, structures, and care delivery, and Perform will be pivotal in driving sustainable improvements throughout the organisation. We are currently refreshing our Medium-Term Financial Plan (MTFP) to reflect funding announcements presented in the Scottish Government's budget for 2024/25. The MTFP identifies significant cost savings across all years covered by the financial plan. Work is underway through the RTP programme to support the change required across the organisation to deliver financial balance The Board will maintain its focus on reaching the full National Resource Allocation (NRAC) allocation over the medium- term.	Above	High 16	Mod 12 by 31/03/24	◄►	Director of Finance & Strategy	Finance, Performance & Resources (F,P&RC)

15	 **MODERATE**	**Prioritisation & Management of Capital funding** There is a risk that lack of prioritisation and control around the utilisation of limited capital and staffing resources will affect our ability to deliver the PAMS and to support the developing Population Health and Wellbeing Strategy.	Ongoing governance through FCIG with capital plan being submitted through FP&R and the Board. Annual Property and Asset Management Strategy (PAMS) updates to provide strategic direction. Rolling 5-year equipment programme and implementation of medical devices database. Implementation of medical devices database. Rolling 5-year Digital & Information programme linked to D&I strategy. Ongoing management of estate risks using the Estate Asset Management System (EAMS). Use of Business Case template to present new schemes for consideration. Future consideration/development of prioritisation investment tool. Fleet and sustainability requests will be linked to plans/strategy and presented through SBARs to Fife Capital Investment Group (FCIG). A date for a Board Development Session to consider the risk profile associated with prioritisation of capital resources is currently being explored.	Within	Mod 12	Mod 8 (by 01/04/26 at next SG funding review)	◄►	Director of Property & Asset Management	Finance, Performance & Resources (F,P&RC)
16		**Off-Site Area Sterilisation and Disinfection Unit Service** There is a risk that by continuing to use a single off-site service Area Sterilisation Disinfection Unit (ASDU), our ability to control the supply and standard of equipment required to deliver a safe and	Monitoring and review continues through the NHS Fife Decontamination Group. Establishment of local SSD for robotics is progressing with an indicative date of 31/12/23.	Within	Mod 12	Low 6 (by 01/04/2026 at next SG funding review)	◄►	Director of Property & Asset Management	Clinical Governance (CGC)

	MODERATE	effective service will deteriorate.	Health Facilities Scotland (HFS) has agreed the design and the unit at St Andrews Community Hospital (SACH); the timescale to become operational has been revised from December 2023 to possibly June 2024. Work is underway to meet this target. An option appraisal for delivery of the service is being explored. Ensure that mitigations are in place to ensure that no trays are damaged while they are handled and stored in NHS Fife to include new racking and training Staff have received training in the safe handling of trays. Training is being repeated on a yearly basis. Staff must inspect each tray prior to loading on to storage system. New racking system installed early March 2022 costing £27,000 and prevents the stacking of trays. Tins purchased in early 2022 costing £29,000 in use to protect our heavy trauma and orthopaedic trays. A trial of foam corners has been instigated by Tayside. Ensure that contingency stock has been procured to mitigate the effects of any down-time on the service to include: - •At least 3 Days of Trauma trays •At least 3 days of obstetric trays Consideration being given to increasing stock to 7 days for Trauma and Obstetric trays. Manage the SLA appropriately and consider changes to allow quality issues to be identified and treated seriously and in a timely manner.						

			Regular Liaison meetings to discuss issues with the service have been taking place since 2021. Discussions are taking place about changing some of the terms in the SLA to allow defective trays to be identified at point of use rather than at point of delivery (July 2023). Considering alternative providers to determine whether value for money is being provided and whether increased resilience can be provided (work has been undertaken by Theatres over the last 6 months). Involvement and influencing the National group looking at capacity and resilience in CDU provision across Scotland. This group, facilitated by National Services Scotland (NSS) will make recommendations to the Scottish Government (SG) about how best to increase capacity and resilience within NHS Scotland. This Group was convened in 2021. Work with Regional partners to identify synergies in service delivery including the developing business plan for re-provision of CDU capacity within NHS Lothian. Raise the profile of this issue at National Estates and Facilities Fora including National Strategic Facilities Group which includes key representatives from NSS and SG.						
17		**Cyber Resilience** There is a risk that NHS Fife will be overcome by a targeted and sustained cyber attack that may impact the	The Network Information System Directive (NISD) and now Cyber Resilience Framework Audit has concluded. The compliance rate has increased to 87%, up from 76% from the	Above	High 16	Mod 12 by Sept 2024	◄►	Medical Director	Clinical Governance (CGC)

	MODERATE	availability and / or integrity of digital and information required to operate a full health service.	previous year. The action plan for improvement has been presented to the Information Governance and Security Steering Group. The Deep Dive review for this risk was presented to Clinical Governance Committee in January 2024. Management actions detailed continue to be progressed.						
18	 **MODERATE**	**Digital & Information** There is a risk that the organisation maybe unable to sustain the financial investment necessary to deliver its D&I Strategy and as a result this will affect our ability to enable transformation across Health and Social Care and adversely impact on the availability of systems that support clinical services, in their treatment and management of patients.	Consistent alignment of the D&I Strategy with the NHS Fife Corporate Objectives and the Population Health & Wellbeing Strategy. Active review of the current digital programmes against current strategic objectives is complete and has governed by the Digital and Information Board. The annual delivery plan for 2024/25 will demonstrate a reduced level of activity to match the resource availability and limited levels of finance. (Capital and revenue) The revised strategy will include, financial and workforce planning, to support the mitigation of this risk. D&I Board have established new prioritisation and authorisation processes with ongoing review.	Above	High 15	Mod 8 by April 2025	◀▶	Medical Director	Clinical Governance (CGC)

Risk Movement Key

▲ Improved - Risk Decreased
◀▶ No Change
▼ Deteriorated - Risk Increased

Assurance Principles

Risk Assurance Principles:

Board

- Ensuring efficient, effective and accountable governance

Standing Committees of the Board

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

Committee Agenda

- Agenda Items should relate to risk (where relevant)

Seek Assurance of Effectiveness of Risk Mitigation

- Relevance
- Proportionality
- Reliable
- Sufficient

Chairs Assurance Report

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

Year End Report

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

General Questions:

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

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

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

Level of Assurance:

Substantial Assurance	Reasonable Assurance	Limited Assurance	No Assurance
			

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

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**14 March 2024**
Title:	**Risks and Opportunities Group Progress Report**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Report Author:	**Pauline Cumming, Risk Manager**

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Local Policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This paper provides an update on the Risks and Opportunities Group's progress on key elements of its business since the last report to the Committee on 13 December 2023.

2.2 Background

The Risks and Opportunities Group (ROG) meet to continue to support the development of an effective risk management framework. To deliver on its annual work plan, the Group divides its time between the Corporate Risk Register and in supporting operational risk management practice.

2.3 Assessment

Review of the Risk Assessment Matrix

The matrix used in NHS Fife is based on the NHS Scotland matrix which was originally developed in 2008.The ROG has identified the need to further promote the matrix locally as a tool to support risk assessment and decision making. The Group has also discussed the need to update the matrix to ensure descriptors are current and comprehensive in scope and terminology. For example, possibly expand these to include Environmental Sustainability & Climate Change, and Health Inequalities.

Similar considerations have taken place in other NHS Boards. At a national meeting with Healthcare Improvement Scotland (HIS) on 1 February 2024 in which NHS Fife participated, it was agreed to review the national matrix and expand and modernise the content. A short life working group is being set up to take forward this work.

The ROG has agreed to let the national work emerge and conclude, after which we will reflect on the NHS Fife matrix.

Operational Risk Management - Risk Summary Dashboard

Members recognise their role in shaping productive risk conversations with colleagues and encouraging risk reviews that focus on key points including:

- mitigation of higher rated risks;
- risks in existence, without becoming an issue, for 5 years or more, should have a likelihood score of “unlikely” or “remote”; and / or be considered for closure;
- considering the “current risk rating” and proximity to the “target risk rating” to determine if further mitigation, management and review is required, or risks that have reached or surpassed their target could be monitored or closed

The Group continue to consider the organisational risk profile visualised through the Risk Summary Dashboard. This reveals the dynamic nature of the risk landscape, including fluctuations in numbers of active risks, with reductions in risks in some areas and increases in others. This has prompted interrogation of the data, for example, in a particular category of risk, to better understand such developments and implications.

Risk Summary Dashboard

To date, the Dashboard has been made available to the ROG and demonstrated to various stakeholders. Arrangements are being made to share the tool with specific teams and departments, and promote its use to support operational risk management.

The ROG will take forward a plan to support Dashboard implementation during 2024-25.

Key Performance Indicators (KPIs)

The ROG is currently considering a set of risk KPIs. A KPI report will be shared with EDG during April 2024, before reporting to this Committee on 16 May 2024.

Risk Deep Dive Reviews

Deep dive reviews continue to be a key element of our assurance arrangements. Trigger factors to be considered when determining the requirement for a deep dive review and endorsed by this Committee, were shared with the governance committees in January 2024 and positively received. Triggers include the creation of a new corporate risk, materially deteriorating risks, and proposed de-escalation / closure of a corporate risk, as well as intelligence from operational teams.

The ROG will support implementation of the triggers in the future commissioning of deep dives, and the further development in the content of reviews. This will include:

- taking cognisance of Internal Audit recommendations to enhance the reviews;
- inviting staff undertaking deep dives to use the ROG as a 'sounding board' for comment and feedback. To facilitate this approach, consideration will be given to setting up a TEAMs channel for sharing draft deep dives.

Risk Management Framework

It was previously reported to the Committee, that following the Board's approval of the updated Risk Management Framework in September 2023, there was an intention to also update the related Risk Register / Risk Assessment Policy. In re-drafting the policy, there was considerable duplication with the Framework. Following consultation with Internal Audit and other stakeholders, it was determined that a separate policy is not required and that the Framework should be revised to include key policy elements.

The Committee endorsed this approach on 13 December 2023, and the revised Framework and a Delivery Plan to support implementation are being finalised. These will be considered by the ROG and EDG in April 2024 and presented to this Committee on 16 May 2024 and to the Board for approval on 28 May 2024.

Horizon Scanning

Opportunities

Realistic Medicine has been identified as an area of focus for the year ahead, and members of the Realistic Medicine (RM) team have been invited to present to the ROG. It is anticipated this will enable a better understanding of how RM might connect with the Group's work, and its impact on the future risk profile. This is important, as while RM is mentioned in every strategic document, there may be scope to more clearly identify how it is being practised, and critically, how it might mitigate risk.

The Group will also consider horizon scanning in the context of the Population Health and Wellbeing Strategy and preparation of the related annual report.

Annual Statement of Assurance

An Annual Statement of Assurance is in development; the Group will also undertake a self-assessment of its own effectiveness, using the FORMS on line portal. These will be reported to EDG and this Committee in April and May 2024 respectively.

2.3.1 Quality, Patient and Value-Based Health & Care

Effective management of risks to quality and patient care will support delivery of our strategic priorities. It is expected that the application of realistic medicine principles will ensure a more co - ordinated and holistic focus on patients' needs, and the outcomes and experiences that matter to them, and their families and carers.

2.3.2 Workforce

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

2.3.3 Financial

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

2.3.4 Risk Assessment / Management

Subject of the paper.

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

No specific Equality Impact Assessment has been conducted.

2.3.6 Climate Emergency & Sustainability Impact

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

2.3.7 Communication, involvement, engagement, and consultation

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

2.3.8 Route to the Meeting

Alistair Graham, Associate Director of Digital and Information, Group Co- Chair on 6 March 2024

2.4 Recommendation

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

3 List of appendices

None.

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

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**14 March 2024**
Title:	**Committee Self-Assessment Report 2023-24**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Gillian MacIntosh, Board Secretary**

1 Purpose

This is presented for:

- Discussion

This report relates to a:

- Local policy

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

- Effective

2 Report summary

2.1 Situation

The purpose of this paper is to provide the outcome of this year's self-assessment exercise recently undertaken for the Audit & Risk Committee, which is a component part of the Committee's production of its annual year-end statement of assurance.

2.2 Background

As part of each Board Committee's assurance statement, each Committee must demonstrate that it is fulfilling its remit, implementing its agreed workplan and ensuring the timely presentation of its minutes to the Board. Each Committee must also identify any significant control weaknesses or issues at the year-end that it considers should be disclosed in the Governance Statement and should specifically record and provide confirmation that the Committee has carried out an annual self-assessment of its own effectiveness. Combined, these processes seek to provide assurance that a robust governance framework is in place across NHS Fife and that any potential improvements are identified and appropriate action taken.

A light-touch review of the standard question set was undertaken this year, taking account of members' feedback on the length and clarity of the previous iteration of the

questionnaire. Board Committee Chairs each approved the set of questions for their respective committee.

To conform with the requirement for an annual review of their effectiveness, all Board Committees were invited to complete a self-assessment questionnaire in early February 2023. The survey was undertaken online, following overwhelmingly positive feedback on the move to a non-paper system of completion, and took the form of a Chair's Checklist (which sought to verify that the Committee is operating correctly as per its Terms of Reference) and a second questionnaire (to be completed by members and regular attendees) comprising a series of effectiveness-related questions, where a scaled 'Agree/Disagree' response to each question were sought. Textual comments were also encouraged, for respondents to provide direct feedback on their views of the Committee's effectiveness.

2.3 Assessment

As previously agreed, Committee chairs have received a full, anonymised extract of the survey responses for their respective committee. A summary report assessing the composite responses for the Audit & Risk Committee is given in this paper. The main findings from that exercise are as follows:

Chairs' Checklist (completed by Chair only)

It was agreed that the Committee was currently operating as per its Terms of Reference, with adequate membership, an appropriate schedule of meetings and processes in place to allow for escalation of matters directly to the Board. There was comment that, outwith the annual accounts approval process, there could be scope for the Committee to meet more frequently or receive updates by circulation, in-between the regular schedule of meetings.

Self-Assessment questionnaire (completed by members and attendees)

In total, three members of the Committee who had been in post over 2023/24 (excluding the Chair and a member who has only attended one meeting) and five regular attendees completed the questionnaire. In general, the Committee's current mode of operation received a mixed assessment from its members and attendees who participated.

Some areas for improvement were, however, highlighted. Initial comments identified for further discussion include:

- mixed opinions on whether the required level of independent challenge and discussion is evident on the Committee, particularly around risk-related matters, with some comment also that attendance levels from members could be improved;
- positive comments on the usefulness of training / Development Sessions (such as those given in the last year on the topics of the role of the Non-Executive Board Member and Risk Management Processes), but caveated by rate of member absences therefrom;

- a request for further training around the full scope of assurance responsibilities that sit with the Committee, noting that the Committee's remit is wider than its financial accounting responsibilities; and
- reviewing the volume of papers provided, enhancing the clarity of data therein and adding better signposting in the recommendations for members, to ensure that the business of the Committee is achievable in the time allowed for meetings.

Some of the issues noted above, particularly around size of meeting packs and time in meetings to complete the agenda, are not unique to the Audit & Risk Committee and indeed are common across a number of Board committees, particularly those with wide-ranging remits. Board-wide enhancements to agendas (to add timings for items and to list explicitly thereon whether the agenda item is for assurance, approval etc.) are presently being planned for introduction from the May cycle of meetings. A new Committee Induction Pack has been created (outlining key reading and online TURAS resources), which will be available to new members, and will strengthen the subject-specific training resources available to both current and new appointees.

2.3.1 Quality/ Patient Care

N/A

2.3.2 Workforce

N/A

2.3.3 Financial

N/A

2.3.4 Risk Assessment/Management

The use of a comprehensive self-assessment checklist for all Board committees ensures appropriate governance standards across all areas and that effective assurances are provided.

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

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 Climate Emergency & Sustainability Impact

N/A

2.3.7 Other impact

N/A

2.3.8 Communication, involvement, engagement and consultation

Invitation, and reminders, to complete the questionnaire were sent to all members, allowing for all the chance to submit feedback.

2.3.9 Route to the Meeting

This paper has been considered initially by the Committee Chair and Lead Executive Director.

2.4 Recommendation

This paper is provided for:

- **Discussion** – what actions members would wish to see implemented to address those areas identified for improvement.

2 List of appendices

The following appendices are included with this report:

- Appendix 1 – Outcome of Committee's self-assessment exercise

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

		Strongly Agree	Agree	Disagree	Strongly Disagree	Comments
A. Committee membership and dynamics						
A1.	The Committee has been provided with sufficient membership, authority and resources to perform its role effectively and independently.	1 (12.5%)	7 (87.5%)	-	-	One meeting was cancelled, which was unfortunate, but overall membership is good. May want to consider having more members which would, if required, help any quoracy issues. Agree to some extent - I feel the Non-Executive membership could be strengthened, either with increased numbers or from a more audit/risk background.
A2.	The Committee's membership includes appropriate representatives from the organisation's key stakeholders.	2 (25%)	5 (62.5%)	1 (12.5%)	-	Yes, membership appropriate, with Council representative. I think that clinical staff could be invited to attend/contribute. Perhaps we should consider hearing more from managers and staff who are managing risks day to day.
A3.	Committee members are clear about their role and how their participation can best contribute to the Committee's overall effectiveness.	-	8 (100%)	-	-	As an attendee, I have experienced instances where I would have expected greater interaction from the members. Mindful of discussion at Audit & Risk Development session, albeit not all members present, around some colleagues' views on what they felt they could reasonably be expected to comment and contribute. Agree to some extent - a conversation was started on this at a recent development session which I think needs revisited to ensure we are all confident in our roles and our level of scrutiny/assurance provided. Further clarification into the specific role in relation to risk management was confirmed at a recent development session. Of all the Committees this is perhaps the clearest in remit given the facts and figures element of information we consider and with independent input from Internal auditors and External oversight of accounts.

		Strongly Agree	Agree	Disagree	Strongly Disagree	Comments
A4.	Committee members are able to express their opinions openly and constructively.	3 (37.5%)	5 (62.5%)	-	-	As an attendee, members are able to express opinion openly. Open atmosphere, stakeholders are very welcoming of questioning by Non-Executives.
A5.	There is effective scrutiny and challenge of the Executive from all Committee members, including on matters that are critical or sensitive.	-	6 (75%)	2 (25%)	-	There have been instances where I had expected more scrutiny and challenge. I do think this is invited and exercised, but as per previous comment via Audit & Risk Committee Development session, perhaps there is scope to further develop this aspect. From my observation some committee members are normally more likely to question and raise challenge than others. This could be built on – Non-Executives pre-meeting could be utilised more to help promote discussion. Challenge could be increased to ensure greater scrutiny. Although this can be challenging due to the volume of papers I believe we could question risk on greater details with focus on effectiveness of mitigation. Discussion, scrutiny and challenge on key matters such as risk could and should be improved. The responsibility of the Committee - beyond financial governance matters - does not appear to be fully understood by members.
A6.	The Committee has received appropriate training / briefings in relation to the areas applicable to the Committee's areas of business.	-	8 (100%)	-	-	Good practice that training is provided, and topics are presented to the Audit & Risk Committee pre-meetings and special meetings. Agree to some extent but think this could be built on - possibly worth using development sessions to strengthen knowledge and understanding of core issues.

		Strongly Agree	Agree	Disagree	Strongly Disagree	Comments
A7.	Members have a sufficient understanding and knowledge of the issues within its particular remit to identify any areas of concern.	-	8 (100%)	-	-	Caveat relates to response to Q6 (Committee has received appropriate training / briefings in relation to the areas applicable to the Committee's areas of business). There are a number of newer members within the ARC and as a result wider knowledge and understanding is still being built in some areas. This could be built on - I think due to the high importance of the assurances given by this committee to the Board, there is some work to be done to be confident that this is the case. I feel development sessions could be better utilised to aid this. Although concerns could be lost in the volume of papers.
B. Committee meetings, support and information						
B1.	The Committee receives timely information on performance concerns as appropriate.	2 (25%)	6 (75%)	-	-	Yes. I wonder whether we could receive information that links directly to quality of care.
B2.	The Committee receives timely exception reports about the work of external regulatory and inspection bodies, where appropriate.	2 (25%)	6 (75%)	-	-	Mostly Audit Scotland and Fraud reports and Service Provider report - not on an exception basis, however. Can not recollect an exception report about work of external regulatory and inspection body.
B3.	The Committee receives adequate information and provides appropriate oversight of the implementation of relevant NHS Scotland strategies, policy directions or instructions.	2 (25%)	6 (75%)	-	-	Where required yes – Audit & Risk kept up to date on key developments as required.
B4.	Information and data included within the papers is sufficient and not too excessive, so as to allow members to reach an appropriate conclusion.	3 (37.5%)	3 (37.5%)	1 (12.5%)	1 (12.5%)	The Boardbooks can often run to significant length, and this raises concern with too much information being provided and as a result key points risk being overlooked. Volume of papers excessive.

		Strongly Agree	Agree	Disagree	Strongly Disagree	Comments
B5.	Papers are provided in sufficient time prior to the meeting to allow members to effectively scrutinise and challenge the assurances given.	2 (25%)	5 (62.5%)	1 (12.5%)	-	Papers are always timeous. Due to the volume of papers.
B6.	Committee meetings allow sufficient time for the discussion of substantive matters.	3 (37.5%)	4 (50%)	1 (12.5%)	-	Sufficient time is always allocated. I feel time actually allows for more discussion on some matters. Due to volume of papers sometimes too much focus on one area at the start of the meeting and the later agenda items get rushed through.
B7.	Minutes are clear and accurate and are circulated promptly to the appropriate people, including all members of the Board.	5 (62.5%)	3 (37.5%)	-	-	Minutes are accurate and clear. My one view is that the minutes are of a very high standard, and the overarching administration associated with the Committee is excellent.
B8.	Action points clearly indicate who is to perform what and by when, and all outstanding actions are appropriately followed up in a timely manner until satisfactorily complete.	5 (62.5%)	3 (37.5%)	-	-	Action tracker is well used and reported at each meeting. Updates are always included.
B9.	The Committee is able to provide appropriate assurance to the Board that NHS Fife's strategies, policies and procedures (relevant to the Committee's own Terms of Reference) are robust.	2 (25%)	6 (75%)	-	-	Yes. I agree to the extent that we are assured that fair representation of accounts is provided, and that quality assurance and internal audit process exist but in terms of strategies to meet objects this is not as straightforward.
B10.	Committee members have confidence that the delegation of powers from the Board (and, where applicable, the Committee to any of its sub groups) is operating effectively as part of the overall governance framework.	1 (12.5%)	6 (75%)	1 (12.5%)	-	-

		Strongly Agree	Agree	Disagree	Strongly Disagree	Comments
C. The Role and Work of the Committee						
C1.	The Committee reports regularly to the Board verbally and through minutes, can escalate matters of significance directly and makes clear recommendations on areas under its remit when necessary.	4 (50%)	4 (50%)	-	-	However, this requires additional focus from the Executive attendees to support the Non-Executive members.
C2.	In discharging its governance role, the focus of the Committee is at the correct level.	1 (12.5%)	6 (75%)	1 (12.5%)	-	All agenda items are relevant to the Committee discharging its governance requirements. As mooted at the Audit & Risk Development session, there may be scope for members to further enhance the execution of their governance role through, e.g. requesting updates from other Committees on their discussion on the corporate risk register.
C3.	The Committee's agenda is well managed and ensures that all topics with the Committee's overall Terms of Reference are appropriately covered	3 (37.5%)	4 (50%)	1 (12.5%)	-	Again, due to the volume of papers.
C4.	Key decisions are made in a structured manner and can be publicly evidenced.	1 (12.5%)	7 (87.5%)	-	-	Where required and minutes/papers would demonstrate compliance.

		Strongly Agree	Agree	Disagree	Strongly Disagree	Comments
C5.	What actions could be taken, and in what areas, to further improve the effectiveness of the Committee in respect of discharging its remit?	Risk management knowledge. As per previous point on new committee members, would always be happy to promote any individual discussion outwith to clarify any detail or processes covered in the papers to support understanding. Development sessions can be better utilised - discussion of the role and remit of the committee was valuable at previous sessions and this should be built upon. At times there could be increased questioning and scrutiny. Reduce paper volume, perhaps focus on specific topic per meeting, include presentation from more clinical-based staff. Greater focus on risk management and effectiveness in reaching Board Strategic objectives. This coming year it will be important to be able to escalate issues to Board about finances. Continued education of the Committee members on wider governance and assurance responsibilities - there is perhaps a misunderstood perception among member that the committee is mostly about finance/accounts.				
D. Audit & Risk Committee specific questions						
AR1.	To your knowledge, at least one of the Audit & Risk Committee members has sufficient relevant and recent financial experience.	2 (25%)	4 (50%)	2 (25%)	-	I could not say for certain.
AR2.	All members, including the chair, are suitably independent of the Executive function.	3 (37.5%	5 (62.5%)	-	-	Yes, as distinct from attendees.
AR3.	Members are sufficiently independent of the other key committees of the Board.	1 (12.5%)	7 (87.5%)	-	-	I always ponder this question - maybe around 'sufficiently' as, for example, the chair of Audit & Risk Committee is a member of Finance, Performance & Resources Committee and Remuneration Committee, and there is logic to that.

		Strongly Agree	Agree	Disagree	Strongly Disagree	Comments
AR4.	The Audit & Risk Committee annual schedule of meetings is suitable for NHS Fife's business and governance needs, as well as the requirements of the financial reporting calendar.	3 (37.5%)	5 (62.5%)	-	-	For 2024/25 in particular, there won't be an instance of papers going to the Board before the Audit & Risk Committee.
AR5.	The Audit & Risk Committee appropriately satisfies itself that the arrangements for risk management, control and governance have operated effectively throughout the reporting period.	1 (12.5%	7 87.5%	-	-	Knowledge of risk management could be enhanced. Noting enhanced scrutiny on risk. Reliance on executives.
AR6.	The Audit & Risk Committee effectively considers how accurate and meaningful the Governance Statement is.	2 (25%)	6 (75%)	-	-	We could seek greater input from less senior managers that what we are hearing chimes with day-to-day reality.
AR7.	The Audit & Risk Committee appropriately considers how it should coordinate with other Committees that may have responsibility for aspects of risk management and corporate governance.	-	7 (87.5%)	1 (12.5%)	-	As above - as mooted at the Audit & Risk Committee Development session, there may be scope for members to further enhance the execution of their governance role through e.g. requesting updates from other Committees on their discussion on the corporate risk register.
AR8.	The Audit & Risk Committee has satisfied itself that NHS Fife has adopted appropriate arrangements to counter and deal with fraud.	3 (37.5%)	5 (62.5%)	-	-	Well managed and reported.
AR9.	The Audit & Risk Committee has been made aware of the role of risk management in the preparation of the internal audit plan.	3 (37.5%)	5 (62.5%)	-	-	Internal audit plan has clear links to strategic risks.
AR10.	The Audit & Risk Committee's role in the consideration of the annual accounts is clearly defined.	4 (50%)	4 (50%)	-	-	-

		Strongly Agree	Agree	Disagree	Strongly Disagree	Comments
AR11.	The Audit & Risk Committee has gained an appropriate understanding of management's procedures for preparing NHS Fife's annual accounts.	3 (37.5%)	5 (62.5%)	-	-	-
AR12.	The Audit & Risk Committee approves, annually and in detail, the internal audit plans, including consideration of whether the scope of internal audit work addresses NHS Fife's significant corporate risks.	3 (37.5%)	5 (62.5%)	-	-	As above – Internal Audit plan has clear links to the Strategic Risks.
AR13.	Outputs from follow-up audits by internal audit are appropriately monitored by the Audit & Risk Committee and the Committee considers the adequacy of implementation of recommendations.	3 (37.5%)	5 (62.5%)	-	-	Audit Follow up reports are comprehensive and are adapted to meet the requirements of the Audit & Risk Committee and national guidance.
AR14.	To your knowledge, there is appropriate co-operation between the internal and external auditors.	2 (25%)	5 (62.5%)	1 (12.5%)	-	I feel this is an area that could see improvement.
AR15.	Internal audit performance measures are appropriately monitored by the Audit & Risk Committee.	2 (25%)	6 (75%)	-	-	Included in year-end Annual report.
AR16.	The external auditors effectively present and discuss their audit plans and strategy with the Audit & Risk Committee (recognising the statutory duties of external audit).	3 (37.5%)	5 (62.5%)	-	-	Timing is later in year.
AR17.	The Audit & Risk Committee appropriately reviews the external auditor's annual report to those charged with governance.	4 (50%)	4 (50%)	-	-	-

		Strongly Agree	Agree	Disagree	Strongly Disagree	Comments
AR18.	The Audit & Risk Committee adequately ensures that officials are monitoring action taken to implement external audit recommendations.	3 (37.5%)	5 (62.5%)	-	-	-
AR19.	Agenda papers are circulated timely in advance of the meeting, to allow adequate preparation by Audit & Risk Committee members.	3 (37.5%)	4 (50%)	1 (12.5%)	-	-
AR20.	Reports to the Audit & Risk Committee communicate relevant information at the right frequency, time and in a format that is effective.	2 (25%)	5 (62.5%)	1 (12.5%)	-	I think the reports could be more succinct.

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**14 March 2024**
Title:	**Annual Review of Committee's Terms of Reference**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Gillian MacIntosh, Board Secretary**

1 Purpose

This report is presented for:

· Approval

This report relates to:

· Local policy

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

· Effective

2 Report summary

2.1 Situation

All Committees are required to regularly review their Terms of Reference, and this is normally done in March of each year. Any changes are then reflected in the annual update to the NHS Fife Code of Corporate Governance, which is reviewed in full by the Audit & Risk Committee and then formally approved by the Board thereafter.

2.2 Background

The current Terms of Reference for the Committee were last reviewed in March 2023, as per the above cycle.

2.3 Assessment

An updated draft of the Committee's Terms of Reference is attached for members' consideration, with suggested changes tracked for ease. The proposed amendments relate largely to updates to the Internal Audit sections (following review by the internal auditors) and to reflect the movement for responsibility for Whistleblowing and Information Governance matters to other standing committees (clauses relating thereto have been added respectively to the Staff Governance and Clinical Governance committee remits). A number of minor amendments have been made to improve clarity (viz. clauses 5.25, 5.35 and 5.36) and reflect current arrangements for attendees etc.

Following review and approval by each Committee, an amended draft will be considered by the Audit & Risk Committee as part of a wider review of all Terms of Reference by each standing Committee and other aspects of the Code. Thereafter, the final version of the Code of Corporate Governance will be presented to the NHS Board for approval.

2.3.1 Quality / Patient Care

N/A

2.3.2 Workforce

N/A

2.3.3 Financial

N/A

2.3.4 Risk Assessment / Management

The regular review and update of Committee Terms of Reference will ensure appropriate governance across all areas and that effective assurances are provided to the Board.

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

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 Climate Emergency & Sustainability 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 initially by the internal auditors, Committee Chair, Lead Executive Director and Head of Financial Services & Procurement.

2.4 Recommendation

This paper is provided for

- **Approval** – consider the attached remit, advise of any proposed changes and approve a final version for further consideration by the Board.

3 List of appendices

The following appendices are included with this report:

- Appendix 1 – Audit & Risk Committee's Terms of Reference

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

AUDIT & RISK COMMITTEE
CONSTITUTION AND TERMS OF REFERENCE

Date of Board Approval: ***

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 & 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 & Risk Committee will be:

- Five Non-Executive or Stakeholder members of Fife NHS Board (one of whom will be the Committee 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 & Risk Committee shall not be the Chair of any other governance Committee of the Fife NHS 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 Executive 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 & Strategy (who is also Executive Lead for Risk Management)
- Chief Internal Auditor ~~or representative~~
- Regional Audit Manager
- Statutory External Auditor
- Head of Financial Services & Procurement
- Risk Manager
- Board Secretary

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

2.6 The Board shall ensure that the Committee's membership has an adequate range of skills and experience that will allow it to effectively discharge its

responsibilities. With regard to the Committee's responsibilities for financial reporting, the Board shall ensure that at least one member can engage competently with financial management and reporting in the organisation, and associated assurances.

3. QUORUM

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

4. MEETINGS

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

4.2 The Chair of Fife NHS Board shall appoint a Committee 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 & 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 & 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 in line with the Audit Follow Up Protocol.~~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 Internal Audit Charter.

5.14 To approve the Internal Audit Reporting Protocol and Audit Follow Up Protocol.

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

5.16 To review the operational effectiveness of Internal Audit by review~~consider~~ing the five-yearly external quality assessment or self-assessment with independent validation, and through ongoing consideration of the audit standards, resources, staffing, technical competency and performance measures.

5.17 To ensure that there is direct contact between the Audit & 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.

5.18 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

5.19 To note the appointment of the Statutory Auditor and to approve the appointment and remuneration of the External Auditors for the NHS Fife Annual Accounts and the NHS Fife Patients' Funds Accounts.

~~5.17 To review the Audit Strategy and Plans related to the NHS Fife Annual Accounts and the NHS Fife Patients' Funds Accounts., including the Best Value and Performance Audits programme.~~

5.20 To consider all statutory audit material, in particular:

- Audit Reports;
- Audit Strategies & Plans;
- Annual Reports;
- Management Letters

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

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

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

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

5.24 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

5.25 The Committee has no executive authority, and has no role in the executive decision-making in relation to the management of risk, although it may draw attention to strengths and weaknesses in control and make suggestions for how such weaknesses might be dealt with. The Committee is charged with ensuring that there is an appropriate publicised Risk Management Framework with all roles identified and fulfilled. The Committee shall seek specific assurance that:

- There is an effective risk management system in place to identify, assess, mitigate 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 treat at any time), and that the executive's approach to risk management is consistent with that appetite;

- A robust and effective Corporate Risk Register is in place.

5.26 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 mitigate them;

- Assess whether the Corporate Risk Register is an appropriate reflection of the key risks to the Board and enables the identification of gaps in control and assurance, 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 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

5.27 To review annually the Standing Orders and associated appendices of Fife NHS Board within the Code of Corporate Governance and advise the Board of any amendments required.

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

Annual Accounts

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

5.30 To review the draft Annual Report and Performance Review of Fife NHS Board within the Annual Accounts.

5.31 To review annually (and recommend Board approval of any changes in) the accounting policies of Fife NHS Board.

5.32 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

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

5.34 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.

~~5.35 The Committee shall review the arrangements for employees raising concerns, in confidence, about possible impropriety in financial management or reporting or other matters. The Committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow-up action.~~

5.35 The Committee shall review regular reports on fraud and potential frauds as presented by the Fraud Liaison Officer (FLO), in addition to the Board's response and actions to counter the threat posed by fraud.

5.36 The Chairperson of the Committee will submit an Annual Report of the work of the Committee to the Board, following consideration by the Audit & Risk Committee annually, to give assurance that the Committee has delivered against its Terms of Reference.

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

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

5.39 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" and the Scottish Public Finance Manual.

~~5.40 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 & 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 external advisors 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 & 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 & Risk Committee will advise the Scottish Parliament Public Audit Committee of any matters of significant interest as required by the Scottish Public Finance Manual.

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**14 March 2024**
Title:	**Losses and Special Payments Quarter 3**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Report Author:	**Kevin Booth, Head of Financial Services & Procurement**

1 Purpose

This is presented for:

- Assurance

This report relates to a:

- National policy

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

- Effective

2 Report summary

2.1 Situation

This paper presents a summary of the Board's losses and special payments covering quarter to (01/10/23 – 31/12/23).

2.2 Background

The Boards losses and special payments are controlled by the Financial Services Department and are reported to the Scottish Government as part of the annual accounts process.

As per section 16 of the Financial Operating Procedures, any potential losses or special payments are approved by the relevant Directorate/Department Head. The loss, theft or damage paperwork is then provided to the Deputy Director of Finance for final approval.

The losses and special payments for the quarter are compiled into a report with a format and categories defined by the requirements of the Scottish Government. These categories include losses relating to fraud, damage to buildings/equipment, debtors' balances written off, damage/loss of equipment and stock, vehicle accident and insurance excess payments and compensation payments covering financial losses suffered by patients amongst others. The report also quantifies both the clinical and non-clinical ex-gratia compensation

payments for any legal claims that are negotiated and settled on the Board's behalf by the Central Legal Office following consultation with the Director of Finance & Strategy.

2.3 Assessment

The attached appendix summarises the Boards losses and special payments for the period 01/10/23 – 31/12/23. The reports categorise the types of losses and special payments made in the period whilst also quantifying the number of cases of each and the total monetary value.

There were 235 losses and special Payments in the quarter which was in line with those reported in the second quarter (229). The total cost reported however has significantly increased in the quarter to £1,323,435, up from £351,916 reported in quarter two. This increase was predominantly as a result of the increase in value of the clinical ex-gratia compensation payments (£1,276,577 up from £235,558). The total of Losses and Special Payments out with Clinical and Non-Clinical ex-gratia compensation payments was £17,880 which was an increase in comparison to quarter two (£11,738).

At the end of the third quarter, the total losses and special payments in the year to date are £2,700,715 from 564 reports. This remains below the £4,387,238 from 767 reports that were recorded in the Annual Accounts for the year 2022/23.

The Treasury team carried out their quarterly analytical review to provide additional assurance and the following items were noted:

1 – As a result of the mid-year debtors review, £2,587 was written off in relation to payroll debtors whilst a further was £3,074 written off in relation to other debtors. With no debtors' review carried out in quarter 2, this was the main contributor to the increased losses and special payments in the quarter out with the increase in clinical ex-gratia compensation payments.

2 - Non-clinical ex gratia payments (section 27) decreased in the quarter (£28,978 from £104,620) as a result of only 4 reports being included as opposed to 10 in the previous quarter.

3– Compensation payments for Patients and Staff Financial Loss (Section 28) remained higher than anticipated as a result of a single high value claim for a patient's belongings.

The above findings will be carried into the quarter four review to assist with the identification of any developing trends which may materially affect the Boards expected position at the end of 2023/24.

2.3.1 Quality, Patient and Value-Based Health & Care

The losses and special payments require to be tightly controlled as they can have a material impact on the Boards financial position and ability to maintain budgets to ensure/enhance Patient Care.

2.3.2 Workforce

The procedural guidance for Managers to ensure the appropriate treatment for any losses or special payments is stated in the Financial Operating Procedures.

2.3.3 Financial

The losses and special payments are included within the Boards Annual Accounts process, subject to external audit and submitted to the Scottish Government for oversight.

2.3.4 Risk Assessment/Management

The level of the Board's losses and special payments are monitored to minimise any potential reoccurrence and future exposure to the Board.

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

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

2.3.6 Climate Emergency and Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

The Boards quarterly losses and special payments are compiled by the Treasury Team and are presented to the Head of Financial Services and Procurement ahead of the annual submission to the Scottish Government. The losses and special payments included in the report have been approved by the appropriate Directorate/Department Head or in the case of legal settlements have come through following agreement/notification by the Central Legal Office.

2.3.8 Route to the Meeting

This paper is brought to the members attention to give visibility of the Board's losses and special payments in the quarter to 31 December 2023.

2.4 Recommendation

- **Assurance**

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Summary of Losses and Special Payments 01/10/23 – 31/12/23

Report Contact
Kevin Booth
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FIFE HEALTH BOARD

SUMMARY OF LOSSES AND SPECIAL PAYMENTS

ITEM NO.	CATEGORY	OCT-DEC'23		JAN'23 - DEC'23	
	Miscellaneous / Theft / Arson / Wilful Damage				
1	Cash			1	125
2	Stores/procurement				
3	Equipment	1	236	1	236
4	Contracts				
5	Payroll *Salary Overpayment Debtors Invoices*	8	2588	51	37029
6	Buildings & Fixtures *Vandalism*	18	299	64	5404
7	Other			1	355
	Fraud, Embezzlement & other irregularities (incl. attempted fraud)				
8	Cash				
9	Stores/procurement				
10	Equipment				
11	Contracts				
12	Payroll				
13	Other				
14	**Nugatory & Fruitless Payments**			1	70728
	Claims Abandoned:				
15	(a) Private Accommodation				
	(b) Other *Hardship Accounts / Insurance Excess / Debtors WO's*	172	5814	520	22231
	Stores Losses:				
16	Incidents of the Service :				
	- Fire				
	- Flood				
	- Accident				
17	Deterioration in Store				
18	Stocktaking Discrepancies				
19	Other Causes				
	Losses of Furniture & Equipment				
	and Bedding & Linen in circulation:				
20	Incidents of the Service :				
	- Fire				
	- Flood				
	- Accident *Loss / Damaged Equipment*	9	4314	24	15773
21	Disclosed at physical check				
22	Other Causes				
	Compensation Payments - legal obligation				
23	Clinical				
24	Non-clinical				
	Ex-gratia payments:				
25	Extra-contractual Payments				
26	Compensation Payments - ex-gratia - Clinical	16	1276577	47	3848953
27	Compensation Payments - ex-gratia - Non Clinical	4	28978	25	289550
28	Compensation Payments - ex-gratia - Financial Loss	6	4429	17	9463
29	Other Payments				
	Damage to Buildings and Fixtures:				
30	Incidents of the Service :				
	- Fire				
	- Flood				
	- Accident *Vehicle Expenditure*	1	200	5	1005
	- Other Causes				
31	**Extra-Statutory & Extra-regulationary Payments**				
32	**Gifts in cash or kind**				
33	**Other Losses**				
		235	1323435	757	4300853

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**14 March 2024**
Title:	**Waiver of Competitive Tenders Quarter 3**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Kevin Booth, Head of Financial Services & Procurement**

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Government policy / directive
- Legal requirement

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

- Safe

2 Report summary

2.1 Situation

In order to allow the Audit & Risk Committee to take assurance that the Boards Procurement Function is operating within the legal requirements of the Scottish Government. This paper presents oversight of the Contract Awards over £50,000 in the period October 2023 – December 2023 that were subject to a waiver of competitive tender.

2.2 Background

As per the Guidance in the Public Contracts Scotland Act 2015. Any non-competitive award of a contract with an anticipated value of £50,000 or more (inclusive of vat) must have a waiver of competitive tender completed prior to award and be signed off by both the Head of Procurement and then counter signed by both the Director of Finance & Strategy and the Chief Executive.

The waiver of competitive tender confirms the restricted conditions which when in existence, the Board is permitted to award the contract without following the existing procurement journey route 2 as prescribed in the Act.

The restricted, permitted conditions (as per the Code of Corporate Governance, appendix 3 Standing Financial Instructions, section 9.11) which must be in existence are as follows:

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

Any other justification including the unavailability of time should not be considered without the prior agreement with the Scottish Government.

2.3 Assessment

During the period October 2023 – December 2023 the Procurement Team had no requirement to award any contracts of £50,000 or above. Therefore, there were no contracts subject to a waiver of competitive tender.

2.3.1 Quality, Patient and Value-Based Health & Care

A waiver of competitive tender will only ever be considered by Procurement where all applicable information is provided to a high quality, allowing for an effective decision to be made.

2.3.2 Workforce

The current guidance for the application of a waiver of competitive tender is contained within the Financial Operating Procedures section 11(a) for staff to refer to when consideration is required. The qualifying criteria contained mirrors that within the Boards Standing Financial Instructions.

2.3.3 Financial

As per the Public Contracts Scotland Act 2015 any procurement of £50,000 or above is subject to Procurement Journey Route 2 (or Route 3 if £138,760 or above), where a Tender would be posted through the Public Contracts Tender Portal. The implementation of the Tender Waiver negates the requirement for this process.

2.3.4 Risk Assessment / Management

The implementation of a Waiver of Competitive Tender needs to be robustly controlled to ensure the Board does not expose itself to challenge which could result in legally imposed financial penalties and reputational damage.

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

The governed application of the waiver of competitive tender ensures applicable treatment of suppliers across the marketplace.

2.3.6 Climate Emergency & Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

The consideration of the application of a waiver of competitive tender is considered by the Senior Procurement Team following discussions with the order requisitioner and service lead before being approved if applicable by the Head of Procurement and then issued to the Director of Finance & Strategy and the Chief Executive for final sign off.

2.3.8 Route to the Meeting

The Procurement Governance Board monitors the Procurement KPI's which includes the number of Competitive Tender Waivers implemented.

2.4 Recommendation

- **Assurance** – Members are asked to take assurance that the Procurement process for the waiver of competitive tenders was correctly applied in the period.

3 List of appendices

None.

Report Contact
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DRAFT AUDIT & RISK COMMITTEE

ANNUAL WORKPLAN 2024 / 2025

Governance – General						
	Lead	**16/05/24**	**20/06/24**	**12/09/24**	**12/12/24**	**13/03/25**
Minutes of Previous Meetings	**Chair**	✓	✓	✓	✓	✓
Action Plan	**Chair**	✓	✓	✓	✓	✓
Escalation of Issues to NHS Board	**Chair**	✓	✓	✓	✓	✓
Governance Matters						
	Lead	**16/05/24**	**20/06/24**	**12/09/24**	**12/12/24**	**13/03/25**
Audit Scotland Technical Bulletin	**Head of Financial Services**	✓ **2024/1**		✓ **2024/2**	✓ **2024/3**	✓ **2024/4**
Annual Assurance Statement 2023/24	**Board Secretary**	✓ Draft	✓ Final			
Annual Assurance Statements from Standing Committees 2023/24	**Board Secretary**		✓			
Annual Review of Code of Corporate Governance	**Board Secretary**	✓				
Committee Self-Assessment	**Board Secretary**					✓
Corporate Calendar / Committee Dates 2025/26	**Board Secretary**			✓		
Delivery of Annual Workplan 2024/25	**Director of Finance & Strategy**	✓	✓	✓	✓	✓
Financial Operating Procedures Review	**Head of Financial Services**	(Two yearly review. Next review due December 2025)				
Governance Statement	**Director of Finance & Strategy**	✓ Draft	✓ Final			
IJB Annual Assurance Statement 2023/24	**Board Secretary**		✓ TBC	✓ TBC		
Internal Audit Review of Property Transactions Report 2023/24	**Internal Audit**			✓ TBC		

Governance Matters (cont.)						
	Lead	**16/05/24**	**20/06/24**	**12/09/24**	**12/12/24**	**13/03/25**
Losses & Special Payments	**Head of Financial Services**	✓		✓	✓	✓
Procurement Tender Waivers Compliance 2024/25	**Head of Financial Services**	✓		✓	✓	✓
Review of Annual Workplan 2025/26	**Board Secretary**				✓ Draft	✓ Approval
Review of Terms of Reference	**Board Secretary**					✓ Approval
Risk						
	Lead	**16/05/24**	**20/06/24**	**12/09/24**	**12/12/24**	**13/03/25**
Annual Risk Management Report 2023/24	**Risk Manager**	✓ Draft	✓ Final			
Corporate Risk Register	**Director of Finance & Strategy/Risk Manager**	✓	✓	✓	✓	✓
Risk Management Key Performance Indicators 2023/24	**Risk Manager**	✓ **2023/24**		✓		
Risks & Opportunities Group Progress Report	**Risk Manager**	✓		✓	✓	✓
Governance – Internal Audit						
	Lead	**16/05/24**	**20/06/24**	**12/09/24**	**12/12/24**	**13/03/25**
External Quality Assessment (5 yearly)	**Internal Audit**					✓
FTF Shared Service Agreement / Service Specification	**Internal Audit**				✓	
Internal Audit Progress Report	**Internal Audit**	✓		✓	✓	✓
Internal Audit Annual Plan 2024/25	**Internal Audit**	✓ Draft	✓ Final			
Internal Audit Annual Report 2023/24	**Internal Audit**		✓			
Internal Audit – Follow Up Report on Audit Recommendations 2023/24	**Internal Audit**	✓		✓	✓	✓

Governance – Internal Audit (cont.)						
	Lead	**16/05/24**	**20/06/24**	**12/09/24**	**12/12/24**	**13/03/25**
Internal Audit Framework	**Chief Internal Auditor**					✓
Internal Controls Evaluation Report 2023/24	**Internal Audit**				✓	
Governance – External Audit						
	Lead	**16/05/24**	**20/06/24**	**12/09/24**	**12/12/24**	**13/03/25**
Annual Audit Plan 2023/24	**External Audit**				✓	
External Audit – Follow Up Report on Audit Recommendations	**Director of Finance & Strategy**					✓
Patients' Private Funds - Audit Planning Memorandum	**Head of Financial Services**					✓
Service Auditor Reports on Third Party Services	**Head of Financial Services**		✓			
Annual Accounts						
	Lead	**16/05/24**	**20/06/24**	**12/09/24**	**12/12/24**	**13/03/25**
Annual Accounts Preparation Timeline	**Head of Financial Services**	✓ Follow Up				✓ Initial
External Auditors Annual Accounts Progress Update	**External Auditor**	✓				✓
Annual Accounts & Financial Statements 2023/24	**Director of Finance & Strategy / External Audit**		✓			
Annual Audit Report 2023/24	**External Audit**		✓			
Letter of Representation 2023/24	**Director of Finance & Strategy / External Audit**		✓			
Patients' Funds Accounts 2023/24	**Head of Financial Services**		✓			
Annual Statement of Assurance to the NHS Board 2023/24	**Board Secretary**		✓			
Counter Fraud						
	Lead	**16/05/24**	**20/06/24**	**12/09/24**	**12/12/24**	**13/03/25**
Counter Fraud Service – Quarterly Report (Alerts & Referrals)	**Head of Financial Services**	Private Session		Private Session	Private Session	Private Session
Counter Fraud Standards Assessment	**Head of Financial Services**	Private Session				Private Session

Counter Fraud (cont.)						
	Lead	**16/05/24**	**20/06/24**	**12/09/24**	**12/12/24**	**13/03/25**
Counter Fraud Action Plan 2024/25	**Head of Financial Services**	✓				
Counter Fraud Annual Report 2023/24	**Head of Financial Services**	✓				
Adhoc						
	Lead	**16/05/24**	**20/06/24**	**12/09/24**	**12/12/24**	**13/03/25**
Private Meeting with Internal / External Auditors	**Committee**			Private Session		Private Session
Appointment of Patients' Private Funds Auditor	**Director of Finance & Strategy**	**As required**				
Legal & regulatory updates (e.g. Audit Scotland reports etc.)	**Head of Financial Services**					
Progress on National Fraud Initiative (NFI)	**Head of Financial Services**				✓	
Additional Agenda Items (Not on the Workplan e.g. Actions from Committee)						
	Lead	**16/05/24**	**20/06/24**	**12/09/24**	**12/12/24**	**13/03/25**
Training Sessions Delivered						
	Lead	**16/05/24**	**20/06/24**	**12/09/24**	**12/12/24**	**13/03/25**
Members' Training Session – the Annual Accounts: The Role & Function of the Audit & Risk Committee	**External Auditors**	✓				

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**14 March 2024**
Title:	**Audit Scotland Technical Bulletin 2023/4**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Kevin Booth, Head of Financial Services & Procurement**

1 Purpose

This is presented for:

- Assurance

This report relates to a:

- Emerging issue
- Government policy/directive
- Legal requirement

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

- Effective

2 Report summary

2.1 Situation

The Audit Scotland Technical Bulletin 2023/4 is a resource shared across members of the Finance Directorate and is provided to the Audit and Risk committee to raise awareness of emerging developments from an Audit perspective.

2.2 Background

The Audit Scotland Technical Bulletins are prepared on a quarterly basis and are provided to support auditors appointed by the Auditor General for Scotland and Accounts Commission for Scotland with:

- Information on the main technical developments across the public sector in the quarter.
- Information on professional matters during the quarter that are expected to have applicability to the public sector.

- Summaries of responses to any requests from auditors for technical consultations with Audit Scotland Professional Support.

2.3 Assessment

The Audit Scotland Technical Bulletin 2023/4 is arranged by sector with content applicable to specific sectors and also across the public sector as a whole. There is no specific section in relation to Health in quarter four with Audit Scotland's focus remaining on the Local and Central Government sector audits.

Section two references the guidance issued to appointed auditors ahead of the 2023/24 audit cycle to assist with their planning assignments.

Section five on professional matters to note, highlights that the Financial Reporting Council (FRC) has issued a revised version of ISA (UK) 505 for auditors' awareness. In addition, a thematic review on audit sampling was carried out by the FRC and the findings have been published to support areas of best practice.

Section six provides a summary of fraud cases and other irregularities that have recently been reported by auditors as a result of weaknesses in internal controls at audited bodies.

2.3.1 Quality, Patient and Value-Based Health & Care

N/A

2.3.2 Workforce

The Technical Bulletin is shared widely across the Finance Directorate.

2.3.3 Financial

Technical and Financial developments are addressed from Audit Scotland's perspective.

2.3.4 Risk Assessment/Management

Emerging Risks relating to the Health Sector are addressed from Audit Scotland's perspective.

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

N/A

2.3.6 Climate Emergency and Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

The Audit Scotland Technical Bulletins are provided to Boards through the Technical Accounts Group meetings and any impending issues are discussed.

2.3.8 Route to the Meeting

This paper has been provided to support the Audit & Risk Committee following discussions between the Head of Corporate Governance and the Head of Financial Services & Procurement

2.4 Recommendation

- **Assurance**

3 List of appendices

The following appendices are included with this report:

- Appendix 1, Audit Scotland Technical Bulletin 2023/4

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Technical Bulletin 2023/4

Technical developments and emerging risks from September to December 2023

AUDIT SCOTLAND

Prepared by Audit Scotland for appointed auditors and audited bodies in all sectors

18 December 2023

Contents

1: Introduction

Purpose

The purpose of Technical Bulletins from the Professional Support section within Audit Scotland's Innovation and Quality business group is to provide auditors appointed by the Auditor General for Scotland and Accounts Commission for Scotland with:

- information on the main technical developments in each sector during the quarter
- information on professional matters during the quarter that are expected to have applicability to the public sector
- summaries of responses to any requests from auditors for technical consultations with Professional Support.

Appointed auditors are required by the Code of Audit Practice to pay due regard to Technical Bulletins. The information on technical developments is aimed at highlighting the key points that Professional Support considers auditors in the Scottish public sector require generally to be aware of. It may still be necessary for auditors to read the source material if greater detail is required in the circumstances of a specific audited body. Source material can be accessed by using the hyperlinks.

Any specific actions that Professional Support recommends that auditors take are highlighted in green.

Technical Bulletins are also published on the Audit Scotland website and therefore are available for audited bodies and other stakeholders to access. However, hyperlinks to source material indicated with an asterisk (*) link to files on Audit Scotland's SharePoint* and are only accessible by auditors.

Highlighted items

Professional Support highlights in the following table a selection of the items in this Technical Bulletin that are of particular importance:

Highlighted items		
Professional Support has issued guidance on planning the 2023/24 audits [**paragraph 1**]	Professional Support has issued a TGN on the 2022/23 WGA returns **[paragraph 6]**	Professional Support has issued a TGN on the risks of misstatement in the 2023/24 audit of local government bodies **[paragraph 10]**
The Scottish Government has issued guidance on accounting for capital grants **[paragraph 14]**	CIPFA has published guidance on the reporting of pension surpluses and the asset ceiling **[paragraph 19]**	The Scottish Government has issued a consultation on proposed amendments to calculating repayments to loans fund advances **[paragraph 23]**
The Scottish Government has issued a consultation on statutory guidance on accounting for service concession arrangements **[paragraph 33]**	The Scottish Government has issued a consultation on a proposed extension to the statutory overrides for infrastructure assets **[paragraph 38]**	Treasury has issued a PES paper on discount rates **[paragraph 43]**
The FRC has issued a revised auditing standard on external confirmations **[paragraph 49]**	The FRC has issued proposals for a revised auditing standard on laws and regulations **[paragraph 50]**	The FRC has published a thematic review of audit sampling **[paragraph 53]**

Consulting with Professional Support

Auditors should consult with Professional Support by sending an email to TechnicalQueries@audit-scotland.gov.uk.

2: All sectors

Guidance on planning 2023/24 annual audits

1. Professional Support has issued guidance to assist all appointed auditors in planning their 2023/24 annual audits of public bodies. The guidance supplements the Code of Audit Practice and sets out the range of core annual audit activity and related outputs required for 2023/24, and the timescales for completing the audit in each sector.

2. Auditors should comply with the guidance when planning, performing and reporting their 2023/24 audits. The guidance is accessible by auditors with other supporting materials on SharePoint* but it is also freely available from the Audit Scotland website.

3. The largest component of core annual audit activity is the audit of a public body's annual accounts. However, the audit of the annual accounts has a wider scope than the private sector, and requires conclusions on aspects of public bodies' arrangements and performance. In local government, public audit includes considering arrangements to secure Best Value and community planning and publishing performance information. Auditors also provide important intelligence to the Auditor General, Accounts Commission and Audit Scotland in areas where they are best placed to do so.

4. Audit Scotland's policy is not to compromise on audit quality or the wellbeing of audit teams, but that timescales are negotiable. The guidance is intended to strike the right balance in 2023/24 between ambitions for public audit and the capacity for auditors to carry out the work to the appropriate high quality. Target audit completion dates are considered to be stretching but achievable for the majority of audits.

5. The following table provides a summary of the key changes from last year, along with the paragraphs of the guidance in which further information is provided:

Nature of change	Paragraph
Removal of the cap of £250,000 on the 'clearly trivial' threshold for accumulating and reporting misstatements.	21
No mandated wider scope areas of risk for auditors to consider.	61
Updated guidance on auditing Best Value in local authorities to reflect the thematic review of workforce innovation.	81 to 86

Nature of change	Paragraph
Updated guidance on the process for Current Issues Returns in local government.	115 to 130
Guidance on completing a brief information return for each body participating in the National Fraud Initiative.	139
Updated guidance on arrangements for sharing intelligence on risks in the health and social care system .	167 to 171

TGN on 2022/23 WGA returns

6. Professional Support has published a Technical Guidance Note (TGN) to provide auditors with guidance on examining and reporting on the 2022/23 Whole of Government Accounts (WGA) returns of public bodies in Scotland. TGN/WGA/23 is provided with supporting material to auditors on SharePoint* and also on the Audit Scotland website.

7. The National Audit Office (NAO) are the group auditor for WGA. Testing and reporting procedures that auditors are required to undertake in respect of providing assurance to the NAO on 2022/23 WGA returns above the threshold is included in the TGN. The procedures are consistent with the NAO's Group Audit Instructions but tailored to Scottish bodies. Reporting procedures include the submission of an Assurance Statement in a form prescribed by NAO.

8. No examination is required for bodies below the threshold, although auditors are required to complete the first eight sections of the Assurance Statement (except for minor bodies) and submit it to the NAO.

9. Auditors should examine and report on the 2022/23 WGA returns of public bodies in Scotland in accordance with the TGN, and make the required submissions as soon as reasonably practicable.

3: Local government sector

TGN on risks of misstatement in 2023/24

10. Professional Support has published TGN 2023/8(LG) to provide auditors with guidance on risks of misstatement in the 2023/24 annual accounts of local government bodies. The TGN is accessible by auditors on SharePoint*, along with supporting material, and is also available from the Audit Scotland website.

11. The TGN is intended to inform auditors' judgement when identifying and assessing the risks of material misstatement. The TGN supplements the Code of Audit Practice and auditors are expected to pay it due regard and use it as a primary reference source when performing 2023/24 audits. Auditors should advise Professional Support of any intended departures from the guidance.

12. The TGN comprises a number of modules as summarised in the following table:

Module	Risks of misstatement area	Purpose
Overview	Areas that are pervasive to the financial statements as a whole	Explains the appropriate related accounting treatment and sets out the action auditors should undertake to evaluate whether the body has followed the required treatment
1 - 9	Specific classes of transactions, balances and disclosures in the financial statements.	
10	Audited part of the Remuneration Report	Explains the requirements and sets out the action auditors should undertake
11	Statutory Other Information (e.g. Management Commentary and Annual Governance Statement)	Sets out the procedures for considering the Statutory Other Information
12	Integration joint boards	Provides guidance on the application of the above modules to these specific bodies
13	Pension fund accounts	
14	Section 106 charities	

13. The risks of misstatement reflect areas of complexity, subjectivity and uncertainty. They have been updated to reflect new requirements and risks which emerged during the 2022/23 audits that remain applicable. A separate note summarises the main changes from 2022/23.

Guidance on accounting for specific capital grant in 2023/24

14. The Scottish Government has published Finance Circular 6/2023 to provide statutory guidance on accounting for capital grant provided in place of revenue grant in 2023/24.

15. The statutory guidance adapts Finance Circular 3/2018 for 2023/24 to permit local authorities to transfer specified capital grant to the Capital Fund (rather than the Capital Adjustment Account) in order that it may be used to repay the principal of loans fund repayments for both General Fund and HRA loan repayments.

16. The amendment applies specifically to the £70 million of General Capital Grant provided in place of revenue grant in 2023/24 and to the additional £22 million of General Capital Grant provided to fund the Local Government pay award. The statutory guidance provides the consent of the Scottish Ministers required for the HRA loan repayments.

17. Once the capital grant held in the Capital Fund is utilised to fund the principal element of loan repayments, it must be transferred to the General Fund or HRA as a transfer from other statutory reserves in the Movement in Reserves Statement.

18. The capital grant must be utilised in 2023/24 and therefore may not be transferred to the Capital Grants (and Receipts) Unapplied Account.

New guidance on accounting for pension assets

19. Technical Bulletin 2023/2 (paragraph 27) provided guidance on recognising a net defined benefit asset in accordance with IFRC 14 when the pension fund reports a surplus as at 31 March 2023. The Chartered Institute of Public Finance and Accountancy (CIPFA) has published Bulletin 15 to provide guidance in this regard.

20. CIPFA considers that the IFRIC agenda decision in 2015 referred to in the technical bulletin guidance is likely to support a view that there is a minimum funding requirement. When a local government body estimates the future minimum funding requirement contributions, it should:

- include the amounts in the schedule of contributions for the fixed period specified by the schedule
- beyond that period, make an estimate that assumes a continuation of those factors establishing the minimum funding basis as determined by the administering authorities.

21. In order to carry out the calculation of any adjustment to the asset ceiling under IFRIC 14, it is necessary to identify the amount of employer contribution in each period that relates to future service. Bodies will need to consider:

- the portion of the employer contributions calculated using the primary rate

- whether any of the contribution calculated using the secondary rate should be included in the calculation.

22. Where an asset ceiling is applied, the bulletin highlights relevant requirements in the accounting code which require disclosure of:

- an explanation as to why the pension surplus reported under IAS 19 is not fully realisable and what 'realisable' means in this context
- the basis used to determine the amount of the economic benefit available.

Proposed amendments to loans fund repayments from 2023/24

23. The Scottish Government has issued a consultation draft* of proposed amendments to the requirements for calculating repayments to loans fund advances from 2023/24. Responses to the consultation require to be sent to Elanor.Davies@gov.scot by 22 December 2023.

24. The consultation seeks views on proposed amendments to:

- The Local Authority (Capital Finance and Accounting) (Scotland) Regulations 20161 (the 2016 Regulations) which set out the statutory requirements for loans fund accounting
- Finance Circular 7/2016 (the statutory guidance) which sets out proper accounting practices for loans fund accounting.

25. The proposed amendments arise from Scottish Government concerns that:

- the application of the current level of flexibility in calculating loans fund repayments creates a future affordability risk for capital investment projects
- some local authorities may be making capital investment decisions that are being justified on value for money grounds by providing for loans fund repayments over excessively long periods
- the use of an annuity calculation to determine the pattern of loans fund repayments may result in a significant proportion of the repayments being deferred to future financial years.

26. The statutory framework differentiates between those advances before 1 April 2023 (covered by Regulation 14 of the 2016 Regulations) and those after 1 April 2023 (covered by the statutory guidance). There are also additional proposals related to capital projects approved after that date. It is therefore helpful to consider the how the proposals apply to three categories of loans fund advances, i.e. advances made:

- before 1 April 2023
- from 1 April 2023 relating to capital projects approved before that date
- from 1 April 2023 relating to capital projects approved after that date.

Loans fund advances made before 1 April 2023

27. The 2016 Regulations (at Regulation 14) permits a local authority to vary the period or amount of repayment of loans fund advances made before to 1 April 2023, if it considers it prudent to do so. The Scottish Government's concerns about the application of this power and how they proposed to address them by amending Regulation 14 is summarised in the following table:

Concern	Proposal
The power has been interpreted by local authorities as permitting the retrospective calculation of loans fund repayments	Any variation to a loans fund repayment may only be • calculated on the balance of the loans fund advance in the financial year of variation • applied to the remaining loans fund repayments from the financial year of variation.
The power is being used as a means of addressing budget pressures rather than to better reflect the financing of capital expenditure over a term commensurate with the benefits.	The repayment period cannot extend beyond the earlier of the remaining useful life of an asset or 50 years from the date of the advance. The decision to vary a loans fund repayment must be taken by the full council and cannot be delegated.

28. There are no proposed changes to the existing four options for repaying the advances set out in statutory guidance (i.e. statutory method, depreciation, asset life or funding profile).

Loans fund advances made from 1 April 2023 relating to capital projects approved before that date

29. Regulation 14 of the 2016 Regulations does not apply to advances made from 1 April 2023. Instead, the repayment of advances is covered in the statutory guidance. The statutory guidance requires prudent repayment of a loans fund advance over a period reasonably commensurate with the period and pattern of the benefits provided to the community from the capital expenditure.

30. The proposals to revise the repayment options in the statutory guidance are similar to the proposed amendments to the 2016 Regulations explained above in that they are intended to:

- clarify that where a loans fund advance relates to an asset, the prudent repayment period should usually align to the asset life but may not exceed 50 years

- confirm that, where an asset life cannot reasonably be attributed to an asset, the loans fund repayment period should align to the period over which benefit of the expenditure will be provided to the community but may not exceed 50 years and may not subsequently be varied.

- require that any variation to loans fund repayments may only be calculated on the balance of the loans fund advance outstanding in the financial year of variation and may only be applied prospectively.

Loans fund advances made from 1 April 2023 relating to capital projects approved after that date

31. The proposals summarised above to amend the statutory guidance for capital projects approved before 1 April 2023 also apply to those approved after that date.

32. However, there are additional proposals for projects approved after 1 April 2023, which are summarised in the following table:

Area	Proposals
Annuity calculation	The use of an annuity calculation (as part of the asset life method of calculating the repayment of the advance) is permitted only where the local authority can evidence that either the flow of benefits of the capital investment or a directly attributable revenue stream will increase over the asset life. Where an annuity is used, the interest rate applied should not exceed the weighted average PWLB borrowing rate of the authority.
Capital receipts	The use of capital receipts to fund the repayment of advances should be minimised.
Identification against a specific asset	Advances and repayments must be readily identified against a specific asset.
Repayment on derecognition	Advances must be repaid in full on derecognition of the related asset. In the case of obsolescence, a local authority may spread the repayment of the remaining loans fund advance over a maximum period of 5 years in order to smooth the effect on the General Fund.
Investment properties	A local authority should fully provide for debt taken on to acquire an investment property over the lifetime of the debt.

Draft statutory guidance on service concession arrangements

33. The Scottish Government has issued a consultation draft* of Finance Circular 7/2023 to provide revised statutory guidance on accounting for service concession arrangements, leases and similar arrangements from 1 April 2024.

34. The draft guidance replaces Finance Circular 10/2022 which temporarily permitted a local authority to recognise the principal repayments for a service concession arrangement over the asset life rather than contractual term. The temporary flexibility is not reflected in the new statutory guidance.

35. With the exception of those service concession arrangements to which the flexibility was applied in either 2022/23 or 2023/24, from 1 April 2024 the annual statutory charge to the General Fund for all existing and new service concession arrangements, leases and similar arrangements will be required to:

- reflect the principal element of the contractual repayments
- be charged to the General Fund over the term of the contract.

36. Finance Circular 10/2022 will continue to apply where the temporary flexibility was exercised.

37. In addition, there is the following proposed amendment to the statutory guidance for leases that are reclassified on transition to IFRS 16, where the authority is the lessor:

Lease reclassified as…	Treatment
Finance lease	Income received under the lease will continue to be treated as revenue income. Any capital receipt recognised on transition will be transferred to the General Fund and reported in the Movement in Reserves Statement.
Operating lease	Any income that would, prior to the reclassification, have been treated as a capital receipt should be transferred from the General Fund to the Capital Receipts Reserve, and the transfer should be reported in the Movement in Reserves Statement.

Proposed extension to statutory overrides for infrastructure assets

38. The Scottish Government has issued a consultation* on a proposed extension to 31 March 2025 of the statutory overrides for infrastructure assets. The statutory overrides are set out in Finance Circular 9/2022 (see Technical Bulletin 2022/3 paragraph 11) and are in respect of the disclosure and derecognition of infrastructure assets.

39. The overrides were intended to apply until 31 March 2024 while CIPFA/LASAAC sought a permanent solution. The proposed 12 month extension is in order to allow more time for the permanent solution to be implemented.

40. Responses to the consultation require to be sent to Elanor.Davies2@gov.scot by 15 December 2023.

Technical consultations with auditors

Professional Support responds to requests from auditors for technical consultations

41. The following tables summarise requests from auditors for technical consultations with Professional Support in respect of issues arising from the audit of the 2022/23 annual accounts of local government bodies, along with the advice offered:

Can an unfunded pension liability be offset against a net defined benefit asset?

Unfunded pension liabilities generally relate to provisions for discretionary enhancements to retirement benefits (e.g. payments for early retirement paid by the body rather than the pension fund). IAS 19 treats them as termination benefits. Bodies do not have a right to set off the unfunded liability against a pension asset. The unfunded liability should therefore be presented separately from the net defined benefit asset.

Where future unfunded payments have been excluded by the actuary from the future employer contributions as part of the asset ceiling calculations, separate presentation should be straight-forward. However, where the actuary has included unfunded payments, bodies may need to request a recalculation. Where a recalculation is not carried out, as a minimum auditors should consider whether narrative disclosure is sufficient to explain that the defined benefit asset is net of the unfunded liability and the reasons for it.

Should the pension amounts as at 31 March 2023 in the balance sheet be adjusted to reflect the 31 March 2023 actuarial valuation?

Due to the timing of 2022/23 local government audits, the results of the triennial valuation as at 31 March 2023 may be available from actuaries before some audits are completed.

The pension amounts as at 31 March 2023 in the balance sheet in the unaudited accounts were based on the 31 March 2020 actuarial valuation rolled forward. Where the audit of the 2022/23 financial statements for a local authority has been completed before the 2023 valuation reports are available, the financial statement will appropriately continue to reflect the 31 March 2020 valuation, as that is the most reliable, uptodate information. The 31 March 2023 actuarial figures will then be reflected in the balance sheet at 31 March 2024.

However, where the 2023 actuarial reports become available before the 2022/23 audits are complete, that would represent an adjusting event. Auditors should assess whether the 31 March 2023 valuation is materially different from the estimate determined using the rolled forward figures currently in the balance sheet. An adjustment will be required if the difference is material.

Auditors should liaise with the local government body to ensure that they can plan accordingly.

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4 Central government sector

Update to SPFM

42. The Scottish Government has issued FGN 2023-2 announcing amendments to the Scottish Public Finance Manual (SPFM) relating to the Scottish Government's Business Investment Framework. The guidance on investment has been enhanced to:

- ensure that proportionate due diligence has been completed prior to support being provided
- highlight approval arrangements for novel or contentious investments
- clarify consideration of the risks of each investment and the estimation of the maximum potential financial exposure
- clarify monitoring arrangements, periodic reviews and exit strategies.

2023/24 discount rates

43. HM Treasury has issued PES (2023)10* to announce changes in the discount rates for general provisions, post-employment benefit liabilities, leases, and financial instruments as at 31 March 2024.

General provisions

44. The nominal discount rates to be applied as at 31 March 2024 for discounting general provisions recognised under IAS 37 are set out in the following table:

Category	Period	Percentage
Short term	Within 5 years	4.26%
Medium term	Between 5 and 10 years	4.03%
Long term	Between 10 and 40 years	4.72%
Very long term	More than 40 years	4.40%

45. As nominal rates do not take inflation into account, cash flows require to be inflated separately. There is a rebuttable assumption that the inflation rates specified in the paper will be used (unless other rates are clearly more applicable). The specified rates are:

- 3.6% for up to one year from the year end
- 1.8% between one and two years
- 2.0% for after two years.

Post-employment benefits

46. The discount rates for post-employment benefits are set out in the following table:

Use	Rate from 31 March 2024
Real rate used for valuing unfunded pension scheme liabilities and early departure provisions	2.45%
Nominal rate for unwinding discount on liabilities (interest)	5.10%
Rate used for funded pension schemes	Based on returns from AA corporate bonds at 31 March

Financial instruments

47. The financial instrument discount rates to be applied at 31 March 2024 are set out in the following table:

Type		Rate
Nominal rate when financial instrument is not linked to an inflationary index		2.05%
Real rate when financial instrument indexed to RPI	In excess of RPI:	
	Until February 2030	(1.05%)
	From February 2030	(0.05%)

Leases

48. Where a body cannot determine the interest rate implicit in a lease, they are required to use the nominal lease discount rate of 4.72%. This is relevant for new leases that commence or are remeasured between 1 January 2024 and 31 December 2024.

5 Professional matters

Revised ISA on external confirmations

49. The Financial Reporting Council (FRC) has issued a revised edition of ISA (UK) 505 External Confirmations. The main revisions are summarised in the following table:

Area	Change
Clarification on what constitutes an electronic external confirmation	Paragraph 6 (a) has been amended to reflect the fact that confirmations may be obtained thorough directly accessing information held by third parties through web portals or software interfaces.
Prohibition on the use of negative confirmations	Paragraph 6(c) prohibits the use of negative confirmations, where the confirming party responds directly only if they disagree with the information provided in the request. This aims to improve the quality of audit evidence obtained when auditors make use of external confirmations.
Designing confirmations to provide evidence for relevant assertions	Paragraphs 7(c) and A6-1 include additional material to ensure that auditors design confirmations to obtain sufficient appropriate audit evidence in relation to all assertions identified in respect of ISA (UK) 330. This is applicable to all means of confirmation but can be particularly relevant to certain forms of digital confirmation.
Enhanced requirements in relation to investigating exceptions	Paragraph 14-1 includes enhanced requirements when investigating exceptions. They direct auditors to consider if exceptions are indicative of fraud or a deficiency in the entity's system of internal control and how follow-up procedures will allow the auditor to obtain sufficient appropriate audit evidence.

Proposed revisions to ISA on laws and regulations

50. The FRC has issued an invitation to comment on proposed revisions to ISA (UK) 250A on laws and regulations. The main proposed revisions are summarised in the following table:

Area	Proposal
Removal of distinction between different categories of laws and regulations	The proposal removes the distinction between laws and regulations that determine material amounts and those that do not. There is a proposed requirement for auditors to identify those laws and regulations where non-compliance may have a material effect on the financial statements. A more robust risk assessment process is proposed to provide an effective mechanism for identifying the above laws and regulations.
Implementing a more risk-based approach	There is a proposal to replace the current overly procedural approach with an overarching requirement for auditors to design and perform risk assessment procedures to obtain audit evidence for the identification of laws and regulations where non-compliance may have a material effect on the financial statements (paragraph 12-1). Additional risk assessment requirements are set out in proposed paragraphs 12-2 and 12-3 . Paragraphs 14-1 and 15-1 introduce explicit requirements in respect of the risks of material misstatement due to fraud or error relating to non-compliance with laws and regulations. Paragraph 16-1 requires auditors to stand back and assess whether they have obtained sufficient appropriate audit evidence regarding whether there is a material misstatement of the financial statements relating to non-compliance with laws and regulations.
Adequacy of disclosures	There is a proposed new requirement for auditors to conclude whether the financial statements adequately reflect or, where appropriate, disclose the non-compliance or suspected non-compliance with laws and regulations.

51. There are also proposals to replace ISA (UK) 250B with a more principles-based standard covering reporting and communication with an appropriate authority.

52. The FRC is requesting comments on this consultation by 12 January 2024. Comments should be sent to: AAT@frc.org.uk.

Thematic review on audit sampling

53. The FRC has published a thematic review on audit sampling. Audit sampling is a fundamental audit tool which allows conclusions to be drawn about a population based on the sample selected. The FRC reviewed the sampling methodologies of the largest audit firms to:

- identify areas of good practice

- highlight any concerns that will drive improvements and support the FRC's monitoring of the firms' systems of quality management.

54. The review concluded that:

- audit sampling for tests of detail and controls is still prevalent despite the advent of tools such as Audit Data Analytics
- most firms' methodologies are based on similar statistical models with firms building on these with their own guidance and preferences.
- significant professional judgements are made in audit sampling, particularly when using sample size calculators, including when assessing inherent risk and determining the contribution of evidence from other procedures. However, the review found insufficient evidencing of the key professional judgements made when determining sample sizes.

55. The review also highlighted the specific points summarised in the following table:

Area	Finding
Key items selection and selecting specific items This involves selecting specific items to test from the population before then selecting a sample of the residual population.	Most firms focus on high value items. The FRC founds insufficient documentation of the reasons for selecting specific items. Justification was generally focused on size, such as "selecting everything over 50% of performance materiality", with no consideration of why that was an appropriate threshold.
Haphazard selection versus random selection: • Haphazard selection involves the auditor selecting the sample without following a structured technique. • Random selection is applied through random number generators and reduces the risk of bias in sample selection.	Haphazard sampling was historically most useful when transaction listings were not available from audited entities in an electronic format that would allow for random sampling. Haphazard sampling may still be appropriate in limited circumstances, but justification should be documented. Random selection is preferable and should be used when feasible to do so. The FRC identified confusion in the sample selection method applied, e.g. where the sample calculator stated "Random" as the means of sample selection but "Haphazard" was actually used by the audit team.

Area	Finding
Testing the reliability of information produced by the entity (IPE) IPE testing used fixed sample sizes to determine if system-generated or manually produced information is reliable before audit procedures are performed on it to obtain audit evidence.	Some audit teams did not understand that IPE testing assesses the reliability of the information to be used as audit evidence, rather than being a test over the monetary value of a population.
Compliance with quality management standards ISQM (UK) 1 states that even when firms belong to networks and make use of resources, the firm "remains responsible for its system of quality management, including professional judgements made in the design, implementation and operation of the system of quality management".	All the firms' methodologies were driven by a global methodology, usually developed centrally outside the UK, and then adopted by the member firms worldwide. Firms need to ensure they have a proper and full understanding of the sampling techniques developed globally, and are able to understand and apply those methodologies in the UK. Some firms struggled initially to explain how, often due to the time that had elapsed from the model's original development. Firms need to be able to clearly explain how they developed their methodologies from more general statistical models even when the deployment was some years ago.

6. Fraud and irregularities

This chapter contains a summary of fraud cases and other irregularities facilitated by weaknesses in internal control at audited bodies that have recently been reported by auditors to Professional Support.

Auditors should consider whether weaknesses in internal control which facilitated each fraud or irregularity may exist in their bodies and take the appropriate action.

Expenditure

Kinship care (1)

56. A kinship carer received £30,000 over a two-year period after a child's placement with them ended.

Key features
The overpayment was identified by the council internal audit service when they were carrying out testing on the council's social work system.
The overpayment occurred as the social worker responsible for the child did not undertake regular monthly checks to ensure that the child was still placed with the stated carer.
Procedures have been strengthened and pre-payment accuracy checking has been introduced on scheduled payment runs.
Recovery action is being taken.

Kinship care (2)

57. A kinship carer received over £5,000 over a six-month period after a child's placement with them ended.

Key features
The overpayment occurred as the kinship carer did not follow due process when the child returned to parental care. In addition, social work staff were unaware of the required process which resulted in a failure to complete appropriate documentation to terminate the kinship placement payments.
The overpayment was identified when an employee was reviewing their caseload in advance of their retirement and identified that the kinship carer was still being paid.

Key features

Although a criminal investigation was carried out, the case was not referred to the Procurator Fiscal as the service was unable to produce admissible evidence in the form of the relevant kinship agreement form.

Following investigation:

- **annual reviews of kinship placements have been introduced**
- **checks are now carried out on children's names to prevent duplicate payments**
- **staff have been reminded that kinship carer agreements must be completed and retained**
- **staff involved in kinship care have been provided with a practical guide which they must acknowledge as having read, understood, and accepted.**

Bank mandate fraud (1)

58. An unknown individual compromised a manager's email account at a public body and committed bank mandate fraud. Payments totalling £15,700 were made to a fraudulent bank account.

Key features

An unsecure internet connection used by the manager appears to have been used to gain access to the manager's email account. Email instructions, purporting to come from the manager, were then sent requesting a change to a supplier's bank details.

The fraud was identified during a review of authorised expenditure on a project.

The fraud was possible due to inadequate procedures around the confirmation of new bank details with suppliers.

The public body has since heightened the vigilance of finance employees and strengthened procedures for verifying new or changes to bank account details. In addition, existing supplier's bank details are being verified.

Bank mandate (2)

59. An unknown individual compromised the systems of a business working with the public body to request a change to bank details. Payments totalling £5,800 were subsequently made to a fraudulent bank account.

Key features

The systems of a business working with the public body were compromised, and correspondence was intercepted.

A similar email address to that of the business was used to send an email to the public body requesting a change in bank details. The public body sought explanation for the change in bank details and accepted the explanations given. However, this was done through the fraudulent email account.

Key features

The fraud was identified when the legitimate business reported that the payments had not been received.

The public body have since strengthened procedures for changes to bank account details. This involves a telephone call to the business or customer using the contact details stored centrally, and monthly management checking of payments made.

The case has been reported to Police Scotland.

Misuse of assets

60. An employee misused a council vehicle and the corporate time recording system to obtain benefits worth over £5,200.

Key features

An employee used a council vehicle for personal use during business time, as well as accruing time on the corporate time recoding system that they had not worked.

The fraud was identified following receipt of an anonymous allegation that the employee was using a council vehicle to take their child to and from school.

The fraud was possible due to a lack of review or monitoring of time records.

Steps have since been taken to ensure staff are aware of the requirements of the flexible working hours policy, the time recording guide and any service-specific requirements. Stricter monitoring by service managers of employees' time recording has been put in place and staff have been reminded that fleet vehicles must not be used for personal use.

The employee's actions have been reviewed under the council's disciplinary policy and full recovery is being progressed through salary deductions.

Technical Bulletin 2023/4

Technical developments and emerging risks from September 2023 to December 2023

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NHS in Scotland 2023

AUDITOR GENERAL

Prepared by Audit Scotland
February 2024

Contents

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Audit team

The core audit team consisted of: Leigh Johnston, Martin McLauchlan, Fiona Lees, Naomi Ness and Liam Prior under the direction of Cornilius Chikwama.

Key messages

1 Significant service transformation is required to ensure the financial sustainability of Scotland's health service. Rising demand, operational challenges and increasing costs have added to the financial pressures on the NHS and, without reform, its longer-term affordability.

2 The NHS, and its workforce, is unable to meet the growing demand for health services. Activity in secondary care has increased in the last year but it remains below pre-pandemic levels and is outpaced by growing demand. This pressure is creating operational challenges throughout the whole system and is having a direct impact on patient safety and experience.

3 There are a range of strategies, plans and policies in place for the future delivery of healthcare, but no overall vision. To shift from recovery to reform, the Scottish Government needs to lead on the development of a clear national strategy for health and social care. It should include investment in preventative measures and put patients at the centre of future services. The current absence of an overall vision makes longer-term planning more difficult for NHS boards.

Recommendations

The Scottish Government should:

- develop and publish a national NHS capital investment strategy in 2024, stating how spending is being prioritised and the overall estate is being managed (paragraph 30).
- ensure that the relationship between new financial engagement arrangements and the NHS Scotland Support and Intervention Framework is widely understood by stakeholders ahead of NHS boards preparing and submitting their 2024/25-26/27 financial plans (paragraph 39).
- publish a revised Medium-Term Financial Framework (MTFF) for health and social care, following publication of its wider Medium-Term Financial Strategy (MTFS) in 2024 (paragraph 41).
- confirm which indicator(s) will be used to measure year-on-year reductions in waiting times (paragraph 49).
- publish a National Workforce Strategy update for health and social care that includes guidance on improving staff wellbeing and culture (paragraph 75) and indicative workforce growth projections (paragraph 79) in 2024.
- revisit its NHS Recovery Plan commitments and use its annual progress updates to report clearly and transparently on what progress has been made and whether those commitments, or the targets and delivery timeframes related to them, need to change and why (paragraph 92).
- publish clear and transparent annual progress reports on:
  - the work being undertaken on the reform of services showing the effectiveness and value for money of new innovations and ways of delivering NHS services (paragraph 103)
  - the Care and Wellbeing Portfolio to better show how it is making a difference (paragraph 108).
- work with NHS boards, their staff, partners, and the public to develop a new long-term vision for the wider health system by 2025 that sets out national priorities and recognises the interdependencies in the healthcare system, to enable the necessary reforms that will ensure the future sustainability of health services (paragraph 121).

The Scottish Government and NHS boards should:

- work together to progress the 13 actions set out in the Value Based Health and Care Action Plan, empowering staff to take advantage of innovative opportunities for service reform and transformation and measuring the difference Realistic Medicine is making to outcomes and service sustainability[1] (paragraph 116).
- ensure that the new approach to self-assessment within the revised Blueprint for Good Governance in NHS Scotland is rolled out across all NHS boards in 2024 and that any areas for improvement identified are addressed (paragraph 126).

Introduction

1. The NHS provides a range of vital services to thousands of people, everyday, across Scotland. We publish an annual report on the NHS in Scotland to provide assurance over NHS Scotland's performance and finances and to assess the progress of ongoing reforms.

2. Our NHS in Scotland 2022 report focused on progress against the NHS Recovery Plan 2021–2026 (published in August 2021), as the health system emerged from the Covid-19 pandemic. It highlighted that progress against recovery ambitions had been slow, and that the financial, workforce and demand pressures faced by the NHS presented an ongoing risk to recovery from the pandemic.

3. This report reflects the need for short-, medium- and long-term investment and reform to ensure the future sustainability of the NHS in Scotland. It provides an update on the implementation of longer-term reforms, such as the Sustainability and Value Programme and the Care and Wellbeing Portfolio approach, alongside reporting on how recovery has progressed.

4. This includes an increased focus on funding and financial performance, position and sustainability compared to our recent reports; analysis of service performance and patient safety; and progress on wider reforms aimed to ensure services are sustainable into the future. We outline our audit methodology in Appendix 1, provide more detailed board level performance data in Appendix 2 and comment on the progress made against the recommendations from our NHS in Scotland 2022 report in Appendix 3.

To note:

5. When reporting on funding and finances, we refer to changes in real terms in this report. This means that we are showing financial information for past and future years at 2022/23 prices, adjusted for inflation so that they are comparable. To adjust for inflation we use gross domestic product (GDP) deflators, which are published quarterly by HM Treasury. GDP deflators are the standard approach adopted by both the UK Government and Scottish Government when analysing public expenditure. As a result of the way that GDP is calculated, Covid-19 resulted in volatility across 2020/21 and 2021/22. To compensate for this, and to provide meaningful comparisons between years, we have used an average GDP growth rate for 2020/21 and 2021/22 in our calculations to separate inflation (increases in prices) from changes in outputs and those largely attributable to Covid-19 spending.

1. Financial performance and outlook

The NHS in Scotland faces medium-term financial challenges that highlight the need for service reform

Health funding has been increasing in real terms, and is projected to take up an increasing share of the Scottish Government's budget

6. The Scottish Government manages health spending as part of its overall budget process. Health remains the single largest area of Scottish Government spending, accounting for 39 per cent of the budget in 2022/23. Between 2013/14 and 2022/23, direct health spending has increased by 21 per cent in real terms. The Scottish Government health budget in 2022/23 was £17.8 billion. Most health funding is provided to territorial boards to deliver services (Exhibit 1, page 8).

7. NHS boards delegate a significant proportion of their budget to **Integration Authorities (IAs)** to fund health services such as primary and community care. In 2022/23, territorial boards delegated £7.2 billion directly to IAs, 49 per cent of their budgets. In turn, NHS boards received £7.5 billion back to provide services on behalf of IAs. Alongside these payments NHS boards also transferred £0.7 billion on behalf of themselves and IAs directly to councils. The Accounts Commission produces an annual report on the finances and performance of Integration Joint Boards (IJBs), next due for publication in June 2024.

8. The Scottish Government received significant Covid-19 related funding linked to increased UK Government spending in both 2020/21 and 2021/22. A total of £2.9 billion (2020/21) and £2.6 billion (2021/22) of this funding was used to support health and social care. From 2022/23 onwards, however, any spending related to Covid-19 was expected to be funded from the Scottish budget rather than from specific funding allocations and be managed as part of NHS boards' annual budget-setting processes. This resulted in a real-terms decrease in health spending between 2021/22 and 2022/23, reflecting the reduction in Covid-19 related funding (Exhibit 2, page 9).

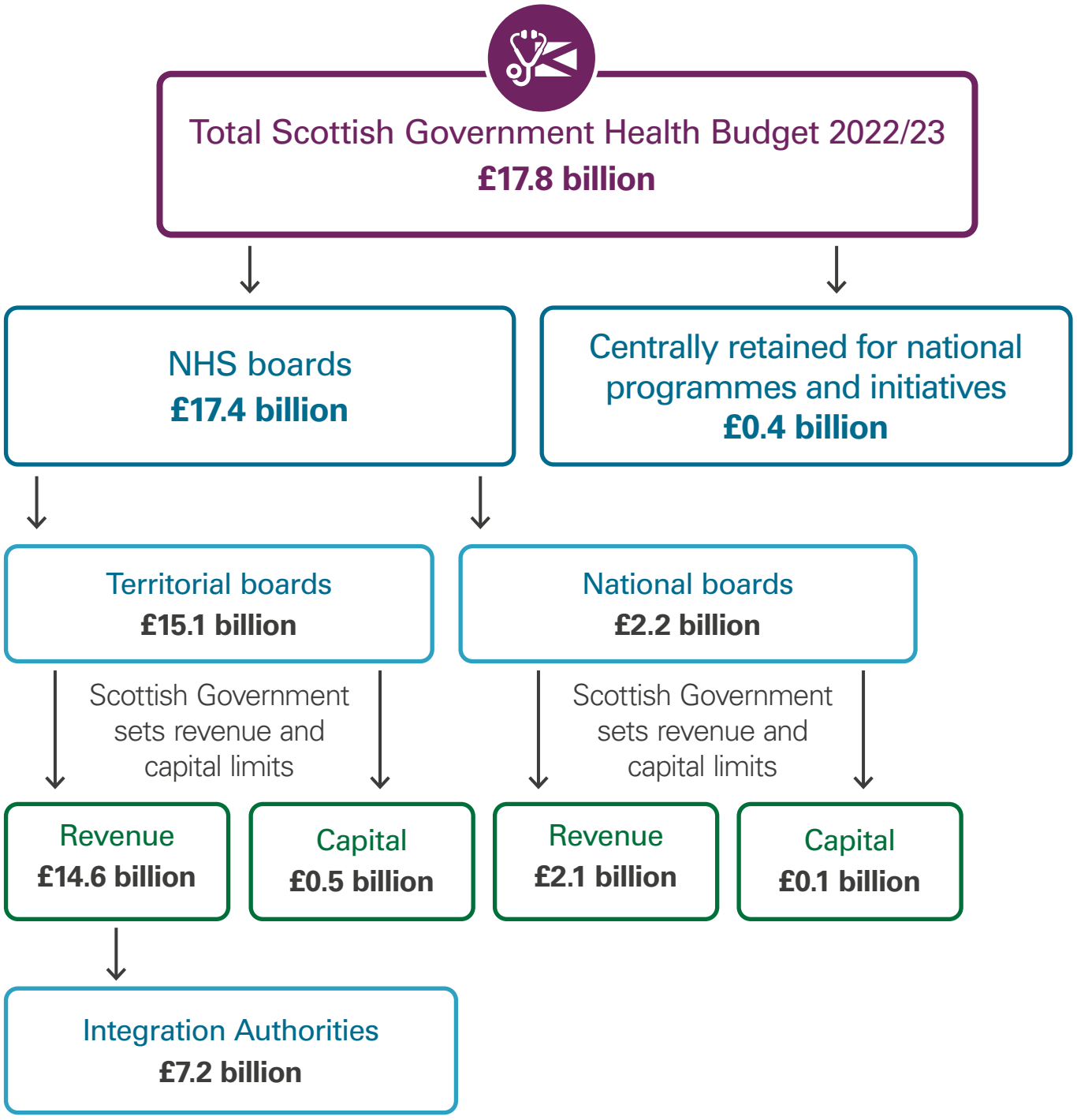
9. The overall health and social care budget for 2023/24 was set at £19.1 billion, representing over one-third of the total Scottish budget and 38 per cent of the discretionary budget, although in-year changes reduced this to £18.9 billion.[2] This means, in real terms, there was a small annual reduction in the health budget of 0.2 per cent. However, this relates mainly to increases in the annual transfers of social care funding to the local government portfolio to support social care and mental health service delivery.

Integration Authorities

The Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) requires councils and territorial NHS boards to work together in partnerships, known as Integration Authorities (IAs).

As part of the Act, new bodies were created – Integration Joint Boards (IJBs). The IJB is a separate legal entity, responsible for the strategic planning and commissioning of the wide range of health and social care services across a partnership area. Of the 31 IAs in Scotland, 30 are IJBs and one area, Highland, follows a Lead Agency model.

Exhibit 1.
Scottish Government health funding in 2022/23



Note: Figures may not balance due to rounding.

Source: Scottish Government Budget documents and NHS boards' audited accounts

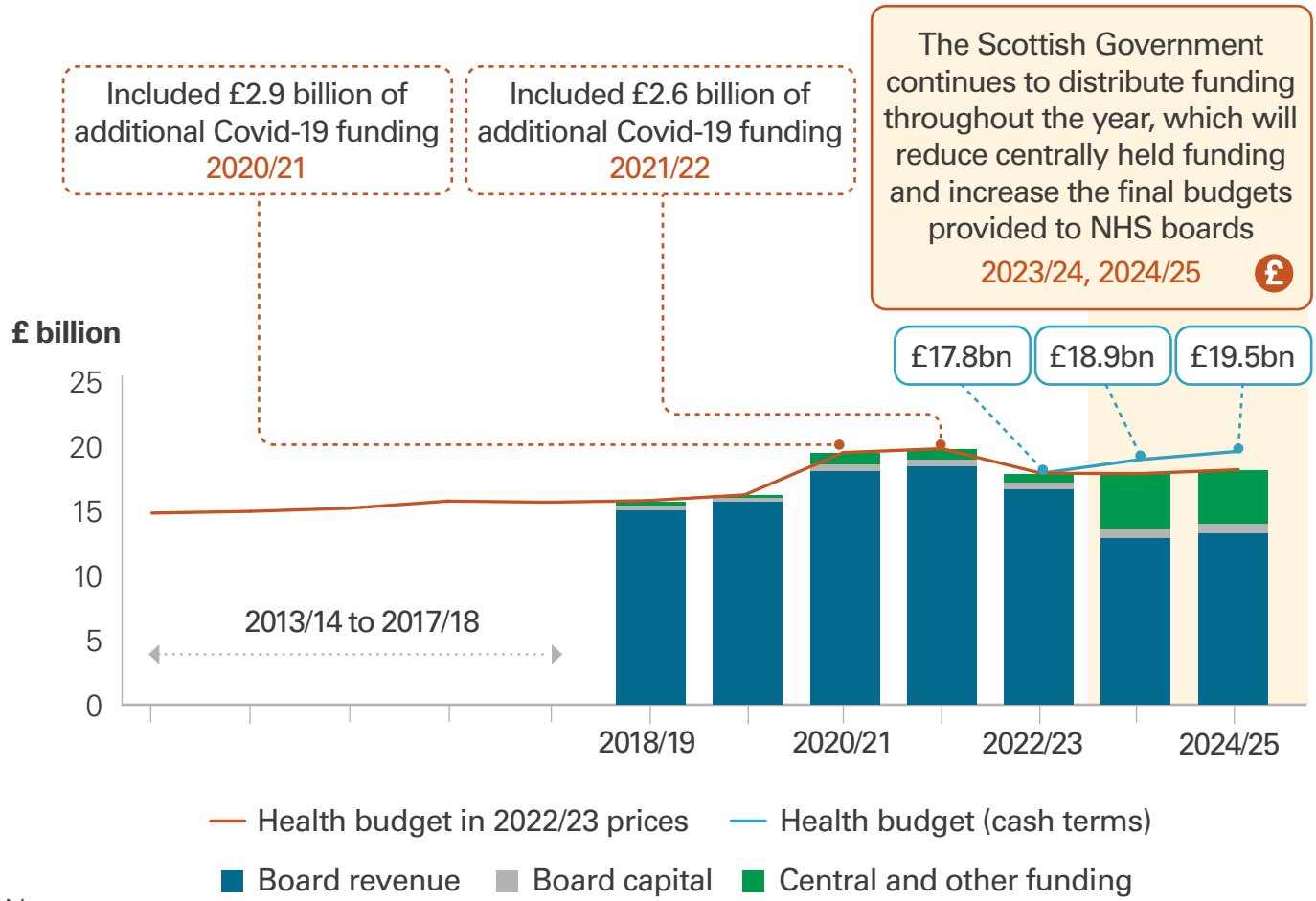
10. In its Medium-Term Financial Strategy (May 2023), the Scottish Government reflected the Scottish Fiscal Commission's projections that health spending will grow faster than that of other public services.[3], [4] The growth in health spending up until 2027/28 was, however, one reason that the Scottish Government forecast that its budget would potentially not be enough to meet its spending commitments. This highlights the challenge of meeting healthcare costs in the medium term.

11. The Scottish Government published its 2024/25 budget plans in December 2023, with the health budget of £19.5 billion representing a real-terms annual increase of 1.7 per cent and reflecting the longer-term trend of real-terms increases in health spending. The Scottish Government published a single-year budget but has indicated that it intends to provide further public sector-wide spending plans in 2024, including a refreshed Medium-Term Financial Strategy, Resource and Capital Spending Reviews and an Infrastructure Investment Plan.

Exhibit 2.

The health budget has been increasing in real terms since 2013/14

Specific funding was given to support the response to Covid-19, and funding is now increasing again annually.



Notes:

1. The total health budget reflects the position from relevant Scottish Government budget documentation as at December 2023. From 2022/23 it is shown in both cash and real terms, but all other figures have been adjusted to 2022/23 prices.
2. Board allocations reflect the final allocations to NHS boards up to 2022/23 and assume all capital funding distributed to boards from 2023/24 onwards.
3. Central funding represents the difference between the health budget and direct board allocations and, from 2023/24 onwards, funds distributed in-year. It also includes some technical elements of the Scottish Budget and so differs from the 'Centrally retained' funding in Exhibit 1.

Source: Audit Scotland analysis of Scottish Government budget documentation and NHS boards' audited annual accounts

The Scottish Government has made progress in moving boards towards receiving their calculated share of the health budget

12. The Scottish Government uses a formula developed by the NHS Scotland Resource Allocation Committee (NRAC) to assess how much funding each of Scotland's 14 territorial NHS boards should be allocated. NRAC funding covers hospital and community health services and GP prescribing. It considers many factors that influence the need for, and cost of, providing healthcare such as population size, deprivation levels and geographical differences.

13. The Scottish Government currently adjusts NRAC allocations to reflect specific need and ensure stability of funding, with some boards receiving more than their formula allocation (and others less). The Scottish Government committed to moving all boards closer to receiving their NRAC calculated share of funding, known as parity, by gradually increasing all annual resource allocations to boards in real terms, but giving those boards receiving above target allocations smaller relative increases.[5]

14. Following the extraordinary measures taken throughout the Covid-19 pandemic, including suspending medium-term planning arrangements and using Covid-19-specific funding to ensure that boards were fully funded, moving towards parity has resumed in 2023/24. Currently no board is more than 0.6 per cent below parity (compared to 0.8 per cent in 2018/19).[6] The Scottish Government has committed to reviewing the NRAC formula and this work is currently ongoing.

All boards met financial break-even requirements in 2022/23, but over one-third of territorial boards needed financial support to do so

15. In 2020/21 and 2021/22, the Scottish Government provided non-repayable financial support to ensure all NHS boards delivered financial balance due to the exceptional financial challenges related to responding to the Covid-19 pandemic. From 2022/23, however, boards were again expected to operate within their financial targets. They can also make use of limited financial flexibilities, allowing them to operate within one per cent of their **core revenue budget**, offsetting any annual overspend over the next two years ('three-year break-even').

16. All 22 NHS boards met their break-even requirements in 2022/23, but this was achieved only after five territorial boards received additional funding from the Scottish Government, and one made use of the three-year flexibility:

- NHS Ayrshire and Arran (£25.4 million), NHS Borders (£11.7 million), NHS Dumfries and Galloway (£9.3 million), NHS Fife (£9.7 million) and NHS Highland (£16.0 million) all received additional financial support (brokerage).

Core revenue budget

NHS boards receive budget limits from the Scottish Government. These are referred to as the revenue resource limit (RRL) and capital resource limit (CRL).

Core revenue budgets are those spent on delivering services, for example to pay staff and buy medicines.

Core capital budgets are spent on building and maintaining the NHS estate or investing in new medical equipment.

Non-core budgets are for technical accounting adjustments, for example depreciation.

- NHS Tayside made use of the three-year flexibility to allow it to spend an additional £9.6 million in 2022/23.

From 2022/23, additional funding will again be repayable. The Scottish Government will set repayment terms only once these boards have returned to a break-even position.

Seven boards failed to make planned savings in 2022/23 and the NHS remains reliant on one-off savings

17. In 2022/23, NHS boards were once again required to produce three-year financial plans. Boards had to prepare to manage the end of Covid-19-specific funding streams despite some associated costs continuing. The three-year plans submitted to the Scottish Government in 2022 indicated that, in 2022/23, three of the 14 territorial boards and seven of the eight national boards expected to break even, subject to achieving £620.6 million of savings.

18. The final health budget undergoes significant in-year changes due to a number of factors. In-year funding allocations to boards, alongside additional support and flexibilities, reduced the 2022/23 required savings to around £464 million, with boards collectively achieving £441 million of this target. Notably, however, two-thirds of the savings delivered were one-off, non-recurring measures which will not contribute to efficiencies on an ongoing basis.

19. For 2023/24, the Scottish Government has set an NHS-wide target for boards to deliver recurring annual savings equivalent to three per cent of their **baseline RRL**. While boards did deliver savings equivalent to three per cent of the baseline RRL in 2022/23, two-thirds of savings were non-recurring in nature and seven boards failed to achieve their own revised savings targets. The level of savings, both in value and the reliance on one-off, non-recurring savings, was in line with historical (pre-Covid) savings delivered (Exhibit 3, page 12).

Even if ambitious future savings targets are achieved, boards are likely to require further financial support

20. The savings identified in the 2023/24 three-year financial plans will not be sufficient to allow boards to break even. At the beginning of 2023/24 only 62 per cent of required savings had been identified, with a further 20 per cent to be drawn from identified potential savings and 18 per cent remaining unidentified. Even if savings in excess of those delivered in recent years are achieved, and savings are delivered as per the plans, it was forecast that annual deficits in excess of £0.5 billion would still require to be addressed by 2025/26 (Exhibit 4, page 13).

Baseline RRL

Boards' revenue budgets are further split into recurring funding that will be received every year, and specific funding.

This allows boards to identify their 'baseline' revenue funding, which is the funding they can be certain they will receive in future years to meet day-to-day spending.

The Scottish Government and NHS boards can then use this baseline budget as part of their medium-term financial planning, including the savings they may need to make.

Exhibit 3.

Historically boards have found it difficult to deliver planned savings and have often relied on non-recurring measures, as in 2022/23

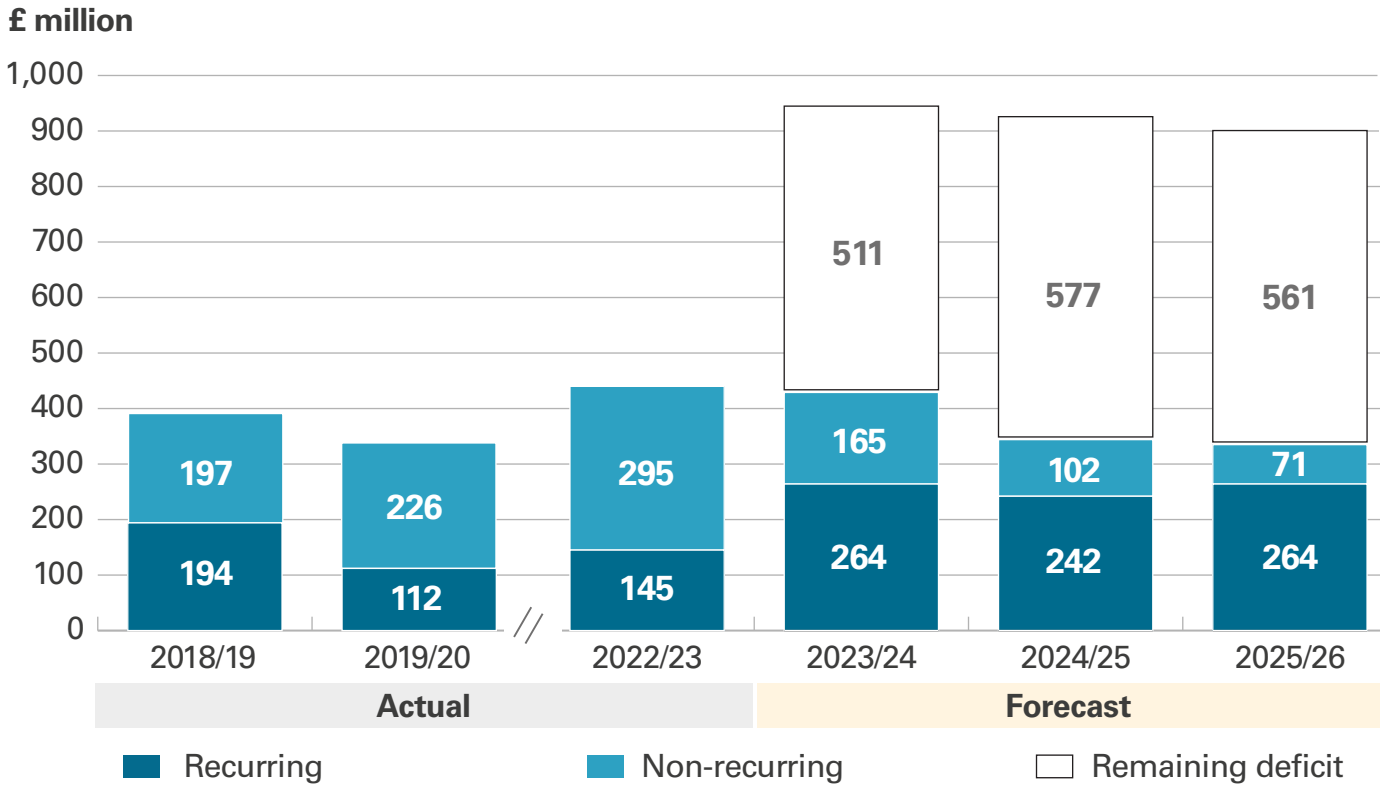
NHS Board	Savings made (£ million)			Savings target (£ million)	Savings made as a percentage of baseline RRL (%)
	Recurring	Non-recurring	Total		
NHS Scotland	**145.5**	**295.5**	**441.0**	**464.0** ✗	**3.5**
NHS Ayrshire & Arran	6.5	4.8	11.3	16.7 ✗	1.4
NHS Borders	2.4	7.6	10.0	11.5 ✗	4.3
NHS Dumfries & Galloway	2.2	21.3	23.5	23.5 ✓	7.0
NHS Fife	3.0	6.8	9.8	11.7 ✗	1.3
NHS Forth Valley	9.0	20.3	29.3	29.3 ✓	4.9
NHS Grampian	2.5	7.7	10.2	5.4 ✓	1.0
NHS Greater Glasgow & Clyde	54.8	119.7	174.5	174.5 ✓	7.0
NHS Highland	3.0	7.0	10.0	26.0 ✗	1.4
NHS Lanarkshire	9.5	45.0	54.5	54.5 ✓	4.0
NHS Lothian	14.7	9.1	23.8	25.9 ✗	1.5
NHS Orkney	0.9	2.4	3.2	4.9 ✗	5.7
NHS Shetland	1.2	2.9	4.1	3.1 ✓	7.2
NHS Tayside	4.4	19.0	23.4	23.4 ✓	2.7
NHS Western Isles	2.2	1.8	4.0	4.0 ✓	4.8
NHS 24	1.3	1.4	2.6	2.6 ✓	3.2
NHS Education for Scotland	0.0	2.8	2.8	2.8 ✓	0.6
NHS Golden Jubilee	1.0	2.0	3.0	4.6 ✗	4.3
NHS National Services Scotland	14.7	3.1	17.8	16.8 ✓	4.8
Healthcare Improvement Scotland	0.4	0.0	0.4	0.0 ✓	1.2
Public Health Scotland	4.3	0.3	4.6	4.6 ✓	8.7
Scottish Ambulance Service	7.5	9.9	17.4	17.4 ✓	5.5
The State Hospital	0.0	0.8	0.8	0.8 ✓	2.1

✓ Savings target met ✗ Savings target not met

Source: Audit Scotland analysis of NHS audited information

Exhibit 4.

Even if savings are delivered as planned over the next three years, significant forecast deficits remain to be addressed



Notes:
1. 2020/21 and 2021/22 are excluded due to operational pressures and funding arrangements related to Covid-19. 2022/23 totals differ between Exhibits 3 and 4 by £1 million due to rounding.
2. Savings achieved in 2022/23 were equivalent to 3.5 per cent and planned savings in 2023/24 are equivalent to 3.2 per cent of baseline RRLs. Planned savings in 2024/25 and 2025/26 are around 2 per cent of forecast annual Core RRLs. Remaining deficit is against forecast Core RRLs.
3. Figures for 2023/24 onwards have not been adjusted by Audit Scotland as they were adjusted by boards when preparing their financial plans.

Source: Audit Scotland analysis of NHS audited information and the Scottish Government's summary of NHS board three-year financial plans submitted to them in summer 2023

21. A total of £200 million was provided to boards over the summer of 2023 in in-year adjustments, including money for new medicines funding, movement towards NRAC parity and to address issues of financial sustainability. The latest assessment, made at the mid-point of 2023/24, is that this additional funding has now reduced the forecast 2023/24 deficit to around £400 million but the level of savings achieved by NHS boards is behind schedule.

NHS boards faced significant cost pressures in 2022/23, with staff and prescribing costs increasing alongside inflation

22. Direct responses to Covid-19 within the healthcare environment, the pandemic-related healthcare backlog, and wider societal and behavioural changes have altered how health services are delivered. In 2022/23, boards had to manage the end of Covid-19-specific funding streams, although some associated costs continued. At the same time, general inflationary pressures, increasing utility prices and higher than expected pay deals have increased significant areas of NHS spending. For example, the costs associated with primary and secondary prescribing rose, in real terms, with increases in unit costs. These external factors have resulted in increased volatility as boards have tried to plan in the medium term (Exhibit 5, page 15).

Staffing remains the most significant cost for NHS boards and will continue to increase

23. Staff costs across the NHS increased again in 2022/23, both in real terms and as a proportion of overall NHS spending, to £9.8 billion. Commitments around pay, and terms and conditions, play an important role in the recruitment and retention of staff. Staff costs are subject to annual increases but will also rise because of recruitment ambitions to increase the number of NHS employees, including nurses and doctors There is an ongoing commitment to no compulsory redundancies for NHS staff.

24. Recently agreed pay deals, reflecting higher than expected inflation, resulted in significant wage increases across the public sector. For example, junior doctors in Scotland agreed to a 4.5 per cent wage deal in 2022/23, with an average increase of 12.4 per cent agreed for 2023/24. Similarly, NHS workers subject to the Agenda for Change agreement (which includes nurses, midwives, paramedics and others) agreed an average 7.5 per cent increase in pay in 2022/23, with a further 6.5 per cent average increase in 2023/24.

25. The National Workforce Strategy for Health and Social Care in Scotland (March 2022)[7] committed to increasing the NHS workforce over the next five years by one per cent (1,800 Whole Time Equivalent (WTE)) to ensure there is sufficient workforce capacity, but this does not take into account any reduction in WTE hours. Forthcoming changes such as the intention to move staff, including nurses, to a 35-hour working week will mean more WTE staff being needed to meet staffing requirements and provide the same number of working hours.

Exhibit 5.

Boards faced significant cost pressures in 2022/23 and these pressures are likely to continue

	Change since last year[1]	Change from five years ago[1]
Net expenditure **£17.0 billion**	↓ **-6.0%**	↑ **13.6%**
Staff costs **£9.8 billion**	↑ **0.4%**	↑ **23.5%**
Medical and dental staff £2.3 billion	Nursing and midwifery £3.7 billion	Other staff, including AHPs £3.8 billion
Agency staff costs[2] **£381.8 million** (3.9% of total staff costs)	↑ **27.5%**	↑ **97.2%**
Including medical agency[3] £119.6 million (+10% since last year)	Including nursing agency[3] £169.7 million (+79% since last year)	Cost of using the nursing bank[4] £277.7 million (+12% since last year)
Prescribed drugs costs **£2.1 billion**	↑ **0.6%**	↑ **3.7%**
In primary care: £1.1 billion	↑ **0.5%**	↓ **-5.4%**
In secondary care: £979.9 million	↑ **0.7%**	↑ **16.9%**
Capital and estate costs Expenditure: **£528.5 million**	↓ **-3.1%**	↑ **38.7%**
Backlog maintenance of **£1.1 billion** at the end of 2022 Energy costs: **+21%** in a year Cleaning costs: **+28%** in a year		

Cont.

	Change since last year[1]	Change from five years ago[1]
Clinical negligence and other risks indemnity scheme (CNORIS)		
Set aside to manage future potential clinical negligence payments: £804.2 million	↑ 3.5%	↑ 11.5%

Notes:
1. All changes are in real terms.
2. Agency staff costs (£381.8 million) are as reported in NHS staff and remuneration reports. This includes all agency and directly engaged staff, for example those on temporary contracts, and not just medical and nursing agency staff.
3. Medical agency (£119.6 million) and nursing agency (£169.7 million) costs are included in this overall figure and are published separately by NES.
4. Costs related to the use of the nursing bank are not included within agency costs, or separately disclosed in NHS board accounts, but are published by NES.

Source: Audit Scotland analysis of NHS boards' 2022/23 audited accounts, Scottish Government management information and NES Workforce statistics

26. Total agency staff costs continued to rise in 2022/23, increasing by over 25 per cent overall, and with a significant annual increase in spending on agency nurses (79 per cent). Increases in spending on agency staff, however, pre-date this and, at the same time, use of nursing bank staff has also been increasing. Boards spent £278 million on nursing bank staff in 2022/23, an annual real-terms increase of 12 per cent and 50 per cent since 2018/19.[8] In 2023, the Scottish Government removed flexibilities on the use of agency staffing which it had introduced during the Covid-19 pandemic, with the impact of this likely to be shown in 2023/24 NHS spending. Nonetheless, agency and bank staffing is likely to remain a significant cost while vacancies are filled on a permanent basis (paragraph 71).

Capital funding will not be sufficient to deliver new healthcare facilities and also maintain the current estate

27. The capital budget available to NHS boards has been increasing in recent years, but this has largely been committed to pay for specific new building projects, including the development of the National Treatment Centres (NTCs). Hospitals represent 60 per cent of the total estate, and investment in recent years has resulted in a newer estate. Around 70 per cent of the estate is in good condition and used efficiently.[9]

28. Future capital funding available, however, is likely to be constrained. The Scottish Government's overall capital funding now includes ring-fenced funding for research and development. The funding that can be spent on equipment, new buildings and maintenance is therefore unlikely to keep pace with increasing costs and existing commitments related to delivering the NTCs. While this will impact wider investment in new buildings, it also means that the funding available for maintaining the current estate is unlikely to be sufficient (Case study 1).

Case study 1.
National Treatment Centres

In the NHS Scotland Recovery Plan 2021-2026, the Scottish Government announced plans for a network of National Treatment Centres (NTCs). These were expected to contribute to the overall ambition of delivering 55,000 additional inpatient and day case procedures by 2025/26 (NTC's delivering 40,000 of these) and involve significant recruitment (1,500 NTC-based staff).

Initially, nine NTCs were announced, to be completed by 2026 at an estimated cost of £400 million, including the second phase of development at the Golden Jubilee Hospital. The programme was then extended to include the redevelopment of the Princess Alexandria Eye Pavilion, bringing the total number of NTCs to 10, with costs revised to £600 million.

Currently, only three NTCs are operational (Golden Jubilee Phase 1, NHS Fife and NHS Highland), with Golden Jubilee Phase 2 and the NTC located in NHS Forth Valley now due to open in 2024.

The NTC located in NHS Ayrshire and Arran was scheduled to open as planned in 2025, but delays and slippage across the programme meant the remaining five NTCs would not be delivered until 2027, impacting their contribution to the 2025/26 activity targets. Due to global supply chain issues and construction inflation, the cost of building the remaining NTCs has also been significantly revised. The latest estimates available indicated that the first four NTCs have cost around £190 million to build, and that the cost of building five of the six remaining NTCs would be £730 million (not including the NTC based in NHS Lanarkshire).

Following the 2024/25 budget in December 2023, the Scottish Government indicated that all major projects in construction will be completed, including Phase 2 of the Golden Jubilee, but that NHS boards should pause the development of any projects that have not yet passed certain development milestones. This includes the remaining six NTCs.

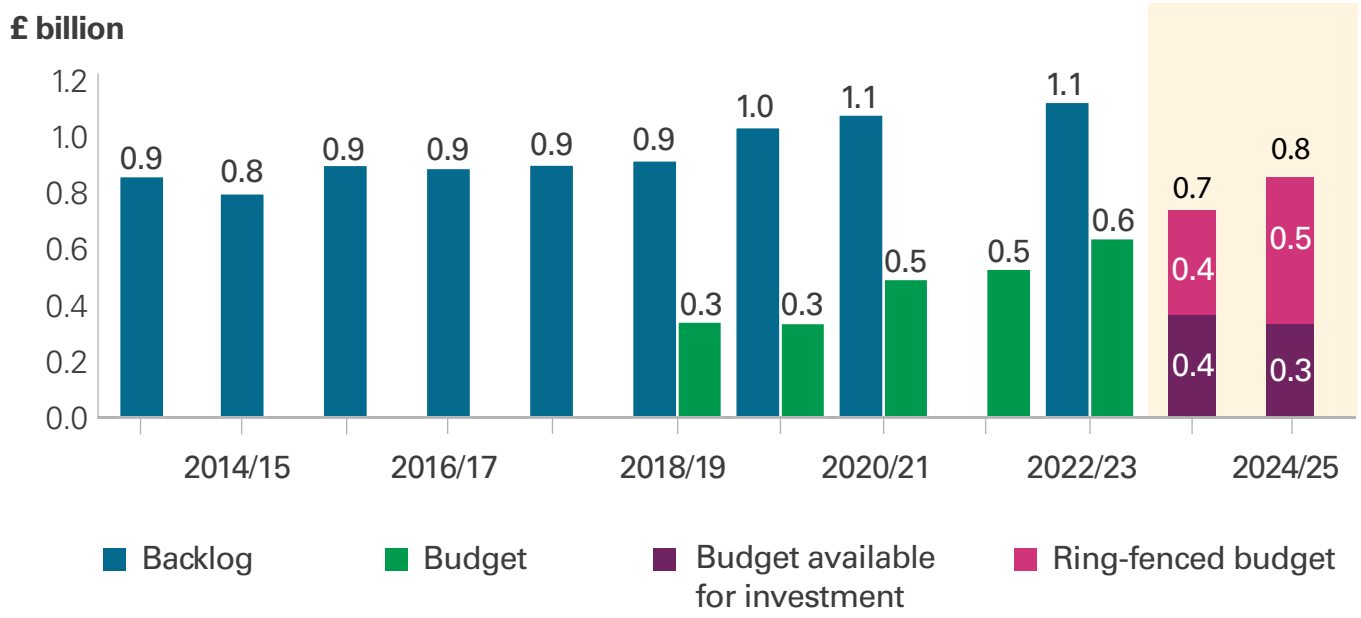
Source: Audit Scotland

29. There is already a significant backlog of maintenance required across the NHS estate, with the identified backlog now exceeding £1.1 billion (Exhibit 6). As capital budgets available for new buildings and maintenance decrease, it is not clear how boards will address both routine and backlog maintenance requirements as the existing estate ages.

30. In our recent briefing Investing in Scotland's Infrastructure, we set out the challenges the Scottish Government faces as it looks to manage a decreasing capital budget while meeting its infrastructure investment ambitions. Deployment of limited health capital funding will require clear strategic oversight of the national estate, alongside transparency about how projects are being prioritised, and coordinated action to address the maintenance backlog. A national NHS capital investment strategy, drawing upon current information about the state of the estate and up-to-date cost projections for new building projects, would help to ensure that the existing estate can be maintained and reshaped to meet future clinical needs.

Exhibit 6.

The maintenance backlog across the NHS estate now exceeds £1.1 billion, almost double the total 2022/23 capital budget and three times the future budgets that can be spent to address it



Notes:
1. Work to assess the value of maintenance required was not undertaken in 2021.
2. Figures may not total due to rounding.

Source: Audit Scotland analysis of Scottish Government budget documentation and management information related to backlog maintenance

Currently, Reinforced Autoclaved Aerated Concrete (RAAC) across the NHS estate is unlikely to require significant spending in the short term

31. RAAC represents a risk to the public sector estate and, under certain circumstances, requires immediate remedial work to be undertaken. Initially, a desktop survey was completed by NHS boards to assess which properties may contain RAAC. Across 11 territorial boards, 254 properties were identified as having a high or medium likelihood of containing RAAC. Information about these properties was published on relevant board websites and on the NHS Scotland Assure website. NHS Scotland Assure then led a national programme of physical surveys of these properties to assess the presence of RAAC across the NHS estate in Scotland, concluding this work in November 2023.

32. Of the buildings physically surveyed, RAAC was identified as being present in 32. This resulted in the planned closure of one building being brought forward, and remedial work being undertaken at another. No urgent remedial work was required at the other 30, with ongoing monitoring deemed appropriate. This has limited the immediate potential demand on the capital budget that widespread remedial work would have necessitated.

33. Since the initial survey work was undertaken, a further 150 buildings have been identified or reclassified as having a potentially medium or high likelihood of containing RAAC. The programme of physical survey work has been extended to these sites and is expected to conclude in March 2024, prior to physical surveys then being carried out on those properties identified as having a low likelihood of RAAC being present.

Recognising the scale of the overall financial challenge the Scottish Government has put in place a range of support for boards

34. The Scottish Government has now established the Financial Improvement Group (FIG) to monitor and support boards in delivering their planned savings and wider elements of financial planning. Made up of senior stakeholders from across NHS boards and the Scottish Government, the FIG meets monthly to support boards and Health and Social Care Partnerships (HSCPs)/Integration Joint Boards (IJBs) to work towards achieving financial balance, supporting the wider Sustainability and Value Programme (paragraph 98).

35. Boards continue to develop their own financial plans but, on submission to the Scottish Government, these are reviewed by the FIG which gives its opinion on the level of detail and assurance provided. In 2023, a small number of boards were asked to resubmit their financial plans following this initial review (Exhibit 7, page 21).

36. The Scottish Government has now established a central Financial Delivery Unit (FDU). The FDU is aiming to support the delivery of board savings at a more operational level, assisting boards in identifying savings and supporting their delivery by issuing detailed guidance on how individual boards made specific savings so that others can look to implement the same measures.

There is a need for greater clarity about Scottish Government monitoring and support as financial challenges become more widespread

37. Alongside the work of the FIG and FDU, the Scottish Government has introduced new financial support and engagement arrangements for 2023/24 to help individual boards address the financial challenges they are facing. NHS boards have been categorised into three engagement groups: Tailored Support; Enhanced Monitoring and Quarterly Engagement. Those in the first two categories received specific support to develop current financial plans aimed at improving the underlying financial health of the board.

38. Where NHS boards are not delivering effective performance against agreed outcomes or appropriate governance, or are facing significant financial challenges, boards may be subject to additional scrutiny and support through the **NHS Scotland Support and Intervention Framework** (the framework).[10] The Scottish Government's National Planning and Performance Oversight Group (NPPOG) considers both performance and finances when deciding where to place a board on the framework, which consists of five levels. Each increase in the level assigned corresponds to increased formal monitoring and intervention from the Scottish Government. Six NHS boards are currently escalated to stage three or above on the framework (Exhibit 7, page 21).

39. Historically, where a board required additional financial support (brokerage), or was forecasting significant deficits, they would have been escalated up the framework. Escalation on the framework was paused at the end of March 2020 to enable all boards to focus on ensuring an effective response to the pandemic. Due to systemic financial pressures emerging across boards in the medium term there is a need for greater clarity around the level of support offered to boards. This includes clearly communicating how decisions are made about boards being assigned to an engagement level; how boards can move to a lower engagement level; and the relationship between financial support categories and placement on the more formal framework. The Scottish Government needs to clarify the plans for future escalation on financial grounds and ensure that the placement of boards on the framework, and what this means, is communicated and understood.

NHS Scotland Support and Intervention Framework

Stage 1 – steady state: NHS boards are delivering in line with agreed plans. Normal reporting arrangements in place.

Stage 2 – enhanced monitoring: Some variation from agreed plan(s), possible delivery risk if no remedial action is taken.

Stage 3 – enhanced monitoring and support: Significant variation from plan, risks materialising, Scottish Government commissioned tailored support package is required.

Stage 4 – senior external support and monitoring: Significant risks to delivery and tailored support is not producing the required improvements. Senior level external support required.

Stage 5 – statutory intervention: The level of risk and organisational dysfunction is so significant that the NHS Board requires direct intervention using statutory powers of direction.

Exhibit 7.
Scottish Government financial support arrangements 2023/24

Scottish Government engagement	Criteria	NHS boards	Current framework level	Financial support sought in 2022/23
Tailored support	• Financial forecast deficit position significant deviation from average position. • Appropriate Scottish Government support to develop and implement financial recovery plan.	NHS Borders	**3** (financial)	**£11.7 million** brokerage
		NHS Dumfries and Galloway	**2**	**£9.3 million** brokerage
		NHS Highland	**3** (financial and non-financial)	**£16.0 million** brokerage
		NHS Ayrshire and Arran	**3** (financial)	**£25.4 million** brokerage
		NHS Orkney	**3** (financial)	
Enhanced monitoring	• Financial plan requires to be resubmitted, either due to financial position or significant weaknesses identified in plan. • Specific actions set for board to complete to address issues. This may be supported potentially with less formal Scottish Government support. • Regular engagement with board to ensure delivery of these actions.	NHS Fife	**2**	**£9.7 million** brokerage
		NHS Tayside	**3** (non-financial)	**£9.6 million** flexibility
		NHS Grampian	**2**	
		NHS Shetland	**1**	
		Scottish Ambulance Service		

Cont.

Scottish Government Engagement	Criteria	NHS Boards	Current framework level	Financial support sought in 2022/23
Quarterly engagement	• Board to be subject to regular monthly monitoring and quarterly review. • Board expected to continue to participate with national forums to share good practice and learning with other boards.	NHS Forth Valley	4 (non-financial)	
		NHS Greater Glasgow and Clyde	1	
		NHS Lanarkshire	1	
		NHS Lothian	1	
		NHS Western Isles	1	
		All other National Boards		

Note: The framework applies to NHS territorial boards only. National boards are covered by separate arrangements.

Source: Scottish Government

Boards require greater certainty to appropriately plan for the medium term

40. Boards submitted financial plans for the period 2023/24 to 2025/26 to the Scottish Government in the summer of 2023, after the preparation of the 2023/24 Annual Delivery Plans (ADPs) and three-year Medium Term Plans (MTPs). Financial plans made assumptions relating to allocation uplifts, inflation, pay and prescribing cost growth as well as ongoing Covid-19 costs and targeted efficiency savings. Boards prepared and submitted these plans in the absence of a revised MTFF. Auditors at a number of boards recommended that detailed scenario planning be included in future financial plans and reporting submitted in public to boards, as well as in quarterly forecasting to the Scottish Government.

41. The 2018 MTFF aimed to provide a clear indication of future financial scenarios for health and social care over the medium term, it being aligned to the Scottish Government's own wider MTFS. In our NHS in Scotland 2022 report, we recommended that the Scottish Government publish a revised MTFF as soon as possible after the May 2023 MTFS was published. This is still required, which the Scottish Government recognises and has stated its aim is to publish a revised MTFF in spring 2024. This is needed alongside the better alignment between the annual activity planning cycle that the Scottish Government has introduced for 2024/25. NHS boards are now required to develop their existing MTPs and produce three-year delivery plans for submission, alongside their three-year financial plans (paragraph 97).

2. Operational performance and recovery

The NHS in Scotland is still struggling to recover following the Covid-19 pandemic, and increasing demand is adding to capacity issues

42. In addition to the financial pressures the NHS is facing, described in Part 1, its operational performance and recovery continues to be challenged by a range of other systemic issues. Even before the Covid-19 pandemic, NHS boards were finding it difficult to consistently meet waiting times standards, particularly for planned care.

The NHS in Scotland is still struggling to provide healthcare in a timely way; most waiting times standards are not being met

43. Performance against national waiting times standards shows that the NHS in Scotland is still struggling to provide healthcare in a timely way for many patients. Only three out of eight key waiting times standards have been met at a national level in any quarter in the last five years (Exhibit 8, page 24). Between July and September 2023, only one out of eight key waiting times standards was met at NHS Scotland level. When the latest quarter is compared with the equivalent quarter a year ago, performance has improved against four standards, but has deteriorated in the other four. Performance against each standard varies among boards. (Webpage table)

44. Although waiting times standards are an official measure of performance, they do not provide a comprehensive picture of post-pandemic service performance or recovery. Performance against the standards continues to be influenced by the backlog of care that built up during the pandemic, efforts to reduce the number of long waits for planned care, the availability of staff and hospital beds, and other factors that affect activity and capacity.[11]

45. There are no current plans to change the waiting times standards; the Scottish Government and NHS boards still aim to reduce waiting times and meet the standards in the future. They have agreed interim targets and trajectories to help monitor performance as services recover from the pandemic. The Scottish Government has recently reviewed and updated official guidance on planned care waiting times, reflecting newer working practices.[12] This includes how appointments at NTCs should be managed and the waiting list improvement work led by the national Centre for Sustainable Delivery (CfSD).

Exhibit 8.

Performance against key waiting times standards, September 2018 to September 2023

Only one out of eight key waiting times standards is currently being met in NHS Scotland.

Waiting times standard (target)	Quarterly trend (quarter ending) September 2018 – September 2023	Change in latest year (percentage points)
People referred to **CAMHS**[1] should start treatment within 18 weeks (90%)	69.0% → 75.6%	7.7 ↑
People referred for help with **drug and alcohol** use should receive treatment within 3 weeks (90%)[2]	93.9% → 92.3%	2.3 ↑
People attending **A&E** should be admitted, discharged or transferred for treatment within 4 hours (95%)	92.0% → 71.3%	1.8 ↑
People referred urgently with a suspicion of **cancer** should begin treatment within **62 days** (95%)[3]	81.4% → 72.0%	-3.1 ↓
People diagnosed with **cancer** should begin treatment within **31 days** of the decision to treat (95%)[3]	95.2% → 94.9%	0.5 ↑
People referred for a **new outpatient** appointment should be seen within 12 weeks (95%)	75.7% → 63.4%	-4.4 ↓
People should begin **inpatient/day** case treatment within 12 weeks of the decision to treat (100%)	73.6% → 56.1%	-0.4 ↓
People **referred** for planned care should begin **treatment** within 18 weeks (90%)[4]	82.2% → 68.7%	-3.7 ↓

- - - Target ○ Standard met in latest quarter Sep 2022–Sep 2023

Notes:
1. Child and Adolescent Mental Health Services (CAMHS).
2. Drug and alcohol standard includes community and prison based services only.
3. The cancer waiting times standards do not apply to all referrals/cancers.
4. National trend data for the referral to treatment standard is unavailable for some quarters.

Source: Public Health Scotland

Meeting waiting times standards for cancer remains a priority, but performance against the 62-day standard is poor

46. The Cabinet Secretary for NHS Recovery, Health and Social Care has the objective of showing an improvement in cancer waiting times by April 2024, set by the First Minister as part of the 2023/24 Programme for Government.[13] In our NHS in Scotland 2022 report, we noted that cancer referrals had increased and were higher than pre-pandemic. This growth in referrals has continued in 2023. In the quarter ending 30 September 2023, NHS Scotland was struggling to meet the 31-day standard, with four boards not meeting it. No boards were meeting the 62-day waiting times standard (Exhibit 8, page 24).[14]

Planned care activity has increased in the last year, but so has demand, and so waiting lists continue to grow

47. Waiting lists for planned care are still substantially larger, and waiting times substantially longer, than before the pandemic (Exhibit 9, page 26). The number of new outpatient attendances and inpatient/day case admissions increased in the year to September 2023, but so did demand. Furthermore, activity is still running below pre-pandemic levels, and more cases are being added to waiting lists than are being removed. In the year to September 2023 waiting lists continued to grow, but the rate of growth has slowed for the inpatient/day case waiting list.[15]

48. Although some progress has been made in reducing some of the longest waits, key targets for eradicating long waits have been missed and reducing the number of long waits remains a priority:

- The number of ongoing waits for a new outpatient appointment, where patients have been waiting over a year, increased in the year to September 2023 by 7.2 per cent. This means that the target to eradicate these waits in most specialties by March 2023 was not achieved.
- The number of ongoing waits for inpatient/day case treatment, where patients have been waiting over 18 months, increased in the year to September 2023 by 7.8 per cent. This means that the target to eradicate these waits in most specialties by September 2023 was not achieved.

New commitments on waiting lists and waiting times are unlikely to be met in 2023/24

49. In the 2023/24 Programme for Government, the Scottish Government made commitments to reduce waiting lists and waiting times year on year.[16] Based on current progress, it is unlikely that it will meet these commitments in 2023/24 (Exhibit 9, page 26). The Scottish Government has not stated which indicator it intends to use to measure year-on-year reductions in waiting times, but for 2023/24 the focus is still on eradicating the longest waits.

Exhibit 9.

New outpatient and inpatient/day case waiting list activity, size and waiting times

Planned care activity has increased in the last year, but so has demand, and so waiting lists continue to grow.

	Pre-Covid		Latest year	Change	
New outpatient waiting list activity	**Year to Sep 2019**	**Year to Sep 2022**	**Year to Sep 2023**		**Latest year**
Attendances	1,460,289	1,208,048	1,237,657	↑	**2.5%**
New outpatient[1] ongoing waits and waiting times	**End of Sep 2019**	**End of Sep 2022**	**End of Sep 2023**		**Latest year**
Number of ongoing waits	319,356	475,618	525,654	↑	**10.5%**
Over 12 weeks (standard)	87,365	252,105	302,777	↑	**20.1%**
Over 1 year (long wait target)[2]	3,594	37,353	40,052	↑	**7.2%**
Median ongoing wait (days)[4]	45	93	107	↑	**14 days**
90th percentile ongoing wait (days)[5]	166	332	333	↑	**1 day**
Inpatient/day case waiting list activity	**Year to Sep 2019**	**Year to Sep 2022**	**Year to Sep 2023**		**Latest year**
Admissions	281,785	194,503	232,601	↑	**19.6%**
Inpatient/day case ongoing waits and waiting times	**End of Sep 2019**	**End of Sep 2022**	**End of Sep 2023**		**Latest year**
Number of ongoing waits	77,806	141,286	151,093	↑	**6.9%**
Over 12 weeks (standard)	24,845	95,738	103,112	↑	**7.7%**
Over 18 months (long wait target)[3]	486	16,520	17,812	↑	**7.8%**
Median ongoing wait (days)[4]	48	168	166	↓	**-2 days**
90th percentile ongoing wait (days)[5]	196	582	579	↓	**-3 days**

Notes:
1. Before October 2019, the new outpatient waiting list included some patients waiting for a diagnostic test. These patients are no longer included in this list, so caution is required when comparing figures for September 2019 to later years.
2. New outpatient long wait target to eradicate waits of over one year by March 2023.
3. Inpatient/day case long wait target to eradicate waits of over 18 months by September 2023.
4. Median ongoing wait: half of ongoing waits are less than or equal to this time.
5. 90th percentile ongoing wait: nine out of ten ongoing waits are less than or equal to this time.

Source: Public Health Scotland

50. Waiting lists and waiting times continue to be particularly long for some specialties. For example, nearly one-third of waits for inpatient/day case treatment are for an orthopaedic procedure, and the number of waits for this specialty increased to 45,549 in the year to September 2023 (+7.3 per cent). Orthopaedics has the highest number of ongoing waits lasting over 18 months (6,290 or 13.8 per cent of all ongoing waits within this specialty).[17]

51. Progress in increasing activity, reducing waiting lists and eradicating long waits also varies among boards (Appendix 2). The CfSD is supporting boards to adopt good practices and implement a range of programmes to manage demand and increase capacity. This includes working with specialty delivery groups to reduce unwarranted variation among boards, and initiatives such as active clinical referral triage and patient-initiated review. The National Elective Coordination Unit is helping boards to validate waiting lists, reduce unnecessary appointments and coordinate the use of available capacity across NHS Scotland.[18]

52. Apart from the indicators of activity mentioned above, there are other signs that activity has increased in NHS Scotland in the last year. For example, the number of return outpatient attendances and the number of procedures performed in acute hospitals increased in 2022/23.[19] More planned operations were scheduled in the year to September 2023 compared with the previous 12-month period.[20] Activity in each of these areas is, however, still below pre-pandemic levels.

Winter planning began earlier in 2023 and focused on building resilience across the health and social care system

53. The Scottish Government took a more proactive approach to planning for winter 2023/24 compared with previous years. Building on lessons from 2022/23, planning began in early spring 2023 and involved organisations from across health and social care. This included establishing a single, whole-system oversight and planning group to replace the separate governance structures used in earlier years. A whole-system winter planning summit was also held in August 2023. This was the first time that people from across the health and social care sectors, trade unions, local authorities and the third sector were brought together to plan for winter in this way.

54. Unlike previous winter plans, the 2023/24 plan does not rely on non-recurring funding.[21] Many of the actions in the plan are already being implemented as part of wider reform and improvement programmes. Two announcements relating to funding were made as part of the 2023/24 winter plan:

- £50 million for the Scottish Ambulance Service (SAS) to help support increased demand. SAS's Demand and Capacity Programme began in 2019 with core funding of £40 million, with further funding to set up an integrated clinical hub and patient pathways navigations centre (£5 million) and to cover Covid-19-related costs (£5 million).

- £12 million to create an additional 380 Hospital at Home service beds, over and above the 800 beds already available. In 2022/23 more than 11,000 patients received care through part of this service,[22] and its expansion will allow acute care to be provided to more patients in their own homes. Capacity will also be extended into new service areas to help reduce hospital admissions.[23]

55. The 2023/24 winter plan focuses on building resilience across the system to cope with increased demand and surges in demand no matter when they occur. Winter will always bring particular challenges, but more fundamental capacity and demand pressures need to be addressed. These pressures include workforce shortages in health and social care,[24] an ageing population,[25] the growing burden of disease,[26] an increasing number of people with multiple health conditions,[27] health inequalities,[28] and the healthcare backlog that built up during Covid-19.[29]

Demand for unscheduled care continues to cause pressure, but the Scottish Government and NHS boards are acting to address this

56. The Urgent and Unscheduled Care Collaborative (UUCC), launched in June 2022, is working to protect inpatient capacity for those with the greatest need. The UUCC has five strands focusing on urgent care pathways in the community, flow navigation centres/redesign of urgent care, Hospital at Home services, assessment and care pathways in Accident and Emergency (A&E) departments, and hospital discharge planning.

57. The Redesign of Urgent Care Programme has been incorporated into the UUCC. Originally implemented in December 2020, this programme aims to reduce the number of people who self-present at hospital, particularly when this is not the best place for them to receive care. If they need to attend an A&E department, patients may be given a scheduled, or 'planned', time to attend.

58. According to activity data published by Public Health Scotland (PHS), there are fewer unplanned A&E attendances now than before the pandemic. In the year to September 2019 there were 1.7 million unplanned A&E attendances. This compares with 1.5 million in the year to September 2023.[30] However, it is not known how many people are presenting at A&E departments as planned attendances. PHS is working with boards to improve the consistency and quality of planned attendance data so that it can be reported in the future.

59. The impact of the Redesign of Urgent Care Programme is not yet clear. An independent evaluation of the programme is currently in progress and is due to report in 2024. This evaluation will assess patient and staff experiences of the programme; it will also consider the programme's current performance and how its impact can be evaluated on an ongoing basis.

60. Ninety-five per cent of people attending A&E departments should be seen and admitted, discharged or transferred within four hours. This standard is an important indicator of pressure throughout the acute care system, but currently it applies only to unplanned A&E attendances. Despite the work described above to reduce unplanned attendances, performance against the four-hour standard remains poor and instances of extreme overcrowding in A&E departments have been reported.[31] Performance against the standard fell to a low in December 2022 (62.1 per cent). Although it began to recover in spring 2023, performance levelled out at around 71-73 per cent during the summer months. Performance in September 2023 fell to 70.0 per cent, one per cent better than at the same point a year earlier.[32]

Increased ambulance turnaround times are reducing the effectiveness of work to improve urgent and unscheduled care

61. Additional funding provided to SAS over the last few years has helped the service to increase capacity by employing extra staff (paragraph 54). It has also allowed SAS to focus on reducing the demand for ambulances and on A&E departments through initiatives such as the integrated clinical hub (covered as a case study in NHS in Scotland 2022).

62. Overcrowding and increased waiting times in A&E departments are, however, leading to increased ambulance turnaround times at hospital. This is reducing the effectiveness of SAS's improvement work. On average, compared with before the pandemic, SAS staff are spending around 23 minutes longer at the hospital for every patient conveyed there.[33] This reduces the availability of ambulances for other emergency patients, affects SAS staff rest periods, and undermines patients' experience and safety. Like the A&E service, the ambulance service is not designed to care for patients for extended periods.

63. The Scottish Government issued new guidance in April 2023 to support the safe and timely handover of patients who arrive at hospital by ambulance, particularly when A&E departments are under pressure. It sets out the responsibilities of SAS and receiving hospitals and underlines the importance of working together. The guidance states that, by August 2023, 100 per cent of patients should be handed over within 60 minutes. Turnaround times, however, indicate that handover within one hour is not always achieved and show that turnaround performance varies widely among hospitals.[34]

The Scottish Government and NHS boards have worked to reduce delayed discharges, but they remain stubbornly high

64. In our NHS in Scotland 2022 report, we noted that delayed discharges were a barrier to patient flow through hospitals, which puts pressure on the whole system. Furthermore, patients whose discharge is

delayed can have poorer experiences and poorer outcomes. The Scottish Government developed a Delayed Discharge and Hospital Occupancy Plan early in 2023 and issued it to boards in March. The plan is evidence-based and promotes known good practice in terms of discharge planning and whole-system working. Implementing the plan, however, has not managed to free up as much capacity in hospitals as was anticipated.

65. The number of people whose discharge has been delayed is still higher than pre-pandemic. The Scottish Government had hoped to reduce the number of people who were delayed in their discharge at each monthly census point to around 1,400-1,550 by summer 2023, but 1,688 is the lowest number of people delayed achieved at any census point in 2023 (March). At the end of September 2023, the number of people whose discharge was delayed (1,835) was slightly lower than at the equivalent point a year earlier (1,885).[35]

66. People who are delayed in their discharge continue to occupy a considerable number of hospital beds.[36] The Delayed Discharge and Hospital Occupancy Plan indicates that boards should be aiming for a hospital occupancy rate of around 85-89 per cent. The occupancy rate for acute specialty beds across NHS Scotland was 88.1 per cent in 2022/23. This is higher than the previous year (2021/22: 84.4 per cent) and higher than pre-pandemic (2019/20: 85.8 per cent). But, this annual figure does not capture the variation among hospitals or peaks in particular months or weeks. Board-level data show that eight boards had a hospital occupancy rate above 90 per cent in 2022/23.[37]

67. Hospital occupancy rates and patient flow are affected by the number of delayed discharges, but also by the length of time patients stay in hospital even when their discharge is not delayed. The average length of stay associated with all inpatient discharges, delayed or otherwise, has increased in recent years. This is particularly the case for those patients admitted as an emergency (7.6 days in 2022/23 versus 6.6 days in 2019/20).[38]

68. Alongside work to reduce attendances, admissions and length of hospital stay, some boards are implementing continuous flow models to try to improve patient flow and prevent overcrowding in A&E departments. For example, NHS Greater Glasgow and Clyde has introduced GlasFLOW. This system uses a regular schedule of patient moves from A&E to inpatient wards, in line with expected discharges from hospital. A&E staff report that this model has allowed responsibility and risk to be shared across the hospital system, but have stressed that it is 'not a magic bullet'. The board also noted that the model is supported by other programmes such as Discharge without Delay.[39] When introduced, it is vital that the impact of a continuous flow model is monitored to ensure that patient safety and experience issues are not transferred to other parts of the system.

69. A lack of social care capacity remains an obstacle to improving patient flow and reducing the number of delayed discharges from hospital. This is supported by data showing that many patients whose discharge is delayed are awaiting the completion of care arrangements to allow them to live in their own home (awaiting social care support), waiting for a place in a nursing home, or awaiting the completion of a post-hospital social care assessment. Just over a quarter of delays are for complex reasons, for example when a patient lacks capacity or is awaiting a place in a specialist facility.[40] Our three case study boards highlighted the importance of encouraging patients to plan for the future by putting in place anticipatory care plans and power of attorney arrangements. If a patient loses the capacity to make decisions, having these plans in place can help to reduce delays and also safeguard the patient's wishes.

70. As at autumn 2023, several systemic pressures in NHS Scotland remained unresolved, despite focused work to tackle them. Changing this situation will rely on wider and more rapid reform of services and investment in preventative measures. It will also require a shared sense of responsibility and collaboration across the whole system. The Auditor General plans to consider these issues further in an audit of primary care services in 2024.

Despite growth in the workforce, the number of vacancies remains high and staff turnover and absences have increased

71. The number of staff employed in the NHS in Scotland has increased over the last five years, however the number of vacancies has also increased (Exhibit 10, page 32).[41] The use of agency and bank staff has also increased, with significant growth in the costs associated with this (Exhibit 5 and paragraph 26).

72. Staff sickness absence increased in 2022/23 to 6.2 per cent; equivalent to 9,719 WTE staff over the year. This is above the four per cent national standard set by the Scottish Government, and is the highest rate reported in the last ten years. Given that Covid-19-related absences have been included in this rate since September 2022, the figure for 2022/23 is not directly comparable with earlier years.

73. Workforce capacity is also affected by high staff turnover rates. In the first year of the pandemic turnover dropped markedly, but it has risen sharply since. The expiry of fixed-term contracts among temporary staff, taken on during the pandemic, contributed to a historically high overall turnover rate of 9.4 per cent in 2022/23, but turnover rates for permanent staff are also historically high.

Exhibit 10.

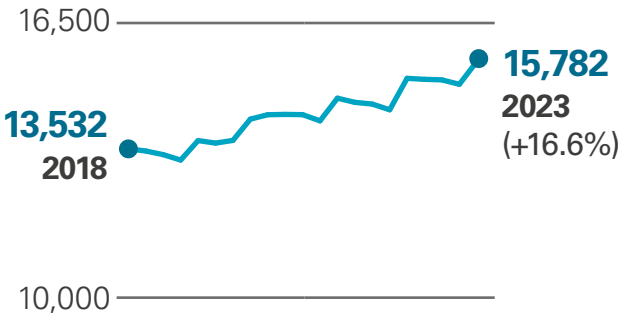
NHS Scotland workforce: September 2018 – September 2023

The NHS Scotland workforce has grown in the last five years, but so has the number of vacancies.

NHS Scotland

Whole-Time Equivalent (WTE) September 2023	**158,375**	**Sickness absence** 2022/23	**6.2%**
Headcount September 2023	**183,858**	**Turnover rate** 2022/23	**9.4%**

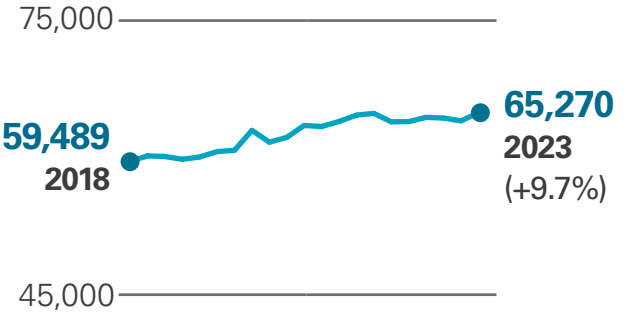
Medical and dental (WTE)



Turnover rate 2022/23: **11.7%**

Vacancies[1]	2018	2023	
Number	398	439	↑
Rate	6.9%	6.9%	←

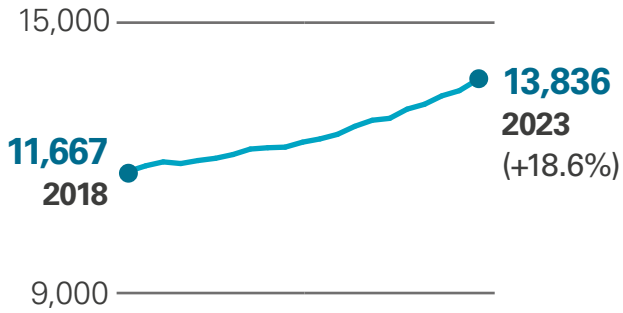
Nursing and midwifery (WTE)



Turnover rate 2022/23: **10.4%**

Vacancies	2018	2023	
Number	3,024	5,447	↑
Rate	4.8%	7.7%	↑

Allied health professions (WTE)



Turnover rate 2022/23: **7.9%**

Vacancies	2018	2023	
Number	542	934	↑
Rate	4.4%	6.3%	↑

Note:
1. Consultant grades only.

Source: NHS Education for Scotland

NHS staff remain under significant pressure and it is not clear that the workforce strategy and other ongoing actions will resolve this challenge

74. The results of the latest iMatter health and social care staff survey indicate that overall employee satisfaction has improved.[42] However, our three case study boards and NHS Education for Scotland (NES) confirmed that the NHS workforce remains under significant and sustained pressure. National support for staff wellbeing has begun to move away from the short-term measures put in place during the Covid-19 pandemic, towards longer-term programmes managed by NES. For example, the Coaching for Wellbeing service, launched in May 2020, provides free coaching to support health and social care staff; 3,709 staff had registered for coaching by the end of 2022/23.

75. The Scottish Government previously committed to publishing the Improving Wellbeing and Workforce Culture Strategy. Instead of a standalone strategy, the Scottish Government now plans to incorporate new guidance and principles into its National Workforce Strategy for Health and Social Care.[43] It is expected to publish an update on the progress of this overarching strategy, including this new guidance, in spring 2024.

76. Several other national programmes are also under way to improve the recruitment, training and retention of NHS staff. One major workstream is the Nursing and Midwifery Taskforce, announced in February 2023. Four working groups focusing on attraction, education and development, culture and leadership, and wellbeing are expected to develop initial recommendations for the taskforce by early 2024. All four groups are considering retention of staff.

77. The recruitment and retention of staff in remote and rural areas is an ongoing concern. The Scottish Government has commissioned NES to establish a National Centre for Remote and Rural Health and Care to help address this issue. The centre will have an initial focus on primary care. The Scottish Government is also developing a Remote and Rural Workforce Recruitment Strategy for Health and Social Care, expected by the end of 2024.

78. Despite these programmes, workforce and performance data show that there is a continuing mismatch between the demand for, and the availability of, staff to work in health and social care. It is not yet clear whether the actions set out in the National Workforce Strategy for Health and Social Care, published by the Scottish Government in March 2022, will be enough to resolve this ongoing challenge.

79. Workforce planning, recruitment, training, retention and wellbeing are closely tied to NHS Scotland's ability to provide safe, high-quality care that ensures the best outcomes for patients. The Health and Care (Staffing) (Scotland) Act 2019 is due to be implemented in April 2024. It sets out statutory requirements for safe staffing across health and care services and aims to support better understanding of workforce requirements. In the National Workforce Strategy for Health and Social Care, the Scottish Government committed to publishing indicative projections of workforce growth and to review these projections annually. The Scottish Government has said that it intends to publish initial projections as part of the workforce strategy update, expected in 2024.

Operational performance and workforce capacity challenges are having a direct impact on patient safety and experience

80. In April 2022 and November 2022, Healthcare Improvement Scotland (HIS) wrote to NHS boards to highlight some serious concerns identified during Safe Delivery of Care inspections of acute hospitals, to enable all boards to review their systems and procedures in light of inspection findings.[44] HIS has confirmed that the issues raised in these letters remain key areas of focus for their inspections to help support the delivery of safe and effective person-centred care (Exhibit 11, page 35).

81. HIS also noted areas of good practice. Examples include staff working well together in challenging circumstances to manage and mitigate risk, positive and caring interactions between staff and patients, and staff working hard to deliver safe care. Several of HIS's concerns, however, relate to workforce issues. For example, high levels of supplementary staffing, staff feeling exhausted, staff feeling unable to provide safe patient care, and staff's lack of confidence in local processes for raising concerns and having them acted upon. The Scottish Public Services Ombudsman/Independent National Whistleblowing Officer echoed these issues in its 2022/23 annual report.[45]

82. The Scottish Government has already taken steps to support NHS staff to raise concerns about patient safety and poor organisational culture through the National Whistleblowing Standards that came into operation in April 2021. The standards are designed to encourage a 'speak up' culture and to ensure that people who raise concerns can do so without fear of victimisation, discrimination or disadvantage. Awareness of the standards is promoted within NHS boards and via online training provided by NES.

Exhibit 11.

Key patient safety concerns raised in Healthcare Improvement Scotland Safe Delivery of Care inspections of acute hospitals

Overcrowding in A&E, the use of non-standard areas, staff wellbeing, medicines governance and the condition of buildings are key areas of concern in relation to patient/staff safety and experience.

Area of concern	Example of impact on patient/staff safety and experience
Extreme overcrowding in A&E and other admission units, and the use of non-standard areas to provide patient care (paragraph 60)	• Patients seated in corridors and waiting areas for long periods of time, without care needs being met. • Patients being cared for in 'locked areas', preventing patients and visitors from leaving the area without staff assistance. • Patients waiting for a dedicated bed space not having the required level of privacy. • Emergency fire evacuation procedures within overcrowded areas not being fully considered.
Staff wellbeing (paragraphs 74 and 81)	• Staff expressing feelings of exhaustion. • Staff expressing concerns about their ability to provide safe patient care. • Staff expressing concerns around their ability to escalate concerns and feel that they are being listened to.
Workforce pressures and higher than normal levels of supplementary staffing (paragraph 26)	• Poor skill mix and high use of agency nurses contributing to gaps in record keeping. • Staff having less or limited experience of the specialty they are working in.
Unsafe practice around medicines governance	• Prepared intravenous medications left unattended. • Inadequate checks of medication, dose or patient details. • Medication cupboards and trolleys left unlocked and unattended.
Poor condition of the healthcare built environment and lack of maintenance (paragraph 29)	• Lack of planned preventative maintenance, including testing of fire safety equipment and water safety testing. • Damaged surfaces, flooring and walls. Leaking pipes and unsealed drains. • Inadequate precautions to manage built environment infection risks to patients.

Source: Healthcare Improvement Scotland

83. If someone working with the NHS raises a concern locally and is not satisfied with the response, they can escalate their concern for external review to the Independent National Whistleblowing Officer (INWO). The number of cases currently being referred to the INWO is still relatively low, but concerns should be referred there only when they have not been resolved locally. In 2022/23, the INWO provided advice to 90 people and received 125 cases, 12 of which it progressed to a full investigation.[46]

Some staff still lack trust in processes for raising concerns

84. Despite the introduction and promotion of the Whistleblowing Standards, some staff still appear to lack awareness of and trust in the escalation process. It also appears that some staff do not believe that raising a concern locally will lead to the necessary action. Responses to questions about raising concerns included in the 2023 iMatter staff experience survey confirm that some staff still lack confidence in this area.[47]

85. There are other indicators of patient safety within NHS Scotland, such as significant adverse event reviews (SAERs). Since January 2020, NHS boards have been required to notify HIS of all category one SAERs; this is the most serious type of adverse event, for example one that may have contributed to, or resulted in, unexpected death. HIS has confirmed that, because of increased compliance with reporting requirements, the number of SAER notifications has generally increased in the last few years. Currently, however, there is no publication showing national trends in SAERs.

86. HIS has highlighted a lack of consistency in the way that SAERs are currently recorded and is leading a programme of national standardisation work to address this. HIS is also reviewing and updating its Learning from Adverse Events Framework. This important work, which will ensure that national data about SAERs is robust, is still ongoing and there are no plans to publish national figures while this work is under way.

87. Alongside patient safety, patient experience remains a valuable indicator of quality of care. NHS boards capture patient experience in a number of ways including through patient surveys, complaints procedures, incident reporting and stories submitted to the Care Opinion website. National information on patient experience, however, is captured less frequently and the National Care Experience Survey Programme is currently under review. The Chief Medical Officer's Value Based Health and Care Action Plan includes an action to develop a national person reported experience measure to improve the provision of person-centred care.[48] The plan also has an action to explore the use of patient-reported outcome measures to drive improvement and better value care.

A new Patient Safety Commissioner will advocate for the welfare and safety of patients

88. The Patient Safety Commissioner (PSC) Bill was passed by the Scottish Parliament in September 2023, and a PSC will now be appointed in

Scotland. The role of this new Commissioner will be to amplify the voice of patients and other members of the public, and improve the safety of healthcare in Scotland.

89. The new Commissioner will be independent of government and will have wide-ranging investigatory powers to look at any issue with a significant bearing on patient safety. The PSC will consider the whole healthcare system, including independent healthcare. The Commissioner's role is wider than the equivalent position in England, where the focus is on medicines and medical devices.

90. The Scottish Government has stated that the role of the PSC is not to replicate the work of other organisations. For example, the Commissioner will not consider individual complaints or harms in the way that the Scottish Public Services Ombudsman does. The PSC is expected to be a small body, so it will need to be focused and work in collaboration with other parts of the system. An advisory group, including patient representatives and subject area experts, will support the Commissioner.

Operational challenges have slowed progress in achieving the ambitions of the NHS Recovery Plan

91. In 2021 the Scottish Government published its NHS Recovery Plan 2021-2026, which outlined its ambitions for recovering and renewing health services and clearing the backlog of care.[49] The Scottish Government published its 2023 annual update on progress made against the recovery plan in December 2023.[50]

92. Previously, we recommended that the Scottish Government report clearly and transparently on progress made against the recovery plan, including whether any changes in indicated targets and timescales would be needed. The 2023 annual update has failed to progress this recommendation. Updates against a range of the ambitions are absent; other targets are mentioned but with no reference to the progress made; and others are reported so that the contribution of the actions taken to overall performance is difficult to identify. In some cases, the way progress towards specific ambitions is now being presented is also different from in the original recovery plan with no explanation given as to why.

93. From the 2023 progress update, however, it is clear that progress in certain areas is behind schedule. Delays in opening NTCs, for example, will have reduced their contribution to planned additional procedures and the recruitment of staff to work in them. Similarly, we note above that across a range of indicators performance is currently below pre-pandemic levels, and has the potential to fall further as a result of pressures in winter 2023/24. There is a clear risk to achieving the planned increases in activity levels that the recovery plan outlined by 2025/26.

3. Reform and redesign

A clear vision is required to move from recovery to reform; and significant service transformation is needed to ensure the future sustainability of the NHS

94. Financial challenges (Part 1) and operational pressures (Part 2) mean that the NHS has continued to focus on recovery and responding to short-term challenges. But the NHS now needs to move away from short-term firefighting to long-term fundamental change.

The Scottish Government and NHS boards have adopted a three horizons approach to planning

95. Work to support boards has adopted a three horizons model, ensuring that the responses to short-term pressures (Horizon 1) are designed to support delivery of outcomes and address emerging financial challenges. Horizons 2 and 3 involve developing larger more complex reforms over the medium and longer term (Exhibit 12, page 39).

96. For 2023/24, the Scottish Government issued national guidance to boards about preparing activity-based Annual Delivery Plans (ADPs) and three-year Medium Term Plans (MTPs), alongside their financial plans. The ADPs and financial plans represented Horizon 1 for boards. Boards agreed their local operational and strategic priorities, aligning these to the **10 national drivers of recovery**. These plans formed the basis of formal performance and improvement discussions between boards and the Scottish Government. The Scottish Government has now moved to strengthen and better align activity and financial planning processes.

97. For 2024/25, NHS boards have been asked to develop their existing MTPs into three-year Delivery Plans, meaning activity and financial plans will cover the same periods and be prepared concurrently. Delivery Plans will continue to refer to the national drivers of recovery, but should also align with the ministerial priorities for NHS Scotland set out in the Programme for Government, and include detailed actions for 2024/25. By setting out high level priorities and aligning activity and financial planning, it is hoped that NHS boards will be better able to plan within their own financial context to deliver both national and local priorities. The Scottish Government is introducing a Delivery Performance Framework that will set out how the progress and impact of the three-year delivery plans will be assessed, and how this will inform performance and improvement discussions.

10 national drivers of recovery

1. Improved access to primary and community care to enable earlier intervention

2. Urgent &Unscheduled Care – Provide the Right Care, in the Right Place, at the right time

3. Improve the delivery of mental health support and services

4. Recovering and improving the delivery of planned care

5. Delivering the National Cancer Action Plan (spring 2023-2026)

6. Enhance planning and delivery of the approach to health inequalities

7. Fast-track the national adoption of proven innovations

8. Implementation of the Workforce Strategy

9. Optimise use of digital and data technologies in the design and delivery of health and care services

10. Climate Emergency and Environment

Exhibit 12.

The Scottish Government acknowledges a wider programme of reform to consider longer-term changes that improve sustainability, including outcomes prioritisation, is now needed and has set this out in their hierarchy of reform planning

Sustainability and Value

The Sustainability and Value Collaborative is a joint effort between Integration Authorities and NHS boards to deliver better value care, make effective use of resources through financial improvement and to optimise within available resources. The intention is not to replace actions that can be agreed and implemented locally in each board area, but to drive opportunities to be identified and implemented on a cross-Scotland basis.

Horizon 1

CHOICES

Review of Health and Social Care Director budgets to prioritise/rationalise commitments, as defined in the Programme for Government, and to set out CHOICES regarding options that can be delivered by the Portfolio within a defined financial envelope. This will require balancing policy priorities, operational recovery and managing within existing resources.

Horizon 2

Reform and Change

Given the residual financial gap, after implementation of CHOICES and Sustainability and Value, decisions regarding reform and change will be necessary if financial balance is to be achieved. This will involve considering options that include both policy and service reform and change. Given the requirement for such actions to close a 'significant' financial gap, decisions will require to balance the need to achieve resource savings while ensuring that changes are consistent with the longer-term priorities and strategy.

Horizon 3

Source: Scottish Government

The Sustainability and Value Programme identifies savings and efficiencies, with a focus on annual break-even rather than longer-term reform

98. Work to support boards in responding to immediate challenges in 2022/23 and 2023/24 was largely delivered through the Sustainability and Value Programme. Launched in 2022, it aimed to support boards to achieve and maintain financial balance. The financial challenges facing boards means that the immediate focus of the programme was to try to reduce the scale of possible deficits in 2023/24, but with some longer-term efficiencies, for example those relating to workforce, featuring in the programme's workplan.

99. Bringing together senior representatives from the Scottish Government, NHS boards and Integration Authorities, four thematic groups supported the Sustainability and Value Board across its work:

- Operational Performance and Delivery Group: has oversight of the progress of national and local plans to deliver planned and unscheduled care waiting times targets, considering the wider system impact on areas such as cancer and diagnostics, and to support identification of national efficiencies.
- Climate Emergency and Sustainability Board: looks at opportunities for efficiencies related to estates, energy management and clinical waste and ensures that they are both financially and environmentally advantageous.
- Workforce: addresses workforce-related programmes, such as the use of agency and locum staff, permanent staffing levels and future workforce requirements to identify a longer-term programme of potential savings.
- Value Based Health and Care Group: its remit is largely aligned to the actions set out in Delivering Value Based Care (2022)[51] and its associated action plan (2023)[52] which look to support the practise of **Realistic Medicine**.[53]

The Financial Improvement Group (FIG) then operates as the primary interface with boards, assisting them to identify immediate savings opportunities and actions to respond to emerging issues (paragraph 34). The impact of the Sustainability and Value Programme and the FIG, which have good visibility and are well understood across boards, has not, as yet, been sufficient to address forecast deficits in 2023/24 (paragraph 21). In November 2023, a new NHS Scotland Planning and Delivery Board was established, with a remit covering national programmes, strategic programmes and national improvements. The Sustainability and Value Board ceased to operate at this point, with its responsibilities being transferred to this new board. The four thematic groups remain in operation but now report to the new board.

The principles of Realistic Medicine

1. Shared decision making.
2. A personalised approach to care.
3. Reduce harm and waste.
4. Reduce unwarranted variation.
5. Managing risk better.
6. Become improvers and innovators.

National commitments to deliver reform and innovation are at risk of not being delivered

100. Adopting digital healthcare solutions is one way the NHS can identify efficiencies and increase productivity, both in response to immediate pressures and to enable longer-term changes in how health services are administered and delivered. The Scottish Government's and the Convention of Scottish Local Authorities' Digital Health and Care Strategy (Care in the Digital Age) was published in 2021 and aims to deliver new digital products and solutions to support priorities including proactive and preventative care and NHS recovery.[54]

101. The Care in the Digital Age 2023/24 Delivery Plan, published in August 2023, stated that 53 out of 60 commitments in the 2022/23 delivery plan were delivered or were on track for delivery, with the remaining commitments carried forward into the 2023/24 delivery plan.[55] However, a further five actions have subsequently been reclassified as at risk and carried forward from 2022/23 into the 2023/24 delivery plan. While some commitments take time to deliver, and can span multiple years, a key risk for digital reform is uncertainty around the availability of the funding to deliver programmes such as Digital Front Door, Digital Dispensing and an integrated health and social care record. Such innovations are required as preparations are made for the proposed development of the National Care Service.

102. Alongside national digital programmes, the Scottish Government has commissioned NHS Golden Jubilee to host the CfSD to assist boards in implementing transformation programmes and adopting new and innovative approaches to delivering care. Part of the CfSD's work is the Accelerated National Innovation Adoption (ANIA) pathway which fast-tracks technological innovations from market to roll-out across boards in NHS Scotland. Through the ANIA pathway, the Scottish Government expects more technological solutions to be implemented on a 'Once for Scotland' basis, meaning that boards can adopt technological innovations more quickly. In the past year, the ANIA pathway has been developing projects to capture digital images for dermatology referrals and to increase access to closed loop monitoring systems for type one diabetes, but the adoption of these national solutions remains a local decision for each board.

103. NHS boards are also putting in place their own innovative approaches to improving care and creating more sustainable services. Boards are working in partnership with local authorities, the third and independent sectors, the academic sector and local industry to develop, test and implement innovative solutions. New models of care are going beyond the use of communication technologies such as Near Me to focus on supporting patients in the community and increasing service efficiency through automation and online data capture. While there is evidence that some nationally developed programmes are being adopted, further monitoring and reporting is needed to determine how digital programmes and the work of the CfSD are contributing to efficiencies on a national basis, both financially and operationally.

There is a need for greater transparency in reporting progress of the Care and Wellbeing Portfolio against its strategic priorities

104. The Scottish Government's Care and Wellbeing Portfolio aims to move towards a more sustainable health and care system that supports improvements in population health and reduces health inequalities. The Scottish Government intends this to be a cohesive portfolio of activity to shape and coordinate reform over Horizons Two and Three, rather than a set of separate projects.

105. Since we reported on its development last year, the portfolio's approach and internal structures have been refined and its membership expanded to include a broader range of Scottish Government and external stakeholders, and it has been adopted across the sector as a way of prioritising preventative care (Exhibit 13, page 43). Some progress has been made in embedding elements of its work, for example strengthening boards' roles as **anchor institutions**. But there is a lack of transparency in reporting overall progress, which is obscuring the risks to the portfolio being able to deliver the reforms needed to reach its ambitions. To address this, the Scottish Government, working with Public Health Scotland, has now launched a publicly available Care and Wellbeing Dashboard. This remains in the early stages of development, but aims to allow the progress that the portfolio is making against specific indicators to be monitored.

106. The portfolio has identified a high risk that immediate priorities will not be successfully delivered due to a lack of strategic direction on scope and priorities. It has struggled to define the scope and direction of the NHS Recovery, Renewal and Transformation programme, resulting in focus shifting to a broader 'Long-term Planning' programme. The portfolio is also reviewing how workforce assumptions and constraints are likely to affect what it can deliver and has identified a risk of portfolio programmes not being sufficiently aligned or integrated with existing strategies and priorities at national and local levels. If these risks are not fully addressed on a sustainable basis, the impact of the portfolio will be limited.

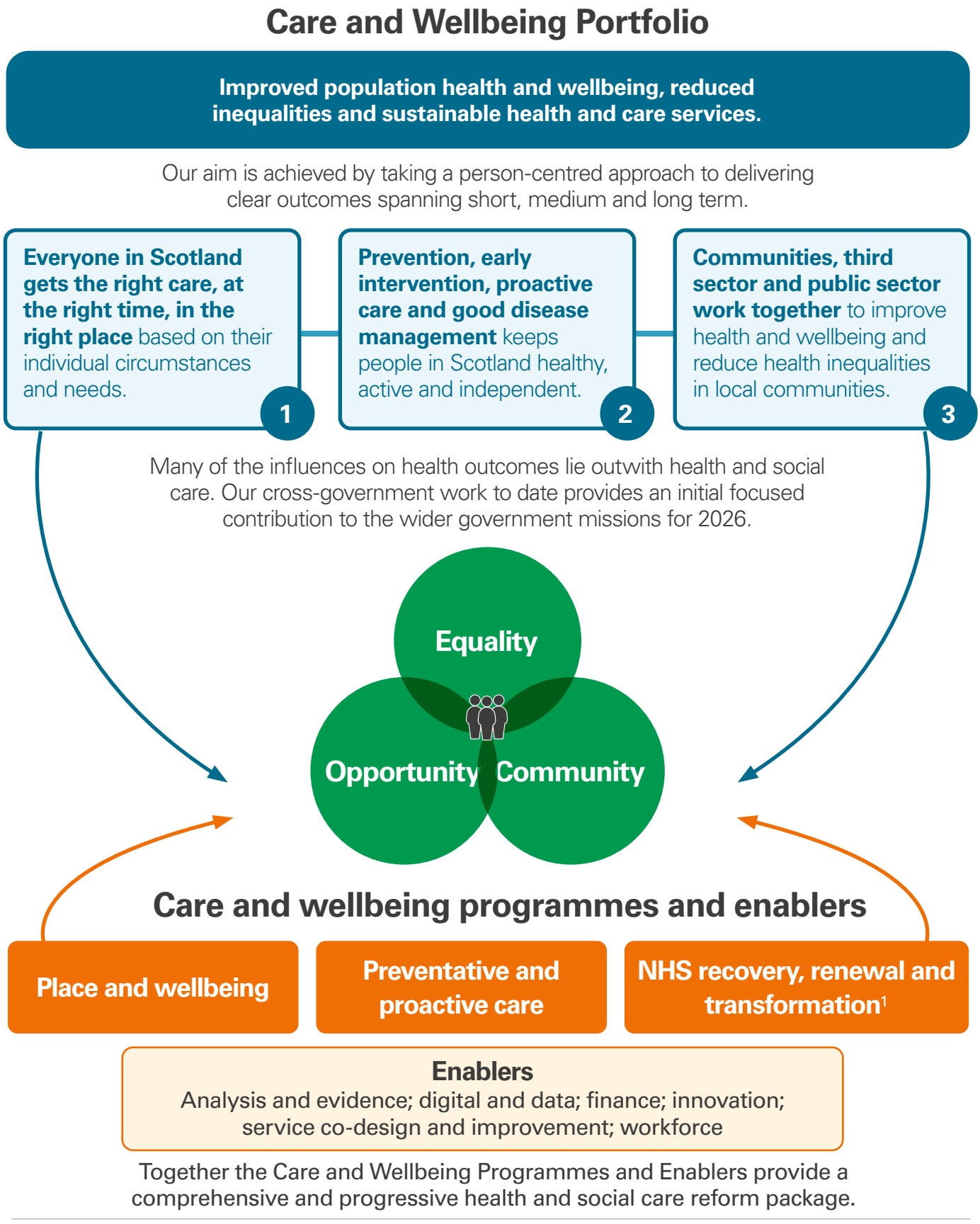
107. The Portfolio Board is taking action to mitigate or reduce these risks, however successfully delivering the strategic aims and outcomes of the portfolio will require significant service change, a widespread shift in focus to preventative care, and effective collaborative working across many boundaries. While links are being made between the portfolio and various ongoing strategies, the Board must have a clear strategic direction for all programmes, effectively plan actions in the short and long term, and strengthen the coherence between portfolio programmes and the many actions taking place across the public sector that affect population health and inequalities.

An **anchor institution** is defined as a large organisation whose long-term sustainability is tied to the wellbeing of its population. Anchors get their name because they are 'rooted' in their communities, are unlikely to relocate, and have significant assets and resources which can be used to influence the health and wellbeing of communities.

NHS boards can increase their contribution to primary prevention by becoming exemplar anchor institutions. By providing access to quality work, procuring goods and services locally where possible, and ensuring their land and buildings are used to advantage the local community. NHS boards can improve the lives of people in the communities it serves by enhancing wealth and wellbeing in the local population.

Exhibit 13.

The Care and Wellbeing Portfolio's mission and objectives were revised in 2023 to reflect the refreshed Programme for Government



Note 1. As noted in paragraph 106, the 'NHS recovery, renewal and transformation' programme has shifted focus to 'Long-term planning'.

Source: Scottish Government

108. Without clear and transparent reporting, it will be difficult for the Scottish Government to demonstrate how the portfolio enablers and programmes are progressing or how its approach is making a difference.

There is an increased focus on public health interventions and prioritising prevention, but this still remains secondary to more immediate operational pressures

109. A whole-system approach to improving the health of the Scottish population is essential to reducing the demand for health and care services. People's health is shaped by social and economic factors, health behaviours, health services, and the physical environment. Investing in preventative measures and implementing service reforms will help to ensure services are sustainable in the future. This work is not the sole responsibility of NHS Scotland; every sector has a contribution to make and it requires long-term and cross-sector investment focused on improving the wider factors that affect health. Public health improvements play an important role in shaping future demand for health and care services. While improving health is everyone's responsibility, the Scottish Government, through its Care and Wellbeing Portfolio, aims to provide leadership on prioritising population health within the public sector. A key partner in this work is Public Health Scotland (PHS).

110. PHS has described **three types of prevention**, detailing their value and how they can be used to help manage current and future demand for health services.[56,57] It has also published analysis which suggests that, despite an overall projected decline in the population of Scotland by 2043, annual disease burdens could increase by 21 per cent.[58] Two-thirds of this increase is predicted to be due to cardiovascular diseases, cancers and neurological conditions. However, this forecast does not factor in changes to prevention activity, service provision, advances in treatments or diagnostics. All types of prevention have a role to play in reducing this burden, but investment in primary prevention has been identified as the area which can make the biggest difference to the population's health and future demand for health services.

111. PHS's modelling of demand and capacity within NHS Scotland is being used by the Scottish Government, NHS boards and some HSCPs to better understand current pressures and to plan how available resources can best be used. Currently this work is mainly based on the acute hospital system, but PHS are working to refine this work and incorporate wider health and care data as they become available. Models to predict disease prevalence and how population change may impact demand for health and care services in the future are now in development. These models are intended to support decision-making around how resources are targeted towards public health interventions that can influence the scale and likely nature of future demand.

PHS has described three types of prevention:

Primary prevention is action that tries to stop problems happening (for example, by improving the conditions in which people work, live and grow).

Secondary prevention is action that focuses on early detection of a problem to support early intervention and treatment and reduce the level of harm (for example, cancer screening services).

Tertiary prevention is action that attempts to minimise the harm of a problem through careful management (for example, rehabilitation support for people who have experienced a stroke).

112. The importance of improving population health and reducing health inequalities, while continuing to deliver operational priorities, is reflected in the delivery planning guidance issued to NHS boards. Delivery Plans have begun to set out how boards will continue working on reducing health inequalities. However, the performance indicators on which boards are currently judged still tend to focus on more immediate pressures such as waiting times, in effect deprioritising the resourcing of preventative measures.

Realistic Medicine can support better use of resources to deliver person-centred outcomes, but stronger clinical leadership is required

113. There are many opportunities for clinicians and patients to work together to make health and care decisions that can contribute to better use of resources and improved health outcomes. After the immediate response to Covid-19, there is now a renewed focus on Realistic Medicine, which aims to develop a culture of shared decision-making between clinicians and patients and reduce the amount of healthcare interventions that do not add value. Realistic Medicine is partly being taken forward under the Value Based Health and Care Group (paragraph 99), but local clinical leadership is needed to apply the principles consistently in everyday practice.

114. Scotland's Chief Medical Officer noted in his annual report that research by the Organisation for Economic Co-operation and Development (OECD) estimates that 20 per cent of spending on healthcare does not result in improvements in health.[59] This is due to various factors including inefficient use of resources, treatment decisions that do not give patients the outcome they would most value, over-investigation and over-treatment, and not taking full advantage of conservative treatment options that deliver better outcomes.

115. Clinicians are being asked to implement the principles of Realistic Medicine by encouraging patients to explore with care teams what treatment options would make the most impact on their own life. Clinical practice should also exhibit a culture of stewardship, where everyone considers their role in the effective use of resources, and clinicians need to be supported by senior clinical and executive leadership to manage clinical risk differently. Staff must be empowered to implement new models of care, reduce practices that are of less value, and take advantage of innovative opportunities for service reform and transformation (paragraph 103).

116. The Chief Medical Officer has set out how the Scottish Government, NHS boards and their partners should deliver Realistic Medicine in the Value Based Health and Care Action Plan.[60] The plan sets out 13 actions related to staff training and development, maximising the use of tools that support further adoption of Realistic Medicine, and measuring the impact of Realistic Medicine on patients. The Scottish

Government intends to publish a measurement framework to evidence progress against these actions and the difference Realistic Medicine is making to outcomes and service sustainability.

Boards are planning over the longer term, but the scale of the challenge requires national coordination and a shared vision

117. Boards are trying to address the current operational challenges they face by implementing a range of approaches to improvement and redesign and working with national partners such as the CfSD. Boards are developing their own longer-term strategies to deliver reform over the next 10-15 years. NHS Tayside intends to refresh its strategic plan this year, and both NHS Dumfries and Galloway and NHS Greater Glasgow and Clyde have developed strategic visions in partnership with Integration Authorities. These plans incorporate key areas such as the importance of digital and innovation, future demand and capacity modelling, and prioritising preventative and person-centred approaches as services are redesigned. Boards, however, told us that there now needs to be greater national leadership to meet the scale of change that will be required.

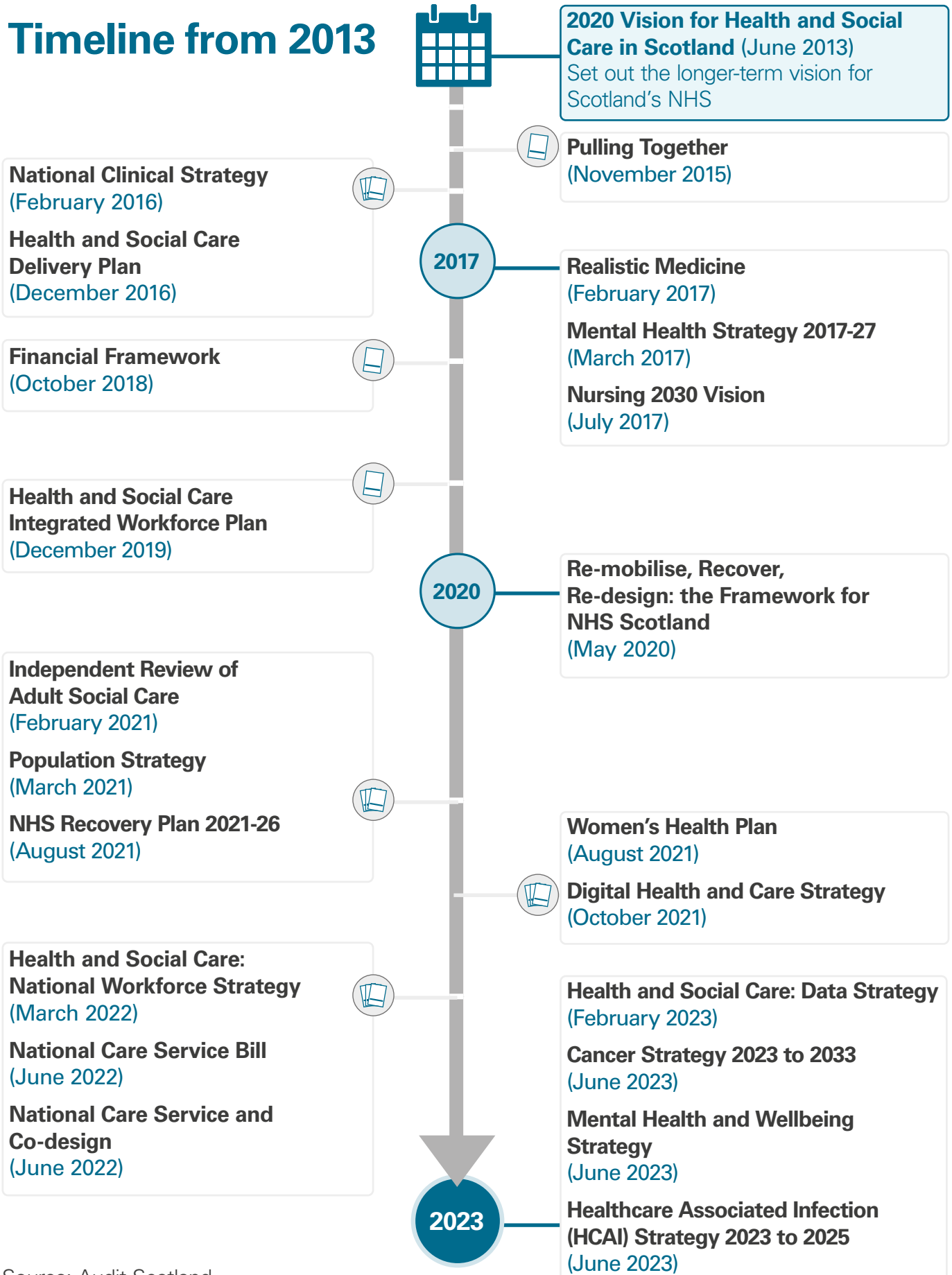
118. National planning is often done in isolation and to shorter timescales, exacerbated by one-year budget settlements. Key considerations for boards such as infrastructure and workforce requirements are planned over several years, and it is difficult to make local changes of the scale required. Boards highlighted the need for difficult financial decisions at a level not seen before, without a coherent sense of direction or an all-encompassing strategy to inform their own strategic planning. This is particularly challenging for smaller or rural boards as they have limited opportunity for radically changing local services in isolation.

119. The Scottish Government has recognised the need to better align boards' operational planning cycle to financial planning and has put plans in place to do this from 2024/25. But there is also a need to ensure that NHS boards' operational Delivery Plans (paragraph 97) are supported by a shared longer-term vision of what future health services will look like.

120. The national policy context in which the NHS operates is complex, with a range of strategies, plans and policies in place but no single, overall vision of what health services will look like in the future (Exhibit 14, page 47). The ambitions within the Scottish Government's 2020 Vision were not achieved by 2020.[61] The Covid-19 health emergency and subsequent recovery has been the immediate focus since then, but the lack of a long-term national vision is hindering boards' ability to plan and deliver reform at the scale, pace and ambition required.

Exhibit 14.

There has been no unified vision for the future direction of the entire healthcare system published since 2013



Source: Audit Scotland

121. To reduce demand on the whole health and care system, public health and preventative health care measures need to be prioritised. As part of the 2024/25 budget statement, the Scottish Government indicated its intention to take forward a 'National Conversation' about the future of the NHS.[62] The Scottish Government should now work with NHS boards, their staff, partners, and the public to develop a long-term strategy for health and social care and support the movement from recovery to reform (Horizon 3). It should set out priorities that support large-scale, system-wide reforms, advancing and building upon ongoing work such as the focus on prevention and Realistic Medicine, and recognise the interdependencies across the health care system. This is increasingly important given the proposed development of the National Care Service.

To support longer-term reform, effective and collaborative leadership will be required

122. Successfully implementing longer-term reforms requires strong executive and clinical leadership to address the current operational and financial challenges, while also looking to implement new approaches to designing services that will meet longer term need. In the joint Auditor General for Scotland and Accounts Commission report on progress with health and social care integration, we highlighted the importance of 'systems leadership' in a complex environment. Effective collaborative leaders should exhibit influential leadership and the ability to empower others, promote awareness of the organisation's goals, engage service users, and prioritise continual development.

123. The current challenges of leading in a complex and uncertain environment are putting leadership capacity across NHS Scotland at increasing risk, and there are concerns that boards are finding it difficult to recruit externally for senior executive and clinical roles. In the past year the Chief Executives at four boards have announced their retirements (NHS Dumfries and Galloway, NHS Forth Valley, NHS Highland, and NHS Tayside). It has subsequently been announced that the Chief Executive of NHS Grampian will take up the same post at NHS Tayside, but this still leaves four out of 14 territorial boards recruiting new Chief Executives.[63]

124. There is a renewed focus on succession planning and leadership skills development at various levels, both within individual boards and nationally. The Scottish Government has commissioned NHS Education for Scotland to deliver a range of leadership development programmes, known collectively as Leading to Change. The national programmes offered include the Aspiring Chief Executives programme (for senior leaders nominated by boards) and the Developing Senior Systems Leadership Programme (with a focus on system-wide collaborative leadership).

To support reform NHS boards must have good governance arrangements in place

125. System-wide reforms will require boards to operate effectively, liaise with their local populations and to report progress transparently. To support this, NHS boards must have good governance arrangements in place that provide sufficient scrutiny and assurance of financial and operational performance. The Scottish Government aims to support NHS boards by issuing guidance and carrying out reviews of governance arrangements across boards. The Scottish Government revised its Blueprint for Good Governance in NHS Scotland in November 2022.[64] The second edition of the blueprint sets out principles of good governance, emphasising the importance of rigorous challenge and scrutiny as well as collaboration with other stakeholders, including the public. The model set out in the revised blueprint places more emphasis on delivering change, and prioritising innovation and a learning culture, at the same time as meeting operational outcomes and targets.

126. The blueprint sets out three levels of evaluation: appraisal of individual board members' performance; a regular board self-assessment exercise; and external review of the organisation's governance arrangements. A new approach to self-assessment has been piloted and is to be rolled out to all boards by March 2024, aiming to provide constructive challenge and strengthen effective scrutiny and self-evaluation. A new Healthcare Governance Advisory Board is being set up and will recommend an approach to external review of board governance. These reviews will include how boards engage with stakeholders, including the public. We will continue to consider the effectiveness of the governance arrangements within NHS Scotland, including the results of the external reviews, as part of both the annual audits of individual NHS boards and our programme of national reporting.

127. There were limited governance and financial management concerns arising from 2022/23 annual audit work. Issues around governance, leadership and culture were, however, highlighted by the auditors of NHS Forth Valley. The board has been escalated on the Scottish Government's NHS Scotland Support and Intervention Framework (paragraphs 37–39). Following escalation, an independent review of the corporate governance arrangements in NHS Forth Valley was undertaken. The learning outlined by the review may enable other NHS boards to identify opportunities to improve their own governance arrangements (Case study 2, page 50).

Case study 2.
NHS Forth Valley Corporate Governance Review

In December 2023, the Auditor General published a report to draw Parliament's attention to concerns in relation to the governance, leadership and culture in NHS Forth Valley and set out the progress the board is making in addressing these issues.

In November 2022, the board was escalated to stage 4 of the NHS Scotland Performance Escalation Framework (since renamed the Support and Intervention Framework). As a result of the escalated governance arrangements an independent review of the corporate governance arrangements in the organisation was undertaken. The review was intended to assist the board in identifying any improvements to their approach to corporate governance that will be required to address the range of performance-related issues included in the Escalation Improvement Plan.

The assessment of the effectiveness of the governance arrangements in NHS Forth Valley is grounded in the NHS Scotland Blueprint for Good Governance (2022). The conclusions in the report focused on the Board's approach to active and collaborative governance.

An active governance approach to delivering good governance requires Board members 'to focus on the right things, consider the right evidence and respond in the right way'. Overall, while the board generally was focusing on the right things, the review noted that there were two notable exceptions to this that should be considered the root cause of many of the significant challenges currently faced by the organisation. These are the failure to agree an appropriate business model for the delivery of integrated health and social care, and the difficulties experienced in building and maintaining a high-performing Executive Leadership Team. The review was also concerned that the Board was not always able to consider the right evidence or respond in the right way.

A collaborative approach to governance needs to be adopted by the key partners in the healthcare system to ensure governance arrangements are understood and aligned to achieve the best outcomes for the population and ensure best value in the use of public funds. The review found there was a lack of a productive and collaborative approach to governance particularly in respect of the integration of health and social care. The reasons behind the lack of collaborative governance reported by the review, reflect those outlined in our 2018 Health and social care integration report, including: an unwillingness by some senior leaders to relinquish power and control; a lack of understanding of responsibilities and accountabilities; and difficult relationships between partners.

The review made 51 wide-ranging recommendations for improvements to the Board's governance arrangements. The review also recommended that there was merit in sharing the learning with all NHS boards to enable them to consider the review and possibly identify opportunities to improve their own governance arrangements.

Source: NHS Forth Valley Corporate Governance Review: Final Report, October 2023 and Audit Scotland

Endnotes

1 Value based health and care action plan, Scottish Government, September 2023.

2 The Health and Social Care Portfolio in 2023/24 represented around one third of Total Managed Expenditure, which includes Non-Domestic Rates (NDR) income and Annually Managed Expenditure (AME) relating to Social Security expenditure, pension costs and accounting adjustments. Excluding these budget elements, around 40 per cent of the funding that the Scottish Government can direct to support its priorities (the discretionary budget) was spent on health and social care.

3 Scotland's Fiscal Outlook: The Scottish Government's Medium-Term Financial Strategy, Scottish Government, May 2023.

4 Fiscal Sustainability Report – March 2023, Scottish Fiscal Commission, March 2023.

5 The NRAC formula was implemented in 2009/10. Upon its adoption, the Scottish Government and TAGRA (Technical Advisory Group on Resource Allocation) committed to movement towards parity over the longer term through management of the annual uplift process as described.

6 This is the current position following distribution of £200 million of funding to NHS boards in Quarter 1 of 2023/24, as outlined in paragraph 21, and provided by the Scottish Government.

7 National Workforce Strategy for Health and Social Care in Scotland, Scottish Government, March 2022.

8 NHS Scotland Workforce, as at September 2023, NHS Education for Scotland, December 2023.

9 Statistics about the age, use and condition of the NHS estate (including levels of identified backlog maintenance) were provided to us by the Scottish Government.

10 Previously known as the NHS Scotland Performance Management Framework, or escalation, it was renamed in September 2023.

11 Inpatient, Day Case and Outpatient Stage of Treatment Waiting Times, quarter ending 30 September 2023, Public Health Scotland, November 2023.

12 NHS Scotland Waiting Times Guidance, Scottish Government, November 2023.

13 Policy Priority Agreements, NHS Recovery, Health and Social Care: First Minister's letter to Cabinet Secretary, Scottish Government, September 2023.

14 Cancer Waiting Times in NHS Scotland, 1 July to 30 September 2023, Public Health Scotland, December 2023.

15 Inpatient, Day Case and Outpatient Stage of Treatment Waiting Times, quarter ending 30 September 2023, Public Health Scotland, November 2023.

16 Policy Priority Agreements, NHS Recovery, Health and Social Care: First Minister's letter to Cabinet Secretary, Scottish Government, September 2023.

17 Inpatient, Day Case and Outpatient Stage of Treatment Waiting Times, quarter ending 30 September 2023, Public Health Scotland, November 2023.

18 National Elective Coordination Unit Annual Report 2022/2023, Centre for Sustainable Delivery, November 2023.

19 Acute hospital activity and NHS beds information (annual), year ending 31 March 2023, Public Health Scotland, September 2023.

20 Cancelled Planned Operations, month ending 30 September 2023, Public Health Scotland, November 2023.

21 Health and social care: winter preparedness plan 2023-2024, Scottish Government, October 2024.

22 Hospital at Home Programme progress update (older people/acute adult), Healthcare Improvement Scotland, March 2023.

23 Meeting of the Parliament Official Report, statement by Michael Matheson on planning for winter 2023-24, Scottish Parliament, 24 October 2023.

24 NHS Scotland Workforce, as at September 2023, NHS Education for Scotland, December 2023.

25 Scotland's Census 2022 – Rounded population estimates, National Records of Scotland, September 2023.

26 Forecasting the future burden of disease: Incorporating the impact of demographic transition over the next 20 years, Public Health Scotland, November 2022.

27 Multimorbidity: A Priority for Global Health Research, Academy of Medical Sciences, April 2018.

28 Scotland's Population 2022, The Registrar General's Annual Review of Demographic Trends, National Records of Scotland, October 2023.

29 Inpatient, Day Case and Outpatient Stage of Treatment Waiting Times, quarter ending 30 September 2023, Public Health Scotland, November 2023.

30 Accident and Emergency Activity, month ending September 2023, Public Health Scotland November 2023.

31 Safe Delivery of Care inspections of acute hospitals – findings letter to NHS boards: November 2022, Healthcare Improvement Scotland, November 2022.

32 Accident and Emergency Activity, month ending September 2023, Public Health Scotland, November 2023.

33 Board Quality Indicators Performance Report, Scottish Ambulance Service, November 2023.

34 Unscheduled Care Operational Statistics, Scottish Ambulance Service, November 2023.

35 Delayed discharges in NHS Scotland, month ending September 2023, Public Health Scotland, November 2023.

36 Delayed discharges in NHS Scotland (annual, planned revision), 2022/23, Public Health Scotland, December 2023.

37 Acute hospital activity and NHS beds information (annual), year ending 31 March 2023, Public Health Scotland, September 2023.

38 Acute hospital activity and NHS beds information (annual), year ending 31 March 2023, Public Health Scotland, September 2023.

39 Using an evidence-based approach to improve unscheduled care, Glasgow Continuous Flow Model (GlasFLOW), NHS Greater Glasgow and Clyde, June 2023.

40 Delayed discharges in NHS Scotland, month ending September 2023, Public Health Scotland, November 2023.

41 NHS Scotland Workforce, as at September 2023, NHS Education for Scotland, December 2023.

42 Health & Social Care Staff Experience Survey 2023, Scottish Government, November 2023.

43 National Workforce Strategy for Health and Social Care in Scotland, Scottish Government, March 2022.

44 Safe Delivery of Care inspections of acute hospitals – findings letter to NHS boards: November 2022, Healthcare Improvement Scotland, November 2022.

45 Annual Report and Financial Statements 2022-23, Scottish Public Services Ombudsman, October 2023.

46 Annual Report and Financial Statements 2022-23, Scottish Public Services Ombudsman, October 2023.

47 Health & Social Care Staff Experience Survey 2023, Scottish Government, November 2023.

48 Value based health and care action plan, Scottish Government, September 2023.

49 NHS Recovery Plan 2021-2026, Scottish Government, August 2021.

50 NHS Recovery Plan 2021-2026 Annual Progress Update 2023, Scottish Government, December 2023.

51 Delivering value based health and care: a vision for Scotland, Scottish Government, December 2022.

52 Value based health and care action plan, Scottish Government, September 2023.

53 Delivering value based health and care: a vision for Scotland, Scottish Government, December 2022.

54 Enabling, connecting and empowering: care in the digital age, Scotland's digital health and care strategy, Scottish Government and COSLA, October 2021.

55 Care in the digital age: delivery plan 2023-24, Scottish Government and COSLA, August 2023.

56 Public health approach to prevention and the role of NHS Scotland, Public Health Scotland, January 2023.

57 The case for prevention and sustainability of health services, Public Health Scotland, July 2023.

58 Forecasting the future burden of disease: Incorporating the impact of demographic transition over the next 20 years, Public Health Scotland, November 2022.

59 Realistic Medicine: doing the right thing – Chief Medical Officer for Scotland Annual Report 2022-2023, Scottish Government, June 2023.

60 Value based health and care action plan, Scottish Government, September 2023.

61 NHS in Scotland 2019, Audit Scotland, October 2019.

62 Scottish Budget 2024 to 2025: Deputy First Minister statement, Scottish Government, 19 December 2023.

63 Internal candidates have been appointed at NHS Highland and NHS Dumfries and Galloway, and interim appointments have been made at NHS Grampian and NHS Forth Valley.

64 The Blueprint for Good Governance in NHS Scotland, second edition, Scottish Government, November 2022.

Appendix 1.

Audit methodology

We aim to answer the following audit questions in this report:

- What was the financial performance of the NHS in Scotland in 2022/23, and what is the medium-term financial outlook?
- How is the NHS in Scotland performing against national commitments, and what progress is being made with recovery?
- What is being done to reform and redesign the NHS in Scotland, including making it financially sustainable?

Our findings are based upon:

- the 2022/23 audited accounts and annual audit reports of NHS boards and supplementary returns provided by appointed auditors
- analysis of NHS board accounts, Scottish Government budget documents
- relevant Scottish Government strategies, plans and publications
- activity and performance data published by Public Health Scotland, NHS Education for Scotland and other national boards
- interviews with senior officials in the Scottish Government and NHS boards.

This central work was supplemented by targeted work at three NHS boards (NHS Dumfries and Galloway, NHS Greater Glasgow and Clyde and NHS Tayside). This included a more in-depth review of board strategies and plans, and interviews and discussions with senior staff.

Advisory Panel

To support our work, an Advisory Panel was established to provide challenge and insight at key stages of the audit process. Members sat in an advisory capacity only and the content and conclusions of this report are the sole responsibility of Audit Scotland.

We wish to extend our thanks to the members of the panel: Andrew Bone (NHS Borders); Lorraine Cowie (NHS Highland); Julie Carter (Scottish Ambulance Service); Stephen Gallagher (Scottish Government); and Scott Heald (Public Health Scotland).

Appendix 2.

NHS board performance against selected waiting list indicators

New outpatient waiting list indicators (September 2023)

NHS board	Attendances in year to Sep 2023	Change in year to Sep 2023 (%)	All ongoing waits Sep 2023	Change in year to Sep 2023 (%)	Ongoing waits over a year Sep 2023[1]	Change in year to Sep 2023 (%)
NHS Scotland	**1,237,657**	**2.5** ↑	**525,654**	**10.5** ↑	**40,052**	**7.2** ↑
NHS Ayrshire & Arran	94,622	5.0 ↑	47,689	7.6 ↑	5,409	-26.5 ↓
NHS Borders	21,677	-9.8 ↓	11,813	11.7 ↑	1,485	-7.1 ↓
NHS Dumfries & Galloway	32,177	7.3 ↑	10,629	3.5 ↑	20	-86.0 ↓
NHS Fife	78,251	4.9 ↑	30,300	14.9 ↑	2,427	161.5 ↑
NHS Forth Valley	68,967	-0.4 ↓	19,312	7.4 ↑	84	-63.3 ↓
NHS Grampian	112,091	2.3 ↑	51,684	21.7 ↑	6,117	45.7 ↑
NHS Greater Glasgow & Clyde	343,198	5.8 ↑	146,522	3.8 ↑	7,463	-38.4 ↓
NHS Highland	51,909	4.4 ↑	25,171	22.5 ↑	2,068	1.0 ↑
NHS Lanarkshire	109,510	1.5 ↑	67,132	37.7 ↑	7,661	266.6 ↑
NHS Lothian	221,444	1.8 ↑	79,510	-2.2 ↓	5,603	4.2 ↑
NHS Orkney	4,231	-4.4 ↓	1,513	39.8 ↑	27	92.9 ↑
NHS Shetland	4,671	-2.9 ↓	1,346	28.2 ↑	9	28.6 ↑
NHS Tayside	86,054	-7.4 ↓	31,319	10.8 ↑	1,675	34.3 ↑
NHS Western Isles	6,279	2.3 ↑	1,367	17.7 ↑	4	0.0 ←
NHS Golden Jubilee	2,576	8.6 ↑	347	7.1 ↑	0	-100.0 ↓
	Fewer attendances than a year ago		More ongoing waits than a year ago		More ongoing waits over a year than a year ago	

Note: 1. There was a new outpatient target to eradicate long waits of over one year by March 2023.

Inpatient/day case waiting list indicators (September 2023)

NHS board	Admissions in year to Sep 2023	Change in year to Sep 2023 (%)	All ongoing waits Sep 2023	Change in year to Sept 2023 (%)	Ongoing waits over 18 months Sep 2023[1]	Change in year to Sep 2023 (%)
NHS Scotland	**232,601**	**19.6** ↑	**151,093**	**6.9** ↑	**17,812**	**7.8** ↑
NHS Ayrshire & Arran	15,949	18.0 ↑	7,863	-8.1 ↓	753	-13.8 ↓
NHS Borders	2,951	24.6 ↑	2,539	7.0 ↑	310	-9.9 ↓
NHS Dumfries & Galloway	7,969	11.9 ↑	4,729	30.8 ↑	2	-60.0 ↓
NHS Fife	13,121	15.6 ↑	7,805	40.4 ↑	134	197.8 ↑
NHS Forth Valley	9,486	6.3 ↑	4,822	15.7 ↑	23	-41.0 ↓
NHS Grampian	18,537	14.0 ↑	16,409	4.6 ↑	2,775	1.5 ↑
NHS Greater Glasgow & Clyde	64,059	21.0 ↑	44,878	9.3 ↑	6,634	36.4 ↑
NHS Highland	13,153	24.5 ↑	7,004	-7.5 ↓	772	-42.9 ↓
NHS Lanarkshire	17,601	29.4 ↑	11,621	-0.7 ↓	1,634	-1.7 ↓
NHS Lothian	40,209	31.4 ↑	27,780	3.2 ↑	3,256	2.5 ↑
NHS Orkney	738	-8.2 ↓	346	-4.7 ↓	2	-71.4 ↓
NHS Shetland	933	-17.3 ↓	359	10.8 ↑	6	0.0 ←
NHS Tayside	20,986	11.0 ↑	12,911	13.6 ↑	1,496	7.3 ↑
NHS Western Isles	1,410	-0.8 ↓	327	-27.5 ↓	0	-100.0 ↓
NHS Golden Jubilee	5,499	10.3 ↑	1,700	8.0 ↑	15	36.4 ↑
	Fewer admissions than a year ago		More ongoing waits than a year ago		More ongoing waits over 18 mths than a year ago	

Note: 1. There was an inpatient/day case target to eradicate long waits of over 18 months by September 2023.

Source: Public Health Scotland

Appendix 3.

Progress against the recommendations from NHS in Scotland 2022

Recommendations for Scottish Government	Progress/status
Publish a revised Medium-Term Financial Framework (MTFF) for health and social care that clearly aligns with the Medium-Term Financial Strategy (MTFS) for the entire Scottish Government, as soon as possible after the next MTFS is published, to determine what financial resources will be available and to give a clear understanding of potential financial scenarios.	**In progress.** The MTFS was published in May 2023, but a revised MTFF has not been published yet. Publication planned for 2024. Further action recommended.
Complete work on modelling demand and capacity to inform planning for future service delivery, taking into consideration demographic change, service redesign options and anticipated workforce capacity.	**In progress.** A model exists and work to develop and improve this model is ongoing.
Revisit NHS Recovery Plan commitments annually and use annual progress updates to report clearly and transparently on what progress has been made and whether those commitments, or the targets and delivery timeframes related to them, need to change and why.	**No progress.** The NHS Recovery Plan update was published in December 2023 but does not clearly report progress. Further action recommended.
Ensure targets for tackling the backlog of care are clear, publish accessible and meaningful information about how long people will have to wait for treatment, and urgently explore all options to provide support to the most vulnerable people waiting for treatment to minimise the negative impact on their health and wellbeing.	**In progress.** Work to improve waiting times information for patients ongoing.
Publish annual progress updates on the reform of services, showing the effectiveness and value for money of new innovations and ways of delivering NHS services.	**Limited progress.** Updates for some programmes published. We repeat this recommendation in this report.

Cont.

Recommendations for Scottish Government and NHS boards	Progress/status
Work with partners in the social care sector to progress a long-term, sustainable solution for reducing delayed discharges from hospital.	**Limited progress.** Awaiting decision on National Care Service.
Ensure focus on staff retention measures is maintained, including wellbeing support, and continually look at ways to increase the impact of these measures.	**In progress.** Awaiting National Workforce Strategy progress update.
Work together more collaboratively on boards' delivery, financial and workforce plans to maximise boards' potential to achieve the ambitions in the NHS Recovery Plan, by balancing national and local priorities against available resources and capacity and setting realistic expectations for the public.	**In progress.** We note the arrangements to support boards to develop plans and to better align activity and financial planning.
Urgently implement a programme of engagement with the public to enable an open discussion about the challenges facing the health sector in Scotland and help inform future priorities and how the delivery of services will change.	**Limited progress.** There is evidence of engagement locally and nationally but longer-term strategies, plans and reforms still need to be developed.

NHS in Scotland 2023

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AUDIT & RISK COMMITTEE

ANNUAL WORKPLAN 2023 / 2024

Governance – General		18/05/23 - Meeting Cancelled				
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Minutes of Previous Meetings	**Chair**	✓ Via email	✓	✓	✓	✓
Action Plan	**Chair**	✓ Via email	✓	✓	✓	✓
Escalation of Issues to NHS Board	**Chair**	✓ Via email	✓	✓	✓	✓
Governance Matters						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Audit Scotland Technical Bulletin	**Head of Financial Services**	✓ 2023/1 – Via email		✓ 2023/2	✓ 2023/3	✓ 2023/4
Annual Assurance Statement 2022/23	**Board Secretary**	✓ Via email	✓ Final			
Annual Assurance Statements from Standing Committees 2022/23	**Board Secretary**		✓			
Annual Review of Code of Corporate Governance	**Board Secretary**	✓ Via email				
Committee Self-Assessment	**Board Secretary**					✓
Corporate Calendar / Committee Dates 2024/25	**Board Secretary**			✓		
Delivery of Annual Workplan 2023/24	**Director of Finance & Strategy**	✓	✓	✓	✓	✓
Governance Statement	**Director of Finance & Strategy**	✓ Via email	✓ Final			
IJB Annual Assurance Statement 2022/23	**Board Secretary**		✓ Letter	Report (for 2024)		
Internal Audit Review of Property Transactions Report 2022/23	**Internal Audit**	No transactions to review for 2022/23				
Losses & Special Payments	**Head of Financial Services**	✓ Via email		✓	✓	✓

Governance Matters (cont.)						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Review of Annual Workplan 2024/25	**Board Secretary**				✓ Draft	✓ Approval
Review of Terms of Reference	**Board Secretary**					✓ Approval
Significant Issues of Wider Interest	**Director of Finance & Strategy**	**No separate letter required this year**				
Risk						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Annual Risk Management Report 2022/23	**Risk Manager**	✓ **Via email**	✓ Final			
Corporate Risk Register	**Director of Finance & Strategy/Risk Manager**	✓	✓	✓	✓	✓
Risk Management Key Performance Indicators 2022/23	**Risk Manager**			**Deferred to March**		**Deferred to May**
Risk & Opportunities Group and Progress Report	**Risk Manager**	✓ **Via email**		✓ **verbal**	✓	✓
Governance – Internal Audit						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
External Quality Assessment (5 yearly)	**Internal Audit**					✓ **included within progress report**
FTF Shared Service Agreement / Service Specification	**Internal Audit**				**Deferred to next mtg**	✓ **Part of Internal Audit Framework**
Internal Audit Progress Report	**Internal Audit**	✓ **Via email**		✓	✓	✓
Internal Audit Annual Plan 2023/24	**Internal Audit**		✓ Final			
Internal Audit Annual Report 2022/23	**Internal Audit**		✓			

Governance – Internal Audit						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Internal Audit – Follow Up Report on Audit Recommendations 2022/23	**Internal Audit**	✓ **Via email**		✓	✓	✓
Internal Audit Framework	**Chief Internal Auditor**					✓
Internal Controls Evaluation Report 2023/24	**Internal Audit**				✓	
Governance – External Audit						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Annual Audit Plan 2023/24	**External Audit**				✓	
External Audit – Follow Up Report on Audit Recommendations	**Director of Finance & Strategy**					**Removed**
Patients' Private Funds - Audit Planning Memorandum	**Director of Finance & Strategy**					✓
Service Auditor Reports on Third Party Services	**Director of Finance & Strategy**		✓			
Annual Accounts						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Annual Accounts Preparation Timeline	**Head of Financial Services**	✓ **Via email**				✓ Initial
Annual Accounts & Financial Statements 2022/23	**Director of Finance & Strategy / External Audit**		✓			
Annual Audit Report (including ISA 260) 2022/23	**External Audit**		✓			
Letter of Representation (ISA 580) 2022/23	**Director of Finance & Strategy / External Audit**		✓			
Patients' Funds Accounts 2022/23	**Head of Financial Services**		✓			
Annual Statement of Assurance to the NHS Board 2022/23	**Board Secretary**		✓			

Counter Fraud						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Counter Fraud Service – Quarterly Report (Alerts & Referrals)	**Head of Financial Services**	**Deferred to August**		Private Session	Private Session	Private Session
Counter Fraud Standards Update	**Head of Financial Services**	**Deferred to August**		Private Session		**Deferred to May**
Adhoc						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Private Meeting with Internal / External Auditors	**Committee**			Private Session		Private Session
Appointment of Patients' Funds Auditor	**Director of Finance & Strategy**	**As required**				
Legal & regulatory updates (e.g. Audit Scotland reports; Technical Bulletin etc)	**Head of Financial Services**					
Progress on National Fraud Initiative (NFI)	**Head of Financial Services**				✓	
External Auditors Annual Accounts Progress Update	**External Auditor**	**No update provided as mtg cancelled**				✓
Additional Agenda Items (Not on the Workplan e.g. Actions from Committee)						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Risk Management Framework and GP/R7 Risk Management Policy	**Director of Finance & Strategy**			✓ **Framework**	✓ **Update**	
Health Board Partnership Agreement April 2023 – March 2028	**Director of Finance & Strategy**		✓			
Procurement, Waiver of Competitive Tenders	**Head of Financial Services**			✓ **Q1**	✓ **Q2**	✓ **Q3**
Counter Fraud Standards Assessment 2022/23	**Head of Financial Services**			✓		
Business Continuity Arrangements Internal Audit Report	**Director of Public Health**					✓
Blueprint for Good Governance Action Plan	**Board Secretary**					✓

Additional Agenda Items (Not on the Workplan e.g. Actions from Committee) cont.						
	Lead	**18/05/23**	**23/06/23**	**31/08/23**	**14/12/23**	**14/03/24**
Fraud Annual Action Plan 2023/24 Progress Update	**Head of Financial Service & Procurement**					✓ Private Session
Training Sessions Delivered						
	Lead					
Members' Training Session – the Annual Accounts: The Role & Function of the Audit & Risk Committee	**External Auditors**	✓ **30/05/23**				
Review of the effectiveness of the new Corporate Risk Register process	**Director of Finance & Strategy**			**12/10/23**		