# FTF Internal Audit Service

# Annual Internal Audit Report 2021/22

# Report No. A06/23

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

**S Urquhart, Director of Finance, Director of Finance**
**Directors / Executive Leadership Team**

**K MacKenzie, Head of Policy and Performance**
**S Hamill, Board Secretary**

**Audit and Risk Committee**
**External Audit**

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| Draft Report Issued | 9 June 2022 |
| Management Responses Received | 21 June 2022 |
| Target Audit and Risk Committee Date | 22 June 2022 |
| **Final Report Issued** | 22 June 2022 |

## INTRODUCTION AND CONCLUSION

1. This annual report to the Audit and Risk Committee provides details on the outcomes of the 2021/22 internal audit and my opinion on the Board's internal control framework for the financial year 2020/21.

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

- The Board has adequate and effective internal controls in place;
- The 2021/22 internal audit plan has been delivered in line with Public Sector Internal Audit Standards.

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

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

## ACTION

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

## AUDIT SCOPE & OBJECTIVES

5. The Strategic and Annual Internal Audit Plans for 2021/22 incorporated the requirements of the NHSScotland Governance Statement and were based on a joint risk assessment by Internal Audit and the Director of Finance. The resultant audits range from risk based reviews of individual systems and controls through to the strategic governance and control environment.

6. The authority, role and objectives for Internal Audit are set out in Section 15.3 of the Board's Standing Financial Instructions and are consistent with Public Sector Internal Audit Standards.

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

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

## INTERNAL CONTROL

8. The Internal Control Evaluation (ICE), issued January 2022, was informed by detailed review of formal evidence sources including Board, Standing Committee, Executive Leadership Team (ELT) and other papers. The ICE noted actions to enhance governance and achieve transformation and concluded that NHS Forth Valley's assurance structures were adequate and effective and did agree recommendations for implementation by management.

9. Progress to address previous ICE and Annual Report recommendations is detailed in Appendix A. Progress with outstanding recommendations is reported through the Audit Follow Up system and will be validated by Internal Audit as part of the 2022/23 Annual Internal Audit Plan.

10. The main themes covered by our previous recommendations were:

- **Sustainability and Transformation**

**Aim:** We recommended a review of the Healthcare Strategy (originally due by September 2021) to ensure NHS Forth Valley can effectively deliver services in the longer term, as well as in the shorter term, through remobilisation and the Annual Delivery Plan.

**Progress:** Review of the Healthcare Strategy is ongoing with a revised completion date of November 2022. The Board was updated in May 2022 and work is ongoing to refresh the strategy and to ensure stakeholder involvement, particularly in changing culture.

- **Governance**

**Aim:** To improve assurance mechanisms, with a focus on key risks, through adoption of assurance principles and implementation of revised documentation and accompanying guidance.

**Progress:** New processes and documentation were introduced at the Board seminar on 7 June 2022 and the Pentana system has been further developed to record assurances. Several previous internal audit recommendations have been addressed through these developments, and will be progressed through 2022/23 with an assessment after 6 months. Planned future work will include revision of annual report templates.

- **Risk Management**

**Aim:** To assist assurance committees in understanding all key aspects of strategic risks aligned to them through improved assurance reporting by risk owners, with a focus on key controls, mitigation and performance. Recommended deep dives would, for example, ensure the Clinical Governance Committee (CGC) is sighted on the clinical governance elements of the risk associated with deferred treatment.

**Progress:** A programme of strategic risk deep dives will be implemented during 2022/23 with the aim of embedding a governance culture that provides assurance that key risks are being effectively mitigated, to allow NHS Forth Valley to achieve its corporate objectives.

- **Performance Management**

**Aim:** To improve assurance reporting on NHS Forth Valley performance against key national, local and Remobilisation targets, and to provide assurance on necessary improvement actions.

**Progress:** The Recovery & Performance Scorecard has been updated and continues to evolve. Work continues to develop performance information within Pentana to support Directorate and Health and Social Care Partnership (HSCP) reviews. An update on progress will be provided by the end of July 2022.

- **Clinical Governance improvements**

**Aim:** To ensure escalation of whole system clinical risks, and to identify any gaps in assurance.

**Progress:** A review of reporting through Clinical Governance structures is ongoing to ensure a focus on key risks and the Clinical Governance Committee (CGC) and Clinical Governance Working Group (CGWG) annual reports for 2021/22 identified gaps in assurance. Papers will clearly signpost each relevant Health Board and IJB committees' scrutiny and assurance responsibilities. The Clinical Governance Strategy is being refreshed to ensure that assurances are provided on whole system clinical and care governance.

- **Staff Governance improvements**

**Aim:** To ensure the Staff Governance Committee (SGC) has a focus on key risks and receives appropriate assurances that NHS Forth Valley has in place a sufficiently robust Workforce Strategy and plan to deliver services.

**Progress:** A refreshed Our People Strategy progress update was provided to the May 2022 SGC instead of the Interim Workforce Plan, which was not available at the time of our fieldwork. The SGC has implemented a forward planner but some recommended reports have not yet been included and the SGC has not considered the workforce plan risk. Reporting on implementing and improving compliance with the Staff Governance Standard has yet to be introduced.

- **Property and Asset Management Strategy (PAMS)**

**Aim:** The Performance & Resources Committee (P&RC) was to be provided with assurance on progress with the emerging PAMS with a clear timetable for delivery.

**Progress:** The timetable for PAMS refresh is aligned to the review of the Healthcare Strategy. This will commence during summer 2022 and is scheduled for presentation to P&RC in February 2023.

- **Information Governance (IG)**

**Aim:** To enhance the Information Assurance report to the P&RC to provide sufficient and reliable assurance on the key aspects of IG & Security, including management of IG related incidents.

**Progress:** Enhanced reporting is scheduled for early 2022/23, to be taken forward by the new Head of IG.

11. NHS Forth Valley has demonstrated steady progress, particularly in enhanced arrangements for governance and assurance. There has been some slippage on some actions and clearly the revision of the overall and supporting strategies will be a significant task and much work remains to be done. The 2022/23 ICE will provide an update on the remaining actions as well as providing an opinion on the efficacy of implementation of all agreed actions.

12. Throughout the year, our audits have provided assurance and made recommendations for improvements. Of these, the ICE was the most significant. We have undertaken detailed follow up of the agreed actions arising from that report as well as testing to

identify any material changes to the control environment in the period from the issue of the ICE to the year-end. We have reflected on the ongoing impact of Covid19 on the governance arrangements in place during the year. Some areas for further development were identified and will be followed up in the 2022/23 ICE. Where applicable, our detailed findings have been included in the NHS Forth Valley 2021/22 Governance Statement.

13. For 2021/22, the Governance Statement format and guidance were included within the NHSScotland Annual Accounts Manual. Guidance includes reference to the March 2018 SPFM Audit and Assurance Committee Handbook and indicates that assurances should include activities under the direction of Integrated Joint Boards (IJBs).

14. The Board has approved a Governance Statement which states that:

*'During the previous financial year, no significant control weaknesses or issues have arisen, and no significant failures have arisen in the expected standards for good governance, risk management and control. Attention is, however, drawn to the key risks reported to Forth Valley NHS Board during 2021/22 and in particular to the treatment time guarantees underpinned by statute'.*

15. Our audit work has provided evidence of compliance with the requirements of the Accountable Officer Memorandum, and this combined with a sound corporate governance framework in place within the Board throughout 2021/22, provides assurance for the Chief Executive as Accountable Officer.

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

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

17. All Executive Directors and Senior Managers were required to provide a statement confirming that adequate and effective internal controls and risk management arrangements were in place throughout the year across all areas of responsibility, with a specific focus on business planning; major investment; project management; fraud and compliance. These assurances have been reviewed and no breaches of Standing Orders / Standing Financial Instructions were identified.

18. The Governance Statement reflects the necessary changes to Board governance and operating arrangements due to Covid19. The Governance Statement includes details of the Board performance profile and risk management arrangements, and the future intention to revise organisational and supporting strategies. All elements of the Governance Statement have been considered by Internal Audit in previous internal audit annual reports and the ICE, and have been followed up in detail in this report.

**Key Themes**

19. Detailed findings are shown later in the report. Key themes emerging from this review and other audit work during the year, as well as consideration of the overall impact of Covid19 and the need to ensure sustainable services, are detailed in the following paragraphs.

20. The NHS is Scotland remained on an emergency footing throughout 2021/22. The Board continues to respond positively to the governance challenges posed by Covid19. The Board's approach to governance was revised to ensure NHS Forth Valley could effectively respond to Covid19 and discharge its governance responsibilities, maximising time available for staff to deal with Covid19.

21. The Board recognises that all strategies will need to be updated, and work to fully refresh the Healthcare Strategy is ongoing, with a revised Strategy scheduled for consultation during summer 2022 prior to Board approval in November 2022.

22. Our ICE report noted that further work was needed to ensure that at both strategic and operational level the impact of Covid19 on the risk profile of the organisation is clearly articulated and all relevant controls are identified together with clear assurance lines. Work has continued throughout the year to reflect the impact of the Covid19 on the Strategic Risk Register. The threat remains from a resurgence of Covid19 and these considerations are now part of business as usual planning. It is recognised that Covid19 is an exacerbating factor impacting on a number of strategic risks and should therefore be a key consideration when reviewing the existing strategic risks, with additional controls added where necessary. There is no longer a standalone risk relating to Covid19.

23. The ICE noted good practice in that a deep dive had been undertaken for the Finance Breakeven risk, however, progress was not maintained due to the departure of the Corporate Risk Manager, and no other risks have been the subject of a similar exercise. In an environment in which risks are likely to remain both volatile and high, a programme of deep dives will be key to maintaining effective oversight.

24. A significant amount of work has been done to enhance governance through the application of assurance mapping principles.

25. Operational performance in the face of the challenges posed by Covid19 has been difficult during the year, in particular performance against Waiting Times targets. It is likely that the challenge will continue in the medium term until strategic solutions can be found, working in partnership with both IJBs.

**Key developments since the issue of the ICE included:**

- A significant improvement in the approach to governance and development of an assurance culture, led by the Head of Policy and Performance, was communicated via Board seminars in April and June 2022. This included development and piloting of the assurance work plan by the P&RC, development of a new Board and Standing Committee report template, and accompanying guidance with a focus on risk, assurance (the three lines of defence) and performance.

- As previously reported in the 2021/22 ICE report, during 2021/22 the necessary focus has been on the immediate priority of the response to Covid19 and on government mandated actions and performance. The challenge will be in balancing short term risks against longer term risks which can only be mitigated through strategic change. The shape of future strategy will be dependent on a number of complex factors, not all of which are known yet, but the Board is instigating the necessary preparatory work and a risk assessment to ensure the most urgent work is prioritised.

- Review and update of the Healthcare Strategy continues to be progressed, with the restart of the Strategic Deployment Matrix model and an ongoing commitment to focus on changing culture. The Healthcare Strategy will be essential to NHS Forth Valley's long term sustainability in the face of significant demand, workforce and financial pressures in the coming years. NHS Forth Valley's overall strategy will need to be realistic, in the context of those pressures. Whilst the Scottish Government Health and Social Care Directorate (SGHSCD) have set a number of very challenging national objectives, NHS Forth Valley will need to ensure that its own strategic objectives are deliverable within acceptable risk tolerances.

- Version 4 of the Forth Valley System Wide Remobilisation Plan (RMP4) was submitted to Scottish Government on 7 October 2021. Scottish Government approval was received on 19 November 2021 and RMP4 was approved by the November 2021 NHS Forth Valley Board.
- Submission of Sustainability Plans to Scottish Government, in order to improve waiting times performance.
- A report was presented to the June 2022 Audit and Risk Committee, confirming consistency of the Governance Statement, Directors' assurances and Standing Committee annual reports.
- Continuous improvement in the format of the Performance & Recovery Scorecard.
- Developing NHS Forth Valley as an Anchor Institution, with a focus on sustainability.
- Development of the Innovation Plan 2022-2027 and a focus on local innovation through the 7 June 2022 Board Seminar.

26. During 2021/22 we delivered 20 audit products with a further two products issued in draft. These audits reviewed the systems of financial and management control operating within the Board.

27. Our 2021/22 audits of the various systems and processes provided opinions on the adequacy of controls in these areas. Summarised findings or the full report for each review were presented to the Audit and Risk Committee throughout the year.

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

29. Board management continue to respond positively to our findings and action plans have been agreed to improve the systems of control. The Audit and Risk Committee Co-ordinator, on behalf of the Chief Executive, currently maintains a system for the follow-up of audit recommendations and reporting of results to the Audit and Risk Committee. As reported to the March 2022 Audit and Risk Committee, 62 actions were due to be completed by 25 March 2022. Of these, 57 actions were complete or partly complete. Of the five actions which were overdue, one was assessed as high risk, two as medium risk and two as low risk.

## ADDED VALUE

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

- Reviewing effectiveness of governance, risk management and performance management arrangements relating to Recovery, Redesign and Renewal.
- Examining a wide range of controls in place across the organisation.
- In conjunction with Local Authority Internal Auditors, undertaking IJB internal audits and providing the Chief Internal Auditor Service for Clackmannanshire & Stirling IJB.
- For Clackmannanshire & Stirling IJB, updating and enhancing the IJB Governance Statement self assessment checklist.
- Evaluating progress against the Primary Care Improvement Plan (PCIP) to agreed timescales and reviewing the effectiveness of PCIP governance, risk management and performance monitoring mechanisms.
- Liaising with the Chair, Chief Executive and Directors, on issues of governance, risk, control and assurance.

- Developing Committee assurance, reporting and risk assessment principles for adoption by Standing Committees and conducting detailed discussions around their implementation.
- The CIA attending NHS Forth Valley Board Development Events for risk management, performance and assurance.
- The CIA providing presentations on assurance.
- Highlighting national governance developments with relevance to NHS Forth Valley.
- Continuing Internal Audit facilitation of Assurance Mapping and promulgation of the principles for assurance developed by that group in order to inform immediate and longer term governance thinking as well as liaison with the SGHSCD and others to ensure local developments are congruent with a range of ongoing national initiatives.
- Continued development and use of the principles for HSCI governance and sustainability within the Board and its IJB partners.
- Detailed review of the preparation for revising Clackmannanshire & Stirling IJB's Strategic Commissioning Plan.
- Providing opinion on, and evidence in support of the Governance Statement at year-end, and conducting an extensive Internal Control Evaluation which permitted remedial action to be taken in-year. This review made recommendations focused on enhancements to ensure NHS Forth Valley has in place appropriate and proportionate governance, which supports and monitors the delivery of objectives and is commensurate with the challenging environment within which it is operating.
- Contribution to the ongoing review of the NHS Forth Valley Risk Management Strategy and Forth Valley IJB Risk Management Framework.
- Provision of the Fraud Liaison Officer function for NHS Forth Valley.

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

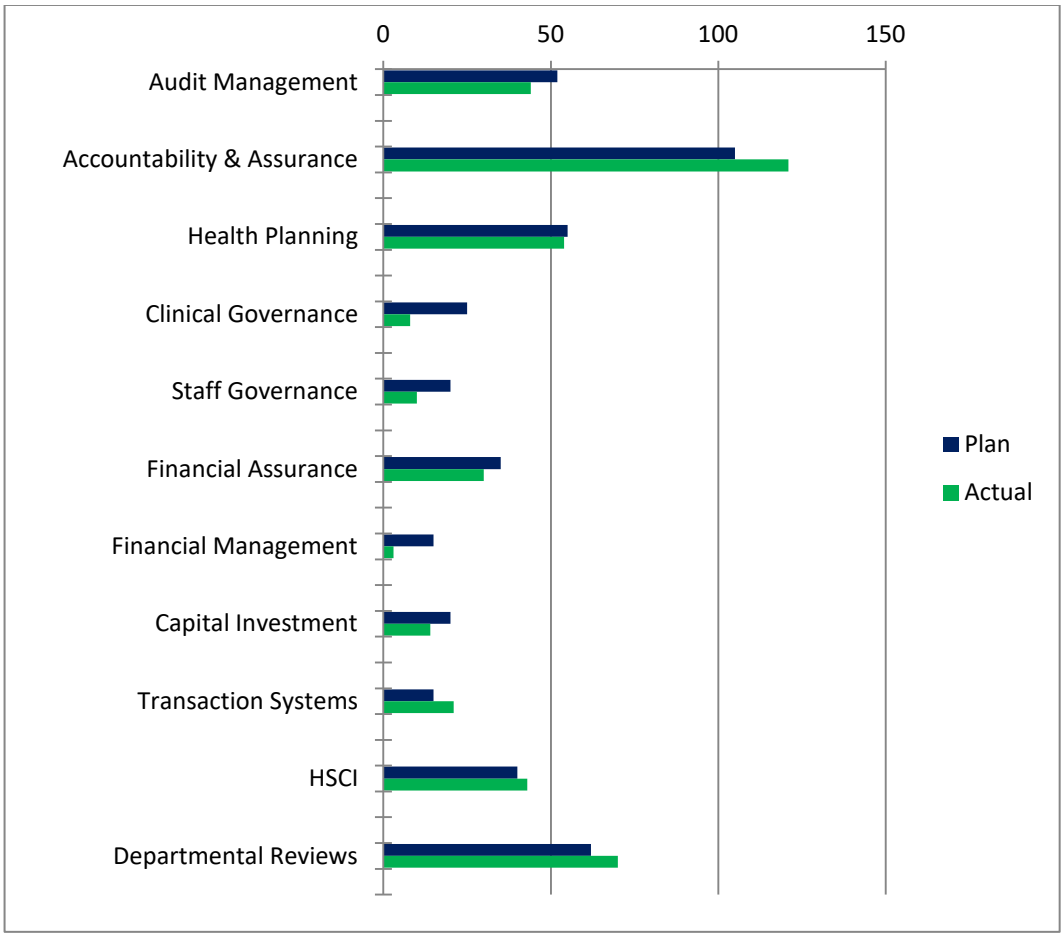
- Update of the Committee Assurance Principles.
- Development of a good practice template for the process of developing new Strategic Plans in IJBs and Health Boards.
- Development of the FTF website.
- Review and update of the FTF self assessment against the Public Sector Internal Audit Standards.
- Review of our recommendation priorities to include an additional category 'Moderate' and updated the assurance definitions.
- Update of the Property Transaction Monitoring Checklist for FTF clients.

32. The 2021/22 Annual Internal Audit Plan included provision for delivering audit services, together with council colleagues, providing the Chief Internal Auditor function to Clackmannanshire & Stirling IJB and contributing to the audit plan of Falkirk IJB. Internal Audit Plans were agreed for each IJB. Internal Audit has continued to highlight governance and assurance aspects of integration and the need for clear lines of accountability and ownership of risk as well as the requirement for revised Strategic Commissioning Plans and working with partners.

33. For 2022/23, the provision of the Chief Internal Auditor function will rotate, with FTF providing the service for Falkirk IJB.

# INTERNAL AUDIT COVERAGE

**34. Figure 1: Internal Audit Cover 2021/22**




35. Figure 1 summarises the 2021/22 outturn position against the planned internal audit cover. The initial Annual Internal Audit Plan was approved by the Audit and Risk Committee at its meeting on 15 July 2021. It was agreed at that time that the plan would be revised as changes to the risk profile and other factors became better known, and the Audit and Risk Committee approved amendments in March 2022. We have delivered 418 days against the 439 planned days. Internal audits of Financial Management, with a focus on cost improvement plans, Capital Planning and Patients' Property have been risk assessed for inclusion within the 2022/23 Annual Internal Audit Plan.

36. A summary of 2021/22 performance is shown in Section 3.

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

37. Due to prioritisation of Covid19 duties, the FTF Partnership Board did not meet in 2021/22. The Partnership Board is chaired by the NHS Tayside Director of Finance and the FTF client Directors of Finance are members. The FTF Management Team are attendees. During the year the Partnership Board virtually reviewed the Internal Audit Framework and the Internal audit self assessment, as well as approving the 2021/22 budget.

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

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

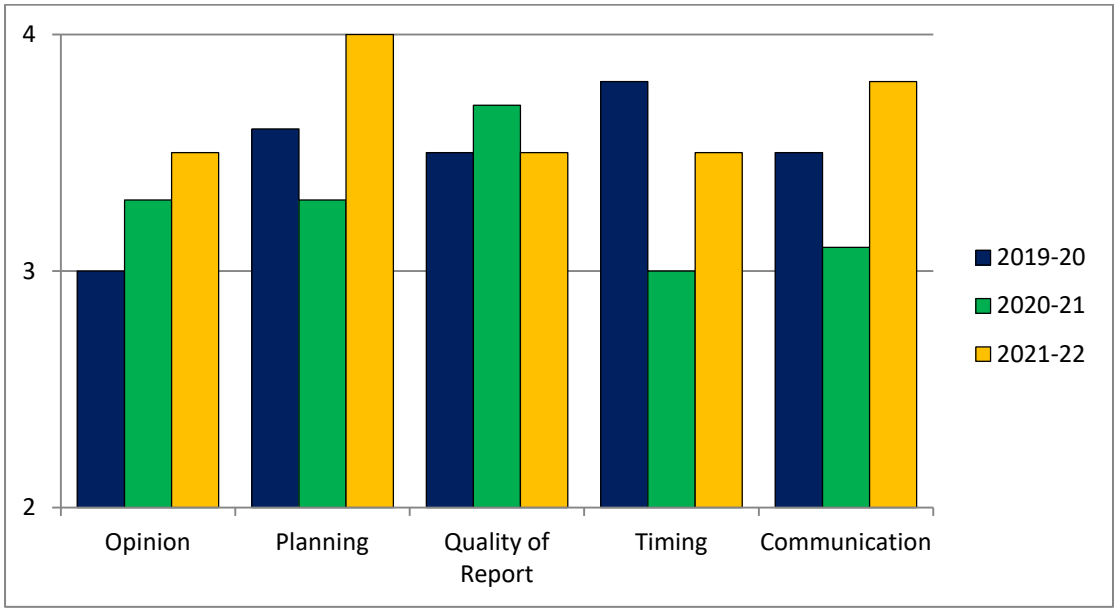
40. Internal and External Audit liaise closely to ensure that the audit work undertaken in the Board fulfils both regulatory and legislative requirements. Both sets of auditors are committed to avoiding duplication and securing the maximum value from the Board's investment in audit.

41. Public Sector Internal Audit Standards (PSIAS) require an independent external assessment of internal audit functions once every five years. The most recent External Quality Assessment (EQA) of the NHS Forth Valley Internal Audit Service in 2018/19, concluded that *'it is my opinion that the FTF Internal Audit service for Fife and Forth Valley generally conforms with the PSIAS.'* FTF has updated its self assessment which is presented to the June 2022 Audit and Risk Committee June.

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

**43. Figure 2: Summary of Client Satisfaction Surveys**

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



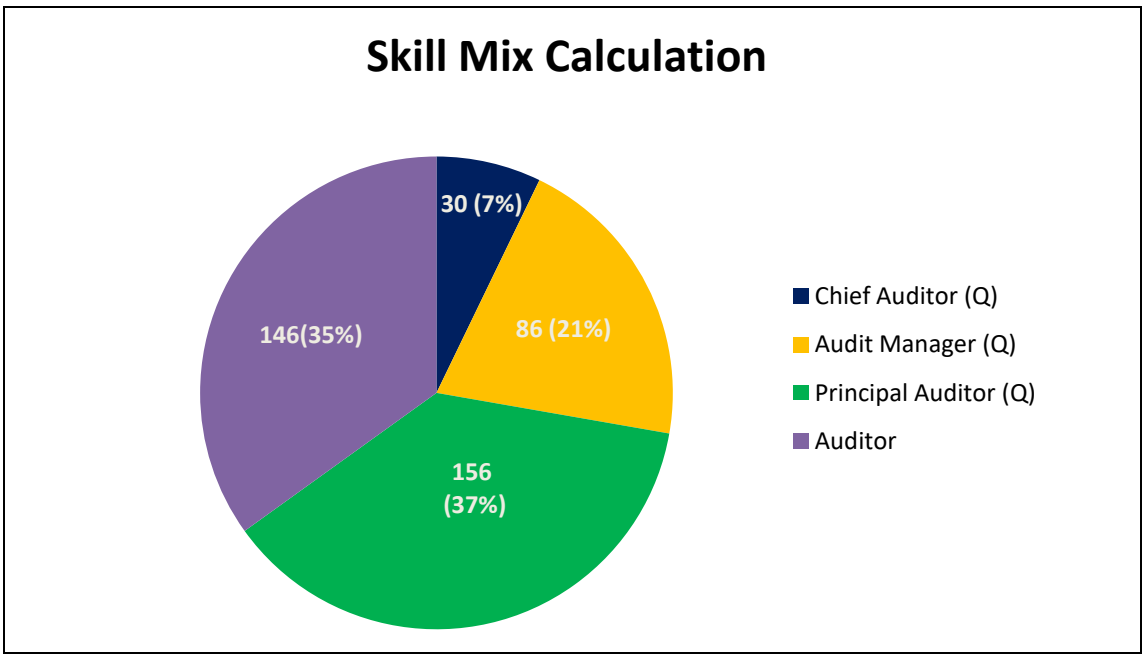

44. Other detailed performance statistics are shown in Section 3.

## STAFFING AND SKILL MIX

45. Figure 3 below provides an analysis, by staff grade and qualification, of our time. In 2021/22 the audit was delivered with a skill mix of 72%, which exceeds the minimum service specification requirement of 50% and reflects the complexities of the work undertaken during the year.

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

**Audit Staff Inputs in 2021/22[days] Q= qualified input.**



## ACKNOWLEDGEMENT

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

48. My team and I have greatly appreciated the positive support of the Chief Executive, Director of Finance, the Head of Policy and Performance, the Audit and Risk Committee and the Audit and Risk Committee Co-ordinator.

**A Gaskin, BSc. ACA**
**Chief Internal Auditor**

## Corporate Governance

### Strategic risks:

- **SRR012 - Covid19 Remobilisation: If NHS Forth Valley does not deliver an effective remobilisation plan in response to Covid19 there is a risk we fail to manage demand on services and miss opportunities for long term change / improvement**

- **SRR014 - Healthcare Strategy: If the planned review of the NHS Forth Valley Healthcare Strategy (2016-2021) does not incorporate learning from the Covid19 pandemic and does not align with government policy and / or Integration Authorities Strategic Commissioning Plans there is a risk the Board's vision, corporate objectives and key priorities will be incorrect, resulting in services that are not sustainable in the long term and an inability to deliver transformation**

**Strategy**

The 29 March 2022 Board approved revised corporate objectives, with a focus on prevention and sustainability. Two new corporate objectives were updated and agreed:

- Protect and Improve the Health and Wellbeing of the people of Forth Valley whilst reducing health inequalities.
- Improve our focus on safety and quality (and sustainability).

The SGHSCD issued the NHS Recovery plan on 25 August 2021. The recent Audit Scotland report 'NHS in Scotland 2021' stated that '*The ambitions in the plan will be stretching and difficult to deliver against the competing demands of the pandemic and an increasing number of other policy initiatives..... The recovery plan will involve new ways of delivering services and these will take a lot of work. There is not enough detail in the plan to determine whether ambitions can be achieved in the timescales set out.'*

The SGHSCD have subsequently issued further guidance reiterating its intention for NHS Boards to deliver the objectives within the NHS Recovery Plan. However, it is clear that the workforce and financial assumptions underlying both the NHS Recovery Plan and the Health and social care: national workforce strategy would require very careful risk assessment, before they could be relied upon in local planning.

Whilst the Board will need to be cognisant of SGHSCD ambitions, its priority must be the production of a realistic, achievable strategy which addresses the needs of the local population post-Covid19 within the parameters of available resources, most particularly financial, digital and workforce. This will almost inevitably involve extremely difficult decisions, which may not fully align with public or SGHSCD expectations.

During the Covid pandemic, there was a necessary shift of focus towards operational priorities, which reflected the extreme risks in those areas as well as an influx of Covid related funding which lessened the immediate financial risk. In future, the risks related to financial sustainability are likely to rise sharply and rapidly, with the acute sector in particular facing very significant financial challenges. Consideration of the changes in culture required to adapt to this change should start now.

The ICE report, issued in January 2022, highlighted NHS Forth Valley's progress towards development of an updated Healthcare Strategy. Since the ICE report, there has been slippage in the revision and update of the strategy due to system pressures and the continued operational impact of the Covid19 Pandemic, and the Scottish Government requirement to prioritise the completion of the 2022/23 annual operating plans.

Development of the revised strategy remains a key priority for NHS Forth Valley and the guiding principles for its development were contained within the Chief Executive's presentation to the 9 May 2022 ELT 'Developing our True North'. A Corporate Management Team (CMT) session on 'Developing our level 0 Strategy Development Matrix' will be held on 7 July 2022, with a focus on the strategic plan for 2022/23, and the vision for future years.

The refreshed Healthcare Strategy is scheduled for presentation to the November 2022 Board for approval and the Chief Executive provided the Board with an update on the timetable to refresh the strategy as part of the Anchor Organisation presentation to the 31 May 2022 meeting.

As part of the Strategy consultation process, a staff event on culture and compassionate leadership planned for March 2022 was postponed due to Covid-19 pressures and requirements and will now take place on 23 and 24 June 2022.

Strategic risk 0014 – Healthcare Strategy is scored as 15 – High, with a target score of 3 - low. Internal audit A14/22 - Strategic Planning is ongoing and will assess in detail the process to develop the updated Healthcare Strategy against the best practice checklist developed by FTF.

**System-wide Remobilisation**

The CMT was established in July 2021 to oversee the development and delivery of the System-Wide Remobilisation Plan.

Following approval of RMP4 by Scottish Government and by NHS Forth Valley Board in November 2021, progress has been reported to NHS Forth Valley Board and the P&RC through the Recovery & Performance scorecard, with the RMP4 delivery plan update appended to the scorecard since March 2022.

At the end of quarter 4, of a total of 133 actions, 65 were green, 27 were amber, one was red and 39 had been closed off.

Internal audit A15/22 – Recovery, Redesign and Renewal provided Reasonable Assurance on this area.

**Operational Planning 2022/23**

Territorial Boards are required to submit Annual Delivery Plans for 2022/23 by the end of July 2022, using the current Delivery Plan template and focussed on a limited set of priorities to enable recovery and strengthen services for any future Covid19 waves and the demands of next winter. This aligns with the submission of three Year Workforce Plans.

**Covid19 & Governance**

The Board has responded positively to the governance challenges posed by Covid19, with reporting during 2021-22 on: Test and Protect; Incident Management Teams; Covid19 vaccination programme; public communications and advice; and roll out of lateral flow testing to staff.

Challenges have continued during 2021/22 and the command structure which was stood down from 1 April 2021 was reinstated in August 2021 due to resurgence in Covid19 cases.

**Governance and assurance developments**

Work to introduce and ensure levels of assurance are evidenced in Board and Assurance Committee papers was launched at the 7 June 2022 Board Seminar.

**Annual Reports**

Our review of Standing Committee annual reports evidenced that they were broadly in line

with the Committee Assurance Principles.

The P&RC annual report will be considered for approval at the 28 June 2022 meeting, prior to submission to Board in July 2022. Action point 2 recommends an improved process for agenda planning to ensure that any issues arising during the year, for example external reports that provide new and important information; flow through to the Governance Statement. The introduction of Standing Committee assurance work plans will assist with this.

**Assurance Mapping**

The Chief Internal Auditor (CIA), working with officers from NHS Forth Valley and other client Health Boards, developed a set of Committee Assurance principles, together with a series of questions which would help Standing Committees assess the assurances they receive on risks delegated to them. The CIA has presented the principles to Executive and Non Executive Board members and these have been adopted.

**Governance Blueprint & Developments**

The steady progress on the Governance Blueprint action plan has continued, although some dates have been extended. Work on Active Governance continues following the November 2021 Board seminar. The national Governance Blueprint has been revised and as at May 2022 it was with the Health & Social Care Management Board for approval. The Chief Executive last reported to the NHS Board on progress against the Blueprint on 25 January 2022. Action plan dates will be kept under review to ensure they are realistic and achievable.

A revised committee structure was approved by the NHS Board on 25 January 2022. As part of this process the NHS Board Chair considered Non-Executive's commitments and met with members to discuss proposed changes.

The revised Code of Corporate Governance was approved by the NHS Board on 29 March 2022.

At the January 2022 NHS Board meeting, the acceptance of a revised Best Value approach was noted; aligned to the 2020 updated Scottish Government guidance on best value. The P&RC monitors aspects of best value, including value for money and performance, as standing agenda items.

The NHS Forth Valley Annual Review was held virtually in February 2022. At the time of audit fieldwork, feedback from Scottish Government had not been received.

**Emergency Department (ED) report**

Progress against the ED Action Plan was monitored by the ED Oversight and Assurance Sub Committee and is reported to the NHS Board through the Standing Committees.

Internal audit A30/22 - Organisational response to Emergency Department external review, was commissioned by the Chair and Chief Executive. The first phase of the review will provide assurance on NHS Forth Valley's response to the external review and will be reported to the October 2022 Audit & Risk Committee. Phase 2 will be included in the 2022/23 internal audit annual plan and will assess whether action taken has been effective in achieving intended improvements, both in the ED department and organisation wide.

The ED report and ongoing actions to address the issues identified feature within the draft 2021/22 Governance Statement.

**Risk Management**

The NHS Forth Valley Risk Management Strategy has been updated but full consultation and

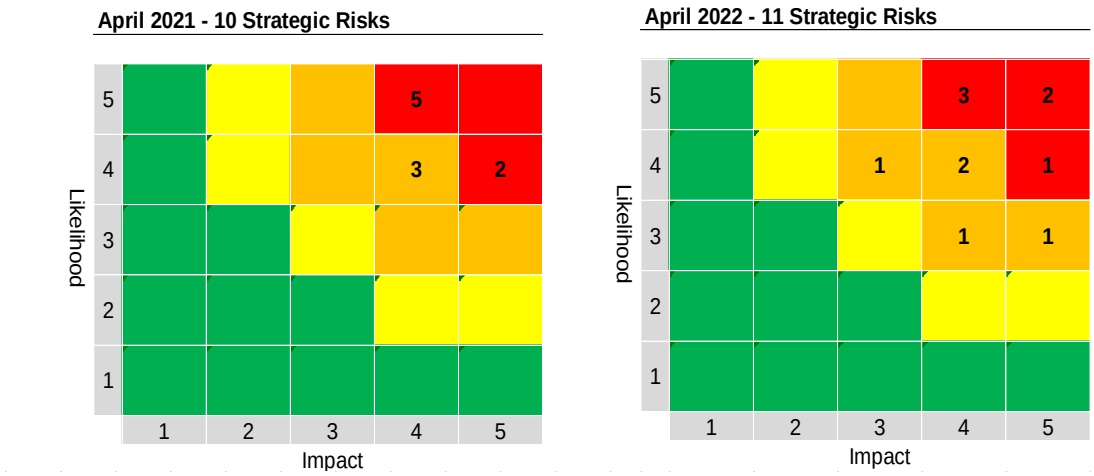
finalisation have been delayed due to staffing changes in the Risk Management Team. Following the departure of the previous post holder in December 2021, a new Corporate Risk Manager commenced in April 2022. The updated Risk Management Strategy is scheduled for presentation to the Audit and Rick Committee on 22 June 2022 and to the NHS Board on 26 July for discussion and approval. The Risk Management Strategy has been developed to become a 3-year Risk Management Framework. It will be further updated in 2022/23 to include risk appetite and a more detailed section on partnership arrangements. Guidance for Risk Owners, Risk Leads and Risk Champions, as well as a toolkit to help Directorates manage their risk profile(s) effectively will also be developed. Internal Audit provided detailed commentary on the draft Strategy.

The Risk Management Annual Performance Report 2021-22 will be presented to the 22 June 2022 Audit and Risk Committee.

Development of risk appetite has been delayed but work is ongoing to set and agree appetite for each of the nine risk matrix categories. Risk appetite approval is planned for the September 2022 NHS Board.

Following the P&RC deep dive in to the Financial Sustainability risk in October 2021, the planned programme of 'deep dives' of strategic risks will be implemented from July 2022 onwards.

The Strategic Risk Register continues to be presented to the NHS Board on a quarterly basis. There are 11 strategic risks, six of which are 'Very high' and 5 of which are 'High'.




The risk score for strategic risk SRR002 - Unscheduled Care has increased from 20 to 25, as increased staff absences and delayed discharges adversely impacted on the delivery of work streams intended to mitigate the risk.

Three risks have reduced in score during the year, and one risk was de-escalated (SRR013 Brexit). There have been three additions to the SRR during the year:

- SRR014 – Healthcare Strategy (current score 15, target score 3);
- SRR015 – Cyber Resilience (current score 20, target score 16); and
- SRR016 – Out of Hours Service (current score 20, target score 9).

Internal audit A18/22 – Scheduled Care is ongoing and will evaluate the design and operation of key controls to mitigate the clinical risk of deferred treatment.

**Performance**

The Unscheduled Care Programme Board has been re-established, with a focus on responsive whole system operational management and escalation, ongoing implementation of the Board's approved Redesign of Urgent Care including redesign of Same Day Emergency Care, and Flow and Navigation Centre to support in and out of hours services and discharge without delay to optimise capacity notable on the acute hospital site. The Scheduled and Unscheduled Care strategic risks are aligned to the Clinical Governance Committee.

NHS Forth Valley has maintained urgent planned care procedures with only one temporary pause in January 2022 due to Covid. From March 2021 to March 2022 performance in outpatients increased by 43% for new outpatient appointments and there was a 26% increase in return outpatient appointments. Excluding additionality within services, overall new outpatient activity increased by 16.3% and return outpatient activity increased by 4.4%.

NHS Forth Valley has submitted plans to Scottish Government to support the aim to build sustainable and resilient services that address local demand built up over time. Through these key sustainability plans, NHS Forth Valley anticipates that performance will be in balance by December/January 2022/23 with a net capacity surplus by January 2023. This ambition does not take into account: Recruitment difficulties; winter pressures; impact of Covid19 surges; staff absence; bed occupancy and delayed discharges; any future pause of elective care.

Performance against key targets at end of March 2022 is detailed below:

| Target | Target or Planned Performance | Actual Performance | Commentary |
|---|---|---|---|
| Treatment Time Guarantee (TTG) | 100% | 51.90% | Below target |
| **Unscheduled Care** | | | |
| 4 hour ED target | 95% | 64.40% | Below target – capacity and flow through the system and system-wide pressures. |
| **Scheduled Care** | | | |
| Inpatients/daycases | 9,723 | 8,077 | 83% on plan achieved. |
| Outpatient appointments | 62,474 | 60,344 | 97% of plan achieved. |
| **Cancer Targets** | | | |
| 31 days | 95% | 97.90% | Target achieved |
| 62 days | 95% | 72.20% | Below target |
| **Diagnostics** | | | |
| Imaging | 35,232 | 36,965 | Plan achieved-105% |
| Endoscopy | 4,124 | 4,493 | Plan achieved- 109% |

| | | | |
|---|---|---|---|
| Psychological Therapies | | | |
| 18-week referral to treatment standard | 90% | 69.2% | Below target |
| 18-week RTT Remobilisation Plan trajectory | 60%. | 69.2% | Plan achieved |
| CAMHS | | | |
| 18-week referral to treatment standard | 90% | 67.2% | Below target |

**Delayed Discharges-** the delayed discharge position at March 2022 was a total of 97 delays, with 32 of these delays of over 2 weeks.

**Integration**

In December 2019, it was agreed that progress with actions from the Ministerial Steering Group (MSG) for Health and Community Care – Self Evaluation were to be reported to NHS Forth Valley Board on a six monthly basis. However, as previously highlighted in the internal audit 2020/21 annual report there are still no updates on progress of the delivery of MSG actions from the IJBs.

Annual reports from the IJBs, outlining 2020-21 performance against agreed plans, were submitted by both Clackmannanshire & Stirling HSCP and Falkirk HSCP to the NHS Board meeting on 30 November 2021, and the NHS Board received IJB minutes throughout the year.

Reviews of the Integration Schemes for Clackmannanshire & Stirling and Falkirk IJBs were paused due to Covid19 pressures and are due to be revisited and completed in September 2022.

## Action Point Reference 1 – Sustainability

### Finding:

For many years, NHS Forth Valley has had strong financial control and clearly understood the importance of financial sustainability, without which it will be unable to achieve its Strategic objectives in the long term.

During the Covid pandemic, there was a necessary shift of focus towards operational priorities, which reflected the extreme risks in those areas as well as an influx of Covid related funding which lessened the immediate financial risk. In future, the risks related to financial sustainability are likely to rise sharply and rapidly, with the acute sector in particular facing very significant financial challenges. However, whilst the longer term financial risks have increased, the culture and conditions which provided financial stability may have dissipated in the face of overwhelming operational pressures, the prioritisation of operational activity and ease of access to funding.

The focus on cost improvement is intended to reset the culture and processes to ensure strong financial grip and strategic prioritisation of financial balance to be re-established.

### Audit Recommendation:

The Board and ELT should ensure that financial sustainability is given appropriate priority in all decisions, recognising that money spent now will not be available for future needs. The Strategic planning process must give suitable priority to financial (and indeed workforce) sustainability. If this is not addressed then the assessment of risk is significant.

There may be benefit in a future Board Seminar giving overt consideration as to how such a culture can be re-established and reinforced in all future decisions, at Board, Standing Committee, SLT and operational levels.

### Assessment of Risk:

| | | |
|---|---|---|
| Significant |  | Weaknesses in design or implementation of key controls i.e. those which individually reduce the risk scores.<br>**Requires action to avoid exposure to significant risks to achieving the objectives for area under review.** |

### Management Response/Action:

**The significant risk on financial sustainability is acknowledged and reflected in the NHS Board Strategic Risk Register. The mitigating actions have been revised and updated in response to the increased level of financial uncertainty and volatility and the requirement to focus on urgent cost improvement plans.**

**The Director of Finance is leading on a systematic and methodical review of key spend areas with all ELT Director colleagues and the Corporate Programme Management Office to develop a structured cost improvement plan in support of current year savings requirements and to build a pipeline of priority plans for future. Progress will be reported quarterly through the Cost Improvement Oversight Group and updates provided to the Performance and Resources Committee from the June 2022 meeting onward.**

**Financial Governance controls will also be reviewed and enhanced in line with the**

| | |
|---|---|
| **escalating risk and this will include new documentation to update financial decision making processes, a review of workforce and recruitment controls and the introduction of Directorate and Partnership Assurance Reviews to drive improved financial performance.** | |
| **Action by:** | **Date of expected completion:** |
| **Director of Finance** | **Strategic financial risk review – June 2022**<br>**Initial Cost Improvement Plan – July 2022**<br>**Decision Making Matrix – July 2022**<br>**Workforce & Recruitment Controls– Aug 2022** |

## Action Point Reference 2 – Flow of assurances

### Finding:

It is important that reporting flows through the Committee structures properly and that key aspects of the control environment arising from the work of Directors and committees are escalated naturally through these processes.

It is particularly important that when there are reports that provide new and important information about the control environment, that these fed through to year end assurance processes so that the Governance Statement is as complete as possible.

For example, the Health & Safety Executive (HSE) identified three Material Breaches relating to a significant adverse event within Mental Health. The ELT (previously SLT) reviewed an action plan which the HSE was satisfied with and, while the operational treatment of the issue was satisfactory, reporting through Standing Committees was not as prominent as it could have been.

### Audit Recommendation:

The process to ensure all issues from external reports are included in committee agendas and annual reports could be strengthened. At agenda planning meetings all relevant, significant external reports should be considered for inclusion on the agenda and, if presented to the committee, the author should focus the cover paper on the following:

- Areas of non-compliance and explanation of the impact on the control environment.
- Assessment of whether the issues had, or should have, been identified by internal assurance systems.
- Action to remedy any significant findings and how these will be monitored.
- Assessment of the impact on the relevant strategic risks.
- Where material, an overt conclusion on whether the issue should be highlighted to the Audit and Risk Committee as requiring consideration for disclosure within the Governance Statement.

### Assessment of Risk:

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

### Management Response/Action:

**NHS Forth Valley acknowledge the assessment of risk and supports the recommendations to enhance assurance processes as outlined and these will be implemented going forward.**

| Action by: | Date of expected completion: |
|---|---|
| **Executive Leads for Standing Committees**<br>**Cathie Cowan, CEO and Executive Lead for P&RC**<br>**Linda Donaldson, Director of HR and Executive lead for SGC**<br>**Andrew Murray, Medical Director and Executive Lead for CGC**<br>**Scott Urquhart, Director of Finance and Executive Lead for Audit and Risk Committee** | **April 2023 (for 2022/23 annual reports)** |

| Action Point Reference 3 - Integration | | |
|---|---|---|
| **Finding:** | | |
| In December 2019 it was agreed that progress with actions from the Ministerial Steering Group (MSG) for Health and Community Care – Self Evaluation were to be reported to NHS Forth Valley Board on a six monthly basis. However, Forth Valley NHS Board did not receive any updates during 2021/22.<br><br>Review of the IJB Integration Schemes has been delayed and progress has not been reported to Forth Valley NHS Board. | | |
| **Audit Recommendation:** | | |
| NHS Forth Valley should request that the two IJBs present a high level progress report to the Board, at least twice annually. This report should provide an update on progress with MSG recommendations, progress with the review and agreement of the Integration Schemes, and should summarise any relevant issues from the IJBs. | | |
| **Assessment of Risk:** | | |
| Moderate |  | Weaknesses in design or implementation of controls which contribute to risk mitigation.<br><br>**Requires action to avoid exposure to moderate risks to achieving the objectives for area under review.** |
| **Management Response/Action:** | | |
| **NHS Forth Valley accepts the audit recommendation and will work directly with the Chief Officers to agree 2 in year updates to the NHS Board from the IJBs.** | | |
| **Action by:** | | **Date of expected completion:** |
| **Head of Policy and Performance** | | **November 2022** |

## Clinical Governance

### Strategic risks:

- **SRR002 – Unscheduled Care: If NHS FV fails to deliver on the 6 Essential Actions Improvement Programme there is a risk we will be unable to deliver and maintain appropriate levels of unscheduled care, resulting in service sustainability issues and poor patient experience (including the 4 hour access standard).**
- **SRR004 – Scheduled Care: If there are delays in delivery of scheduled care there is a risk that NHS FV will be unable to meet its obligations to deliver the National Waiting Times Plan targets, resulting in poor patient experience and outcomes.**
- **SRR016 – Out of Hours Service (OOHS): If NHS FV is unable to provide a fully staffed and functioning OOHS, there is a risk of instability within the service leading to an inability to provide robust and timely care to patients.**

**Clinical Governance Committee (CGC) and Annual Report**

The CGC met four times, a reduction in the planned number of meetings as a result of the continued emergency footing. The CGC annual report 2021/22 provided assurance on the adequacy of clinical governance arrangements in the context of the challenges presented by Covid19, and confirmed that all but three items in the Forward Planner had been considered. The CGC annual report concluded that the gap was not significant, and did not adversely affect the committee's ability to provide the necessary assurance.

The Clinical Governance Working Group Annual Report was not presented to the CGC prior to consideration of their annual report due to the timing of the CGWG meeting in March, but it has now been shared with members.

In addition to the standard items considered by the CGC in line with the requirements of the Vincent Framework, the CGC also considered several other reports including:

- An overview of clinical governance structures.
- A presentation on the Clinical Prioritisation Plan for Remobilisation.
- The internal audit Internal Control Evaluation (ICE) report.
- Updates on the three Adult Support and Protection Inspections.

Since the issue of our ICE, the operation of the CGC has been enhanced through:

- Establishment of clear linkages between the CGC and CGWG Forward Planners and the committee annual reports.
- Consultation with both CGC members and attendees to obtain feedback on CGC reports; the Organisational Development department is supporting training to ensure members understand their role and how to discharge it effectively.
- Completion of work to embed the Vincent Framework for Measuring and Monitoring Safety in the NHS.
- Introduction of a programme of Patient Safety Conversation Visits, incorporating Leadership Walkrounds. Outcome reports are currently shared with local teams and with senior medical, nursing and managerial staff. As a development an annual report will be produced, focussing on themes.
- A presentation on the Cancer Services update was provided to the February 2022 CGC and the 1 March 2022 P&RC, describing the 5 year Cancer Strategy, the framework for effective cancer management, quarterly performance monitoring arrangements and

waiting times. The P&RC asked for the key challenges and opportunities described to be compiled into an action plan describing what is required to support a sustainable service, to be reported back to P&RC.

- Ongoing work to revise clinical governance reporting structures and development of Pentana reports to ensure consistency and focus in reporting.

**Risk**

The three strategic risks aligned to the CGC are SRR 002 – Unscheduled Care and SRR004 – Scheduled Care, both of which are scored as Very High (20). A new risk SRR016 – Out of Hours Service was introduced in March 2022, with a risk score of Very high.

The Scheduled Care risk still focuses on performance targets, rather than on the potentially more significant risk of harm arising from a failure to prioritise services, and patients within those services effectively. The CGC has not yet undertaken a Deep Dive of this, nor of any of the other risks aligned to it. Internal Audit is currently reviewing this risk and will assist in the transition to one which more accurately reflects the clinical risks of deferred treatment, or indeed the creation of a new risk if that is preferable.

Reporting on Scheduled and Unscheduled Care performance has been predominately through the P&RC and not to the CGC, with a focus on performance rather than on clinical governance aspects. The CGC annual report acknowledges that when the risk management work plan is rolled out, significant clinical risks will be escalated to the CGWG and CGC.

The CGWG continued to monitor the operational risk Covid19 capacity pressures (scored as High – orange), which was also presented to the CGC in November 2021 and in February 2022, where it was agreed that Care at Home would be included.

Reporting of the Covid19 infection rates are included within the quarterly Healthcare Associated Infection (HAI) reports to the CGC.

**Safe Care**

The CGC and CGWG are well informed of the challenges being experienced in relation to capacity and maintaining safe staffing. However, we note the continuing capacity issues within the acute hospital, and the constant need for ongoing risk assessment.

**Quality Strategy**

Work to implement the Quality Strategy 2021-2026 was delayed by to Covid19. Now that a full clinical governance team is in place, an implementation plan is being developed. A Clinical Governance Strategy has not been developed and the CGC has not received an update on progress.

**Significant Adverse Events (SAERs)**

Management have informed us that the Adverse Event Policy does not reflect current practice, and will be revised as a priority.

There is now improved liaison and intelligence sharing between the Complaints, Clinical Governance and Human Resources teams, with the aim of triangulating information to proactively mitigate potential risks to patient safely.

At the time of our review, the Duty of Candour annual report had not been drafted but the requirement for this was agreed. In future, it would be beneficial for this to be available to be ready in time to inform year end assurances.

**HSCPs**

IJB representatives are now regular attendees at NHS Forth Valley CGC meetings. The Head

of Clinical Governance attends the two IJB Clinical & Care Governance Committee meetings and has updated the Falkirk IJB Clinical & Care Governance Committee on NHS Forth Valley clinical governance arrangements.

The Falkirk IJB Clinical & Care Governance Care Committee has produced an annual report confirming it had discharged its role and responsibilities, especially in relation to Public Protection Groups and Health and Social Care groups. However, this report has not been provided to the NHS Forth Valley CGC and there is not yet a Clackmannanshire and Stirling IJB report.

## Action Point Reference 4 – Clinical Governance assurances

### Finding:

The CGC have the remit to provide:

- Systems Assurance – to ensure that clinical governance mechanisms are in place and effective throughout the local NHS system.
- Public Health Governance – to ensure that the principles and standards of clinical governance are applied to the health improvement and health protection activities of the NHS Board

Risk Management

There has been no reporting on either the Scheduled or Unscheduled Care risks to the CGC, even through these risks are aligned to the committee. While these risks have performance elements and there was a presentation on Unscheduled Care to the P&RC in January 2022 and presentations on Scheduled Care to both the P&RC and CGC in August 2021, the CGC is not regularly updated on clinical governance elements of the risk. As previously reported, the Scheduled Care risk still does not reflect the significant risk of harm arising from a failure to prioritise services, and patients within those services effectively.

HSCP and Public Health reporting

As previously reported, the CGC does not receive either annual reports or regular assurances from the HSCPs, nor is there regular or annual reporting on Non-Covid related aspects of Public Health, which is a key clinical function.

Other areas

Our review of CGC papers identified two areas where greater depth of discussion could be helpful:

- Focus on stage 2 complaints where targets are not being met.
- Adverse incident as referenced in action point 2.

### Audit Recommendation:

To ensure the CGC fulfils its remit in respect of clinical risk management, systems assurance and Public Health governance, we recommend the following assurances are provided to the Committee:

- Consideration should be given to bifurcating the Scheduled and Unscheduled Care risks so that the performance and clinical aspects can be reviewed appropriately by the correct Committee. The CGC should receive robust assurances on the controls and actions relating to the clinical aspects of these areas, including deep dives where appropriate.
- The CGC should receive updates on Public Health Performance including delivery of Public Health strategy, health improvement, health inequalities and public health updates from the HSCPs.
- There should be increased scrutiny of stage 2 complaints resolved within the required timescales, and findings of the complaints reviewed by the Ombudsman which were reported to both the CGC and CGWG but not referenced in either of their annual reports, nor is there evidence of detailed discussion.
- As referenced in the corporate governance section of this report, in our view the CGC

should have been provided with a standalone report on the clinical governance aspects of the HSE review following an adverse event within Mental Health. While a verbal update on the learning from the event was provided to the March 2022 CGWG, the CGC could have been better assured on the action take to make improvements following this incident.

## Assessment of Risk:

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

## Management Response/Action:

**Bifurcating risks will be difficult to do in practice and would likely lead to duplication of discussion which is unlikely to be helpful to the efficient work of the committee or clarity of ownership of actions. It can be considered by Head of Clinical Governance and Head of Performance, who support these committees, to see if it would add value.**

**Public Health inclusion is critical to the committee but has been difficult during the pandemic. The Director of Public Health will be reminded regarding the CGC and the Public Health requirements.**

**The Complaints Annual Report is discussed at the CGC and CGWG, as per its forward planner, and is transparent in terms of performance and themes. The Complaints Report is also a standing item on both groups and includes considerable detail. It is therefore uncertain what further assurance would be gained by including more complaints detail in the annual reports of the CGC and CGWG. It will be discussed with the incoming Director of Nursing.**

**Detailed discussion is dependent on the Committee and will be picked up through the ongoing CGC members' training needs assessment.**

| Action by: | Date of expected completion: |
|---|---|
| **Medical Director**<br>**Head of Clinical Governance**<br>**Head of Policy and Performance**<br>**Director of Public Health** | **December 2022** |

## Staff Governance

## Strategic risks:

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

**Workforce Planning and Risk Assurance**

The Staff Governance Committee (SGC) has not received any updates on implementation of the 2021/22 interim Workforce Plan since it was approved on 14 May 2021. Reporting has instead focused on implementation of the six strategic themes within the 'Our People' Strategy, which is broadly useful but does not relate specifically to the 2021/22 Workforce Plan.

Workforce planning remains an area of high risk which is fundamental to the achievement of NHS Forth Valley's strategic objectives and the SGC continued to receive regular assurance reports on strategic workforce risks during 2021/22. However, despite an agreed action, there was no deep dive into workforce risks, consideration of the delay in delivering the Workforce Strategy, or detailed understanding of the impact the demographics of the workforce and known pressures on demand for staff. While these deep dives have not yet taken place, we are advised that some work has been done to consider the risks associated with staff absenteeism and further work is planned to consider the impact of long shifts and band 2 working arrangements. In addition, the programme of deep dives is to be implemented in 2022/23.

The May 2022 SGC was informed of arrangements for completing the 3 Year Workforce Plan 2022-25, in accordance with the Scottish Governments Directive issued in April 2022. Internal Audit was advised that the draft Workforce Plan is not yet available, but is on track for completion by 31 July 2022 as required. The timescales for completion of the workforce plan will be extremely challenging.

The National Workforce Strategy for Health and Social Care in Scotland was published in March 2022, and on 1 April 2022, the SG issued associated guidance which required Boards to submit three year integrated health and social care Workforce Plans by 31 July 2022. The risk profile of the national strategy is not available, but our assessment would be that a number of assumptions within the document are very high risk.

The Workforce Strategy / Plan will need to inform and be informed by the overall strategy of the Board. When the new Workforce Strategy / Plan is presented to the SGC, there would therefore be considerable benefit in a companion paper which describes how it will be monitored by the SGC, how it fits with overall strategy and the developing IJB Strategic Plans, how the associated risks will be identified and consolidated within the new risk register and how assurance will be provided on progress.

The draft Internal Audit Plan contains provision for review of this key area, including assessment of whether the Strategy contains a robust assessment of future workforce needs

and key measures to ensure that those needs can be met sustainably.

**Staff Governance Assurances**

There was no requirement for a Staff Governance Action Plan for 2021/22. Instead, NHS Forth Valley put in place arrangements for each directorate to complete a self assessment of compliance with the Staff Governance Standard (SGS) and to prepare an action plan for required improvements. An update was provided to the 13 May 2022 SGC advising that Directorates have completed their initial assessments and a further update will be provided to the September 2022 meeting, detailing progress in implementing resulting action plans. While this indicates that progress is being made in reviewing compliance with the SGS, it does not provide comprehensive assurance to the SGC on compliance with the SGS during 2021/22 and what gaps remain. Updates on the five strands of the SGS are included in the SGC workplan for 2022/23.

**Staff Governance Annual Monitoring Return**

The Scottish Government advised all Health Boards in April 2022 that a different approach was being taken to the review of the 2020/21 monitoring return, which assessed compliance with the different strands of the SGS, in recognition of the continuing pressures faced by Boards. A small number of areas for improvement were highlighted in the Scottish Government response for NHS Forth Valley presented to the May 2022 SGC meeting and these are being taken forward through the Scottish Governance and Staff Governance (SWAG) Committee. An update on the progress resulting from the SWAG meetings is to be provided to the September 2022 SGC meeting and will include a dashboard to enable the areas for improvement to be monitored. Consideration of the 2021/22 monitoring return by the SGC is included in its workplan for 2022/23.

The SGC Annual Report 2021/22 was approved by the SGC on 18 March 2022, prior to SGC consideration of the Organisational Development and Health & Safety Annual Reports at the 13 May 2022 meeting. The Annual Report contains no reference to whether the committee received sufficient assurance on compliance with the SGS, an area it is responsible for overseeing.

**Remuneration Committee**

While no longer a sub-committee of the SGC, the 2021/22 Remuneration Committee Annual Report was presented to the 13 May 2022 SGC, confirming that arrangements were adequate and effective.

**Health & Safety (H&S), including training and Covid19**

A detailed and factual Health and Safety Annual Report 2021/22 was presented to the May 2022 SGC meeting, providing a summary of activity including training. Although the report did not highlight any significant matters for the attention of the SGC, it did include eight key points for noting, and a number of which covered areas where improvement is required. Monitoring of H&S actions is included at Appendix 2 of the H&S quarterly reports to the SGC. We noted good practice in the presentation of a Manual Handling and Violence & Aggression training update to the March 2022 SGC.

Throughout the year there was regular reporting to the SGC on the impact of the Covid19 pandemic and provision of assurance on the evolving measures to ensure NHS Forth Valley's workforce was being supported during the pandemic. This included a revision of training courses to specifically include topics relevant to Covid19. Our review of the reports presented to the SGC, including the Our People Strategy Progress updates and Health & Safety Quarterly updates showed that the Human Resources Directorate continues to respond positively to issues presented by Covid19. Recently, rather than specifically

referring to additional safety measures to prevent becoming infected with Covid19, the emphasis has changed to demonstrating the actions being taken to enable staff to work with Covid19 being present in their working environment. Assurance was also provided on a number of actions to help staff deal with the psychological impact of Covid19, but again the emphasis is on enabling staff to work with that impact being present on an ongoing basis, rather than just recovery.

Sickness absence for March 2022 was 5.52%, which whilst still high, was down from December 2021, when it was slightly above 6%.

**Appraisals**

TURAS appraisal completion continues to be impacted by the Covid19 pandemic, with a 13% completion rate at the end of March 2022. A further 17% are in progress, but 70% have not yet been started. This is an area that requires immediate action to improve compliance. Staff continue to use paper objective setting processes and it is important to move to a TURAS only process during 2022/2023.

At the end of March 2022, 88% of consultants had completed their Medical Revalidation and Appraisal, with the remainder due to be completed by 30 June 2022. Similarly, for GPs 98% had completed their Medical Revalidation and Appraisal.

**Whistleblowing**

Quarterly reports are presented to the SGC; detailing actions taken to implement the National Whistleblowing Standards and address any concerns raised in accordance with the standards. A 2021/22 Whistleblowing Annual Report, providing an annual statement of assurance on implementation of the National Whistleblowing Standards and details of the total annual activity is not scheduled to be provided to the SGC until December 2022. Although the SGC Annual Report for 2021/22 correctly provides assurance on the quarterly Whistleblowing reviews, in future this should be supplemented by provision of the annual Whistleblowing report prior to the issue of the SGC Annual Report, as recommended in the A08/22 – Internal Control Evaluation Report.

| Action Point Reference 5: Staff Governance Standard | | |
|---|---|---|
| **Finding:** | | |
| The responses provided in the National Annual Monitoring Return regarding compliance with the Staff Governance Standard were adequate without providing much useful detail on the topics being considered e.g. on staff uptake of initiatives provided for their support and wellbeing. Such information would provide a measure of success (or failure) for the initiative being considered, allow greater understanding and assurance and help with identification of necessary remedial action. | | |
| **Audit Recommendation:** | | |
| National Annual Monitoring Returns and other reports on compliance with the Staff Governance Standard should provide sufficient detail to allow a definitive conclusion to be reached and to conclude on whether further action is required. A standard reporting protocol should be established for this purpose. | | |
| **Assessment of Risk:** | | |
| Moderate |  | Weaknesses in design or implementation of controls which contribute to risk mitigation.<br>**Requires action to avoid exposure to moderate risks to achieving the objectives for area under review.** |
| **Management Response/Action:** | | |
| **The Staff Governance Self-Assessment Tool and staff governance action plans by Directorate will allow better measurement of success against the Staff Governance Standard. Progress against these Staff Governance action plans will be monitored quarterly at SGC and are a standing item.**<br>**Director of Human Resources will have input into the review of the National Annual Monitoring process by the Scottish Workforce and Staff Governance Committee (SWAG) – aim is to have new Staff Governance Monitoring Dashboard across NHS Scotland which will highlight areas of good practice and also areas for improvement.**<br>**Expectations of what should be reported in next National Annual Monitoring Return by NHS Forth Valley have already been identified in the last report – actions against these will be measurable – Speak UP; BAME Staff Network; Bully and Harassment policy; Whistleblowing etc.** | | |
| **Action by:** | **Date of expected completion:** | |
| **Director of HR** | **September 2022** | |

## Action Point Reference 6: Draft Workforce Plan 2022-25

### Finding:

Although an update was provided to the SGC detailing the arrangements for completing the Draft Workforce Plan 2022-25 by 31 July 2022, a draft was not available to us and the timescales being worked to will be challenging.

That will make it difficult to appropriately identify NHS Forth Valley's future workforce needs to enable a sustainable workforce to be created that is able to meet the Board's revised strategic requirements as well as those of the IJBs. Due to the tight timescales and no draft Workforce Plan currently being available for 2022-25, it is unclear at this stage if all the key areas will obtain sufficient consideration and this could significantly impact on NHS Forth Valley's ability to achieve a sustainable workforce to meet its future needs.

### Audit Recommendation:

The draft Workforce Plan 2022-25 should be considered by the SGC and Board as soon as it is available.

Following presentation of the Workforce Plan, a companion paper should be prepared for the next available meeting covering:

- Full details of current workforce shortages, future workforce requirements and an action plan detailing the individual actions required and the key implementation dates to enable the required sustainable workforce to be achieved. Reporting should focus on key risks and enablers.
- Updates on the steps to be taken in conjunction with the Scottish Government and other bodies involved in providing health and social care training and education to enable future workforce needs to be met.

All actions should be SMART and implementation should be scrutinised and monitored by the SGC on a regular basis and reporting should overtly link to the strategic Workforce Risk.

### Assessment of Risk:

| | | |
|---|---|---|
| Significant |  | Weaknesses in design or implementation of key controls i.e. those which individually reduce the risk scores.<br>**Requires action to avoid exposure to significant risks to achieving the objectives for area under review.** |

### Management Response/Action:

**On track to deliver a draft workforce plan by 31 July 2022 in line with DL 2022(09) and subsequent guidance from National Workforce planning leads**

**Acknowledged by SG that this would indeed be draft and not have gone through local Board Governance processes. This will take place once review and feedback process has been concluded by SG**

**Final workforce plans will be published on Board Website at the end of October 2022.**

**Agreed at SGC that the Workforce plans will be shared virtually in advance submitting to**

**SG.**

**Workforce Action Plans being completed by Mid July 2022 that will identify by Directorate and Service the following:**

- **The anticipated workforce changes**
- **Why the change for staffing is required**
- **How the change to staffing will be achieved e.g. investment, skill mix change**
- **Where will the resources / skills come from e.g. recruitment, development of existing staff**
- **Timescales**
- **Post details, wte and type of contract required e.g. permanent or fixed term**
- **Risk assessment, risk of non-delivery with impact, score and current risk level**
- **RAG status**
- **Lead**

**Approach agreed and quarterly workforce action plan reporting included within the SGC workplan to ensure measurement against agreed actions.**

| Action by: | Date of expected completion: |
|---|---|
| **Director of HR** | **July 2022** |

## Financial Governance

## Strategic Risks

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

**Financial Performance**

As reported to the 31 May 2022 Forth Valley NHS Board, the draft financial outturn position to 31 March 2022, subject to external audit was:

- A £0.290 million under spend on the core Revenue Resource Limit (RRL) of £751.266 million.
- A break-even position against the core Capital Resources Limit (CRL) of £15.050 million.
- A break-even position against the cash requirement, with a closing bank balance of less than £0.05 million.

The 2021/22 savings target of £32.398 million was delivered. £15.474 million (48%) was recurring and £16.924m (52%) was non-recurring.

Falkirk Health & Social Care Partnership (HSCP) reported a net under spend of £0.518 million and this will be transferred to Falkirk IJB general reserves. Clackmannanshire & Stirling HSCP reported a net overspend of £0.114 million, and reserves will be released to offset the position.

**Covid19 Funding**

Total additional costs of £27.4 million were incurred during 2021/22 as a result of the ongoing impact of the pandemic, in respect of Board Directed Services. Total Covid funding of £60.1m was allocated to NHS Forth Valley during the course of the year. The remaining balance of £32.7m was allocated to HSCPs and any unused funding will be carried forward into 2022/23 as an earmarked Covid recovery reserve within IJBs. Further guidance is expected on how the funding will require to be deployed in 2022/23 against key priorities in supporting Covid19 recovery.

No additional Covid19 consequential funding has been agreed with the UK Treasury for 2022/23 and Scottish Government has advised NHS Boards and IJBs to plan on the basis that no further Covid19 funding will be issued in 2022/23. A strong grip on financial spend is required and the Board should avoid wherever possible to commit to new and/or additional recuring costs and instead focus on redesign and cost improvement. A focused, whole-systems approach is required to embed innovation, quality and efficiency in delivering service plans aligned to recovery.

The wider, longer term economic, workforce and service impacts of Covid19 have not fully crystallised and there is a risk that it will continue to have significant and far-reaching impact on the cost profile. To contain costs within available resources under these conditions will be extremely challenging.

The strategic financial sustainability risk will be affected by the absence of Covid19 funding as it seems certain that the financial consequences of Covid19 will be experienced for many years to come.

**Financial Reporting**

Financial reporting throughout the year to the P&RC and Forth Valley NHS Board remained clear and consistent and the position was clearly presented, with good use of visuals and graphs.

**Efficiency Savings**

Significant financial challenges remain as NHS Forth Valley emerges from emergency footing. The Director of Finance has identified key risks as: scale of savings challenge; Covid19 requirements and funding uncertainty; inflationary cost movements including energy prices; workforce recruitment and sustainability. We understand the Financial Sustainability risk is being updated and will reflect these elements.

While the full savings target of £32.40 million for 2021/22 was delivered, the unachieved recurring savings balance of £17m from 2021/22 has been carried forward and is reflected in the underlying deficit and £29.3m savings target required for 2022/23. The 2022/23 Financial Plan stated that *'it is expected that a level of non-recurring savings will continue to be required to supplement recurring savings …This will be identified from slippage, rebates and balance sheet items per previous years, with a target set for a reducing balance from non-recurring sources over the next 3 year term'.*

The approach to savings delivery agreed by the ELT is to revisit and enhance key financial and workforce controls to: stabilise the position; support and expand those savings initiatives already embedded and; sustain the position by developing new pipeline initiatives through processes developed with the Corporate Project Management Office (CPMO). Internal audit A14/22 – Strategy will assess the extent to which the need for financial sustainability is being embedded within the strategic planning process and priorities.

During 2021/22 the Cost Improvement Oversight group was established with CPMO support, and a remit to direct and oversee delivery of savings, efficiency and value opportunities. Opportunities within the finance team and medicine optimisation and efficiencies were identified as areas where savings could be made. This work is intended to continue into 2022/23 with an early focus on resetting core financial and budgetary controls, supporting the expansion of those savings schemes already successfully in place and engaging with staff teams across services to develop new options. One to one meetings with ELT members, attended by CPMO colleagues, to identify cost improvements, have commenced. A single reporting mechanism by the NHS Board to avoid double counting will be implemented and reports to the IJB on NHS cost improvement and redesign/innovation plans should be introduced.

An Innovation Plan 2022-2027 was presented to the ELT in March 2022 and to the Board Seminar on 7 June 2022. Innovation is a key priority within the system-wide remobilisation plan and innovation projects will be assessed against several factors including cost savings. It will be crucial to ensure that innovation is pursued within the context of the financial challenges facing the Board, and an agile innovation governance process will be established to ensure priorities and resources are aligned.

**Financial Planning 2022/23 – 2026/27**

The financial and capital plans for 2022/23 – 2026/27 were approved by the Board on 29 March 2022. The 2022/23 plan is based on a one-year transitional funding settlement detailed in Scottish Government's indicative allocation letter of 9 December 2021. Scottish

Government is expected to publish multi-year spending plans within the Resource Spending Review and refreshed Medium Term Financial Framework on 31 May 2022. Projections for future years from 2023/24 were presented on a planning basis and will continue to be updated as SG information is made available. The Director of Finance informed the NHS Board that Covid19 costs would require to be managed within available ring-fenced funding resources which had not yet been confirmed and highlighted that the Covid19 impact would continue to drive a significant level of increased costs and that clarity on funding arrangements and affordability would be a critical factor in delivering financial balance.

Savings of £29.3 million (5% of baseline) will be required in order to balance the 2022/23 financial plan. This position carries a significant level of risk and uncertainty due to the continued response to the pandemic and an acknowledgement that staff absence, vacancies and additional capacity requirements drive an increased level of supplementary workforce costs across the unscheduled pathway.

The Strategic Plan was prepared prior to the confirmation that there would be no further additional funding for Covid19, and was prepared on the basis that additional in-year funding was anticipated to support costs directly associated with Covid19 and therefore the plan and the associated risks will need to be revised and, if necessary, represented to the P&RC.

The IJB annual financial plans for both Falkirk and Clackmannanshire & Stirling were presented to the P&RC in March 2022. Falkirk presented a revenue shortfall of £7.58 million (3.1% of total IJB budget) with circa £3.8 million savings proposals identified at that stage. The majority of these savings proposals were considered to be high risk. Clackmannanshire & Stirling IJB presented a revenue shortfall of £3.9 million with no articulated savings proposals at that date.

**Financial processes**

The Director of Finance presented his vision for the Finance Team to the ELT in March 2022. The structure includes business partnering staff and aims to deliver improved value to the organisation through efficient transaction processing, closer engagement and collaboration, development of forward-looking business information, and maximising use of available systems. The finance team will maximise available support and advice to service managers to aid in planning and decision making, in the context of the high financial sustainability risk. Innovation in functions and systems that are future-fit will be needed.

A24/22 – Financial Process Compliance, issued on 28 February 2022, provided Substantial Assurance on the accounts receivable and accounts payable systems. Our high level testing confirmed that key controls were in place and operating effectively, and that key controls had not changed due to Covid19. No required actions were identified.

Internal audits A28/22 and A29/22 reviewed departmental payroll systems and processes in the Out of Hours department and in the Estates department respectively, and provided Limited Assurance on both areas. In response to these reviews, Management agreed actions to improve risk management processes, communication and culture. Action was also agreed to ensure more robust controls over timesheet completion and authorisation, including appropriate training and support.

A26/22 – Patients' Property Investigation was undertaken following a loss of property, and reviewed controls and compliance with procedures in a ward area. Management agreed actions to ensure staff understand their responsibilities in respect of Patients' Property, and will carry out supervisory checks to ensure compliance with procedures. A further audit of the management of Patients' property is underway in T25/23.

**Capital Planning and Asset Management**

The Five Year Capital Plan 2021/22 was approved by the Board on 30 March 2021. This presented a balanced position against a core capital resource limit estimated at £18.45 million for 2021/22. The CRL was revised downwards to £15.05m at 31 March 2022, reflecting slippage on planned works and a number of additional ring-fenced allocations received.

A significant adjustment was made towards the end of the financial year in relation to Scottish Government's full funding of the National Treatment Centre (NTC). Capital funding of £10.15m was issued by the Scottish Government for the NTC, however £6.14m was returned following discussion with external audit on timing of expenditure recognition. The balance of funding will be provided in 2022/23 to fund completion of the NTC development.

No property transactions were concluded during 2021/22 and we will therefore not be required to undertake Post Transaction Monitoring as part of the 2022/23 annual internal plan.

The Property Asset Management Strategy (PAMS) update, including key milestones, was presented to the ELT on 28 March 2022 will be presented to the June 2022 P&RC. The development of the PAMS will link to the refresh of the Healthcare Strategy which is scheduled for completion by end of September 2022. Management have agreed that internal audit will be appraised throughout the PAMS refresh process and will input where appropriate as the PAMS is developed. Internal audit will provide an opinion on the process and final outcome in A22/23 – Capital Planning. The final PAMS is scheduled for presentation for approval to the February 2023 P&RC. This will be a key component of the Board's overall strategy, both in terms of determining future options and ensuring their effective delivery.

**Environmental Management**

The paper on Climate Change and Sustainability: National Direction and Local Response, presented to the NHS Board on 31 May 2022 set out proposals to support the whole-system change-management process that will be required to shift climate emergency considerations to the core of this organisation's decision-making. A formal risk assessment in line with the requirements of DL (2021) 38 is under development and will be reviewed by the NHS Forth Valley Climate Emergency & Sustainability Board. The Board agreed the appointment of a Board member to act as the NHS Forth Valley Champion and noted the Resourcing and Financial Implications and associated risks.

**Best Value**

NHS Forth Valley's best value approach was approved in January 2022. The Sustainability and Equality cross-cutting themes apply to each separate characteristic of best value.

| Action Point Reference 7 – Sustainability / Environmental Management Risk | | |
|---|---|---|
| **Finding:** | | |
| There is no specific risk for environmental management and sustainability. A short life working group will be established to plot the way forward to address the requirements in DL (2021) 38 – A Policy for NHS Scotland on the Climate Emergency and Sustainable Development. The CPMO has initiated a project to support NHS FV achieve net zero by 2040. A mandate has been developed for consideration by SRO and governance structure and a delivery tool is in development. Given the scale of this challenge, consideration of this policy will be pervasive in every strategic decision going forward; and the consequences on finance will be considerable. | | |
| **Audit Recommendation:** | | |
| A specific risk around environmental sustainability should be considered for inclusion in the strategic risk register. Sustainability will also require to be reflected in several other strategic risks and reflects the all-encompassing nature of Scottish Government's strategy. | | |
| **Assessment of Risk:** | | |
| Merits attention |  | There are generally areas of good practice.<br>**Action may be advised to enhance control or improve operational efficiency.** |
| **Management Response/Action:** | | |
| **This will added to the agenda of the first meeting of the Board's Sustainability & Climate Change Board for consideration.** | | |
| **Action by:** | | **Date of expected completion:** |
| **Director of Facilities and Infrastructure** | | **30 September 2022** |

| Action Point Reference 8 – Capital Funding Strategic Risk Enhancement | | |
|---|---|---|
| **Finding:** | | |
| Scottish Government's mandatory governance requirements set out in CEL35 (2010) indicate that the organisation's Property Asset Management Strategy (PAMS) should feature in the organisation's risk register. The Board recognises Capital Funding (SRR010) as an identified risk in relation to developing and improving the property portfolio. One of the controls that mitigates the capital funding risk is a regular PAMS report. Strategic Risk SRR010 mainly articulates the risk in relation to property, whilst the PAMS requires a holistic strategy around all assets that the Board safeguards. | | |
| **Audit Recommendation:** | | |
| Strategic Risk SRR010 should be reviewed and updated to ensure that it covers the entire portfolio of board assets. | | |
| **Assessment of Risk:** | | |
| Merits attention |  | There are generally areas of good practice.<br>**Action may be advised to enhance control or improve operational efficiency.** |
| **Management Response/Action:** | | |
| **SRR0010 will be reviewed and updated in terms of asset portfolio coverage.** | | |
| **Action by:** | | **Date of expected completion:** |
| **Director of Facilities and Infrastructure with Director of Finance** | | **August 2022** |

## Information Governance

## Strategic Risks

- **SRR003 – Information Governance: If NHS Forth Valley fails to implement effective Information Governance arrangements there is a risk we will not comply with a range of requirements relating to GDPR and the Network and Information System Regulation (NIS), resulting in reputational damage and potential legal breaches leading to financial penalties.**
- **SRR011 – IT Infrastructure: If there are significant technical vulnerabilities there is a risk the NHS FV IT Infrastructure could fail, resulting in potential major incidents or impact to service delivery.**
- **SRR015 – Cyber Resilience: If NHS Forth Valley does not build and maintain effective cyber resilience, there is a risk that the cyber security of the organisation may be compromised, resulting in disruption to our ICT systems and service delivery. Increased cyber risk as reported by National Cyber Competent authorities (NCSC, SG Cyber Unit).**

IG Strategy and Governance

The Head of IG left NHS Forth Valley in May 2022 and the new Head of IG will commence in July 2022. As there is a statutory requirement to have a Data Protection Officer in place, temporary cover has been identified.

The Information Governance Group (IGG) completed an interim review of the IG Strategy 2016-2021 in June 2020. The IG strategy was due for review in August 2021 but it was not considered appropriate for the outgoing Head of IG to develop the revised 5 year strategy. This will fall to the new Head if IG and is included in the 2022/23 IGG workplan.

The IGG and Information Security Group (ISG) reported to the P&RC through their minutes and the IGG Annual Report was presented to the P&RC on 1 March 2022.

The 2021/22 ICE recommended that the P&RC receive a report to provide clear sufficient and reliable assurance on key aspects of IG & Security, to enable monitoring and to assist the committee in concluding on adequacy and effectiveness of IG arrangements at year end. This has not been implemented and the March 2022 P&RC was informed that a future highlight report would be submitted. We have been informed that while development of this report has been discussed it has not yet been drafted, and the intention is that it will be a monthly report to ensure any issues are identified promptly.

The IGG Terms of Reference have been revised to include Network and Information Systems Regulation (NISR) and the format and layout of the IGG work plan was enhanced in December 2021. The most recent IGG work plan at 21 April 2022 reported the majority of actions as green or amber, with a red status in the areas of: Freedom of Information review of procedures for IJBs, records management actions, training, implementation of Web Based modules and systems, and webpage development.

Several updated policies and protocols were approved by the IGG in April 2022, including FairWarning Guidance for Managers, the Information Security Policy and the Social Media Policy.

**Year-end Reporting**

The P&RC was provided with a comprehensive IG Annual Assurance Report for 2021/22 that stated '*I can confirm as Chair of the IGG, that I can give adequate and effective assurance on*

*the areas that have been progressed during this financial year but would note that there are key outstanding compliance issues that still require to be resolved. It must be noted that the key items could not be addressed without additional resources which will now be resolved early in the next financial year; it is also acknowledged that the work cannot be achieved within one financial year but will be dealt with by a phased approach. Appropriate governance arrangements were in place throughout the year and assurances were provided to the P&RC'.*

**Digital & Cyber**

An update was provided to the 21 March 2022 ELT on the development of a new Digital Health and Care Strategy and the Communication and Engagement Plan. Development of the new strategy will link to the new Healthcare Strategy, and align with the National Digital Health and Care Strategy, published in November 2021. The digital strategy will be a key enabler for the overall Healthcare Strategy and for making savings, particularly in the context of reduced workforce and therefore more need for automation. Consultation will take place between April and June 2022 with a draft circulated during August, and a final version for Board approval scheduled for approximately September 2022. On 30 May 2022 the Digital & eHealth Programme Board approved the review of the Digital Strategy.

The Financial Implications section of the paper to ELT stated that *'Each and every commitment within the emerging new digital health strategy will need to be resourced. However those resources will be detailed in annual delivery plans backed up by approved business cases where appropriate'.* The Digital and eHealth financial plan 2022/23 sets out the revenue and capital budgets for the year. Funding is identified but not fully confirmed for 2022/23, including the eHealth Strategy. Future years funding is also not confirmed.

The Director of Facilities & Infrastructure / Digital & eHealth Lead produced a very clear paper on the Digital & eHealth Delivery Plan 2022/23 for the 30 March 2022 Digital & eHealth Programme Board. The paper set out key risks and interdependencies, including affordability. The focus of the cyber security risk is on disruption of ICT systems and service delivery, and not on the financial support required for the Digital & eHealth Strategy. As the Digital & eHealth Strategy is a key enabler for delivery of the Healthcare Strategy, consideration should be given to how affordability of the Digital & eHealth Delivery Plan can be recognised within the organisation's risk profile. We do note that recommendations for prioritisation of digital funding will be available by September 2022.

As reported to the P&RC on 1 March 2022, of the 32 projects in the eHealth Delivery Plan, one project for the delivery of GP System Replacement was delayed as at Quarter 3 and was classed as 'red', four projects were classified as amber, reflecting potential capacity and timing issues. All other projects were progressing as planned.

The Digital and eHealth Programme Board (DEPB) monitored the implementation of the Digital & eHealth Strategy, and progress against the eHealth Delivery Plan in 2021/22 was reported to the P&RC.

On 10 February 2022 the CMT approved a Cyber Resilience Business Case paper mapping out an investment proposal to support cyber resilience and a plan to utilise earmarked Scottish Government funding for this purpose. The IGG approved the Cyber Resilience Strategy on 21 April 2022. This is a sub-strategy of the upcoming new Digital Health Strategy and is a key component in improving compliance with NISR.

**Covid Response**

The IGG Annual Report 2021/22 noted that the pandemic had continued to drive change and the IG team had enabled efforts to ensure flexible but secure solutions were in place. The Digital & eHealth Programme Board on 30 March 2022 noted the digital response to the Covid19 agenda and that more than 15 initiatives had been implemented over and above the general work plan for Digital.

**Risk Management Arrangements**

As reported to the 29 March 2022 Board the strategic risk for IG was scored as 16, representing a reduction in scoring of 20 from the same time last year. The reduction in the score reflected the improved IG staffing levels, assurances provided by the new NIS Senior Information Risk Owner (SIRO) report and the NISR Highlight report for P&RC.

Verbal updates on the mitigation of the Covid19 working practices risk assessment were reported to each IGG. The risk covered the high volumes of additional work due to the pandemic and the requirement for national documentation reviews. In April 2022 the IGG agreed that the risk could be closed.

The ISG reports to the December 2021 and April 2022 IGG noted that 'Governance of Security' was an amber risk, and that there are still significant pressures on the IG department. This reflects the required IS input where areas have moved to virtual appointments and implemented new systems due to the pandemic, and also because of the requirement to ensure compliance with legal requirements, in particular NISR.

The 1 March 2022 P&RC was informed that a number of fixed term contracts within the IG Team required to be made permanent to avoid difficulties in delivery and an IG Resources paper was approved by CMT on 10 March 2022.

**Digital**

SRR011 – The IT Infrastructure risk is scored at 12 – Medium, with a target score of 6. The risk score has reduced from 16 at March 2021, reflecting the removal of the cyber aspect and progress in strengthening current controls. SRR015 – Cyber Resilience became a risk in its own right in October 2022. The risk score remains at 20 – Very High, with a target score of 16. The risk description has been amended to include 'Increased Cyber risk as reported by National Cyber Competent authorities'.

**Public Sector Cyber Resilience Framework and NISR**

All public sector organisations in Scotland must now report against the Public Sector Cyber Resilience Framework (CRF) which replaces the previous Information Security Performance Framework and is the set of controls against which NISR compliance is reported.

The NISR highlight report to the 18 January 2022 P&RC provided an update on action being taken to address Black (Critical) actions and the IGG Annual Report 2021/22 noted regulatory compliance with NIS as:

- Overall compliance against the framework increased by 10% to 60%.
- Risk exposure dropped 9% to 11% (Risk exposure is the measure of outstanding black (critical) and red (urgent) recommendations.
- Completed controls rose by 8% to 49%.
- Urgent recommendations reduced by 31%.

**Information Governance Incidents**

In 2021 there were nine Information Commissioners Office (ICO) incidents / complaints, six of which related to incidents reported by NHS Forth Valley on behalf of GP Practices or involved another non-NHS party. None represent Governance Statement disclosures.

| Action Point Reference 9 – Affordability of Digital & eHealth Delivery Plan | | |
|---|---|---|
| **Finding:** | | |
| The Digital & eHealth Delivery Plan 2022/23 paper presented to the 30 March 2022 Digital & eHealth Programme Board clearly described key risks and interdependencies, including affordability. These issues are not captured within a strategic risk and the focus of the cyber security risk is on disruption of ICT systems and service delivery, and not on the financial support required for the Digital & eHealth Strategy. | | |
| **Audit Recommendation:** | | |
| As the Digital & eHealth Strategy is a key enabler for delivery of the Healthcare Strategy, consideration should be given to whether affordability of the Digital and eHealth Delivery Plan should be recognised within the strategic risk profile, for example within the existing financial sustainability risk. | | |
| **Assessment of Risk:** | | |
| Merits attention |  | There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.** |
| **Management Response/Action:** | | |
| **Consideration will be made about how best to reflect the affordability issues within the Strategic Risk Register going forward.** | | |
| **Action by:** | | **Date of expected completion:** |
| **Director of Finance and Director of Facilities and Infrastructure** | | **August 2022** |

| Update of Progress Against Actions: ICE 2021/22 (A08/22) | | |
|---|---|---|
| **Agreed Management Actions with Dates** | **Progress with agreed Management Actions** | **Assurance Against Progress** |
| *Recommendation 1 – Risk Management*<br><br>Performance Reports to provide assurance on accuracy of the narrative and scores for related strategic risks as well as the adequacy and effectiveness of key controls.<br><br>***Action Owner:*** **Chief Executive by April 2022** | Assurance levels included in new report template and set up in the Pentana system. |  <br>**Complete** |
| *Recommendation 4: Scheduled Care risk*<br><br>Ensure the CGC regularly scrutinises and undertakes a deep dive of the risks associated with Scheduled Care through further regular risk updates. Update to the CGC to be scheduled in Quarter 1 of 2022.<br><br>***Action Owner:*** **Medical Director and Head of Clinical Governance by March 2022** | The planned deep dive of the Scheduled Care risk has not yet taken place but will be included in the programme for 2022/23. |  <br>Minor slippage |
| *Recommendation 5: Risk Escalation*<br><br>Relevant committee to consider whether an escalated clinical governance risk needs to be recorded as a strategic or operational risk. Report authors should clearly recommend recording of a risk where required.<br><br>***Action Owner:*** **Head of Clinical Governance & Risk Manager by April 2022** | To be addressed upon introduction of new Board and Committee template. Internal audit will revisit in 2022/23 ICE fieldwork. | N/A |
| *Recommendation 6: Enhancements to CGC Forward Planner*<br><br>• CGC Forward Planner to be reviewed and updated to ensure it maps to the CGC Terms of Reference, and compliance against the Forward Planner to be reviewed at each meeting, to ensure that the workplan is on track and the Committee has received the necessary assurances.<br>• Minutes of the CGC and CGWG enhanced to demonstrate a clear focus on risks, assurances provided, scrutiny applied and any subsequent risk | • CGC Forward Planner was included on the CGC agenda in February 2022 where compliance against the forward planner was reviewed to inform the CGC Annual Report 2021/22. The forward planner was not on the CGC May 2022 agenda and we would expect to see this as a Standing Agenda item when the new template is introduced.<br>• All other developments linked to introduction of new governance |  <br>On track |

| | | |
|---|---|---|
| escalation or action.<br>• Consideration of use of assurance reports.<br>• CGC and CGWG Forward Planner referred to at every agenda planning meeting.<br>***Action Owner:*** **Head of Clinical Governance & Risk Manager by April 2022** | templates and accompanying guidance. | |
| *Recommendation 7: Workforce Planning risks*<br>• SGC to complete a deep dive into an updated workforce risk, including the impact of the delay in delivering the Workforce Strategy, and the demographics of the workforce and known pressures on demand for staff.<br>• Interim Workforce Plan cover paper to Board to clearly articulate the risk assessment with overt reference to the workforce Plans risk.<br>***Action Owner:*** **Director of HR by January 2022** | A programme of deep dives is to be discussed and approved at the 7 June 2022 Board seminar.<br>• A refreshed Our People Strategy progress update was provided to the May 2022 SGC, instead of the Interim Workforce Plan. It did not make reference to SRR 009. |  <br>Slippage |
| *Recommendation 8: Staff Governance Standards*<br>Regular Staff Governance Standard monitoring report presented to SGC to ensure compliance is monitored during the year.<br>***Action Owner:*** **Director of HR by April 2022** | The HR Director's report to the May 2022 SGC contained an update on completion of Self Assessment Tools, progress in implementing and improving compliance with the Staff Governance Standard will not be provided to the SGC until September 2022. |  <br>Partial completion, but slippage overall. |
| *Recommendation 9: Enhancements to existing assurance reporting*<br>• HR Director's report to include: progress with staff aspects of RMPV4; progress with the Workforce Plan actions; further information on the efficacy of action taken to address sickness absence; progress with post Sturrock actions.<br>• Consideration of a summary partnership report to the Staff Governance Committee<br>***Action Owner:*** **Director of HR by April 2022** | A review of the 2022-23 SGC Workplan evidenced the following:<br>• HR Directors and Organisational Development reports are submitted to every SGC meeting.<br>• Reporting on Our People Strategy is included bi-annually.<br>• First 4 strands of the Staff Governance Standard are reviewed annually and the fifth (staff safety) is considered at each meeting.<br>• A Whistleblowing update is reviewed at each meeting of the SGC, and quarterly reports are |  <br>Partial completion, but slippage overall. |

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|---|---|---|
| | provided to Board, but the annual report is scheduled to be completed in December 2022, rather than May 2022, which would allow it to be included in the SGC Annual Report.<br>• The May 2022 HR Director's report did not contain any reference to RMPV4, Workforce Plan actions, the efficacy of action taken to address sickness absence and made no reference to Sturrock actions.<br>• A Summary Partnership Report has not been introduced and, as in previous years, the 2022/23 workplan continues to feature minutes of each Partnership Group. | |
| *Recommendation 10: Property Asset Management Strategy (PAMS)*<br>P&RC to be provided with assurance on progress with the emerging PAMS with a clear timetable for delivery.<br>***Action Owner:*** **Director of Facilities & Infrastructure / Digital & eHealth Lead by September 2022** | Property & Asset Management Strategy (PAMS) Refresh paper presented to ELT on 11 April 2022 and update to be presented to P&RC in June 2022. Timetable in place - PAMs is scheduled for presentation to P&RC in February 2023. Work on the refresh will commence over summer 2022. |  <br>On track, in line with revised timelines |
| *Recommendation 11: IG & Security Assurance Reporting*<br>• Enhancement of the Information Assurance report to provide sufficient and reliable assurance on the key aspects of IG & Security.<br>• Provision of assurance on the affordability of the Digital and eHealth Delivery Plan and recommendations for prioritisation of digital funding.<br>***Action Owner:*** **Medical Director by March 2022**<br>**Director of Facilities & Infrastructure / Digital & eHealth Lead by September 2022** | • Not yet introduced. Discussions have taken place regarding the content of the report and Data Protection data for inclusion is still to be agreed. Management have informed internal audit that the report will be monthly and used to inform the Annual Report – errors etc will be picked up quickly at that frequency. Action is to be progressed by the new Head of IG.<br>• On 21 March 2022 the ELT was provided with an update on the development of the new Digital Health and Care Strategy *which stated that resources for every commitment within the emerging new strategy would be detailed in annual delivery plans backed up by approved business cases where appropriate.* The Digital and eHealth |  <br>Slippage<br>  <br>On track |

| | | |
|---|---|---|
| | financial plan 2022/23 sets out the revenue and capital budgets for the year. Funding is identified but not fully confirmed for 2022/23, including the eHealth Strategy. Future years funding is also not confirmed. | |
| *Recommendation 12: Information Governance Incident Management*<br>• Reporting to P&RC on the management of IG related incidents to be highlighted in the cover paper with IGG minutes.<br>• ***Action Owner:*** **Medical Director by March 2022** | As recommendation 11 regarding IG reporting to P&RC. |  <br>Slippage |

| Update of Progress Against Ongoing Actions: Annual Report 2020/21 (A06/22) | | |
|---|---|---|
| **Agreed Management Actions with Dates** | **Management Actions Updates with Dates** | **Assurance Against Progress** |
| *Recommendation 3 Performance Management*<br>• In the longer term, performance management systems to monitor achievement of outcomes set out in the revised Healthcare Strategy should be reviewed and consideration given to how this can be measured.<br>• Consideration should be given to the reinstatement of a system of Directorate / Partnership Performance Reviews, which are already in place for finance considerations<br>***Action Owner:* Head of Policy and Performance** | • Service pressures as a result of Covid19 over the winter period have impacted on the ability to progress. Work continues in respect of developing performance information within Pentana to support directorate reviews however no further progress made in terms of implementation.<br>• An update on progress will be provided by the end of July 2022. |  <br>Minor slippage – timelines revised<br>  <br>**Slippage** |
| *Recommendation 5 Workforce Planning*<br>• Format and content of reporting arrangements to be considered for implementation prior to completion of the Integrated Workforce Plan 2022-2025, in order to provide relevant assurances.<br>***Action Owner:* Director of HR, ~~November 2021~~, December 2021** | A progress update on implementing the Our People Strategy was presented to the May 2022 SGC to provide an update on the 2021/22 Workforce Strategy and Plan. While this does include relevant data, in moving forward the 2022-25 Workforce Strategy and Plan should have a full range of SMART targets to allow effective monitoring |  <br>Partial completion and now superseded by recommendation in this report. |

| Update of Progress Against Actions: ICE 2020/21 (A08/21) | | |
|---|---|---|
| **Agreed Management Actions with Dates** | **Management Actions Updates with Dates** | **Assurance Against Progress** |
| *Recommendation 1 Sustainability & Transformation*<br>• Timetable to support the development of the Healthcare Strategy - ~~March 2021~~, **April 2022**<br>***Action Owner:*** **Chief Executive** | • Draft to be presented to the Board for approval in November 2022. This will be prior to submission of Horizon 2 plan to Scottish government by end of January 2023.<br>• Chief Executive provided an update and reset timetable to support the development of the Healthcare Strategy to the Board on 31 May 2022 as part of the Anchor Institution presentation.<br>• Operationally, focus is on fulfilling Scottish Government requirement for a 2022/23 operational plan by end of July 2022, to align with submission of 3 year workforce plan.<br>• Eight project boards established to develop the strategy and a strategy working group is in place to support this process. |  <br>**Timescale reset to November 2022.** |
| *Recommendation 5 Clinical Governance*<br>• Revision to the Clinical Governance Strategy which will sit within the Quality Strategy which is whole system, encompassing HSCPs and Clinical & Care Governance – **December 2021**<br>***Action Owners*: Medical Director, supported by the Head of Clinical Governance and the Head of Efficiency, Improvement and Innovation.** | A Clinical Governance framework is within the Quality Strategy 2021-2026, but this is not a full Clinical Governance Strategy. |  <br>**Slippage** |
| *Recommendation 6 Staff Governance Committee and Workforce*<br>• Refresh of Workforce Strategy and Plan - ~~**December 2021**~~**, June/July 2022**<br>***Action Owner:*** **Director of HR** | Superseded by ICE 2021/22 (A08/22) - Recommendation 7 | Superseded |

**Key Performance Indicators – Performance against Service Specification**

| | Planning | Target | 2021/22 | 2020/21 |
|---|---|---|---|---|
| 1 | Strategic/Annual Plan presented to Audit and Risk Committee by June. | | Draft 2021/22 plan presented June 2021 | Draft 2020/21 circulated 9 June 2020 |
| 2 | Annual Internal Audit Report presented to Audit and Risk Committee by June. | Yes | August 2021 (later Annual Accounts Audit & Risk Committee | Presented to 22 June Audit and Risk Committee |
| 3 | Audit assignment plans for planned audits issued to the responsible Director at least 2 weeks before commencement of audit | 75% | 94% | 100% |
| | | | | |
| 4 | Draft reports issued by target date | 75% | 60% | 53% |
| 5 | Responses received from client within timescale defined in reporting protocol | 75% | 74% | 80% |
| 6 | Final reports presented to target Audit and Risk Committee | 75% | 77% | 78% |
| 7 | Number of days delivered against plan | 100% at year-end | 95% | 93% |
| 8 | Number of audits delivered to planned number of days (within 10%) | 75% | 69% | 71% |
| 9 | Skill mix | 50% | 72% | 71% |
| 10 | Staff provision by category | As per SSA/Spec | Pie chart | |
| | **Effectiveness** | | | |
| 11 | Client satisfaction surveys | Average score of 3.7 | Bar chart | |

## *Assessment of Risk*

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

| | | | |
|---|---|---|---|
| Fundamental |  | Non Compliance with key controls or evidence of material loss or error.<br>**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.<br>**Requires action to avoid exposure to significant risks to achieving the objectives for area under review.** | Two |
| Moderate |  | Weaknesses in design or implementation of controls which contribute to risk mitigation.<br>**Requires action to avoid exposure to moderate risks to achieving the objectives for area under review.** | Four |
| Merits attention |  | There are generally areas of good practice.<br>**Action may be advised to enhance control or improve operational efficiency.** | Three |