FTF Internal Audit Service

Internal Control Evaluation 2021/22

Report No. B08/22

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

G MacIntosh, Head of Corporate Governance/Board Secretary
Executive Directors Group
H Thomson, Board Committee Support Officer

Audit Follow-Up Co-ordinator

Audit and Risk Committee
External Audit

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Draft Report Issued	29 November 2021
Management Responses Received	07 February 2022
Target Audit & Risk Committee Date	9 December 2021
Final Report Issued	**21 February 2022**

EXECUTIVE SUMMARY

1. As Accountable Officers, Chief Executives are responsible for maintaining a sound system of internal control and to manage and control all the available resources used in the organisation. This review aims to provide early warning of any significant issues that may affect the Governance Statement.

OBJECTIVE

2. The principal objective of this review is to provide assurance to the Chief Executive, as Accountable Officer, that there is a sound system of internal control that supports the achievement of the Board's objectives.

3. This year's Internal Control Evaluation (ICE) was designed to coordinate with fieldwork to be undertaken within B13/22 Strategic Planning and B17/22 Workforce Planning, both of which will be carried out in two phases, with the initial work focussing on the adequacy of the arrangements in place to develop the Health and Wellbeing Strategy and the Workforce Plan. The second phases of both reviews will consider the effectiveness of these arrangements.

4. This ICE also provides a detailed assessment of action taken to address previous internal audit recommendations from the 2020/21 ICE and Annual Report, and assess the adequacy and effectiveness of internal controls, giving time for remedial actions to be taken before year-end, thereby allowing the year-end process to be focused on year-end assurances and confirmation that the required actions have been implemented.

5. This evaluation assessed the design and operation of the controls in place and specifically considered whether:

    - Governance arrangements are sufficient, either in design or in execution, to control and direct the organisation to ensure delivery of sound strategic objectives.

6. Whilst there was no overarching corporate/strategic risk relevant to this review, our audit specifically considered whether governance arrangements are sufficient, either in design or in execution, to control and direct the organisation to ensure delivery of sound strategic objectives.

AUDIT OPINION

7. Ongoing and required developments and recommended actions are included at Section 2.

8. The Annual Internal Audit Report issued 9 September 2021, was informed by detailed review of formal evidence sources including Board, Standing Committee, Executive Leadership Group (ELG), and other papers. 6 recommendations from the 2020/21 ICE remained outstanding at that point with all reported as being on track, and 2 of these now reported as completed.

9. As well as identifying key themes, the Annual Internal Audit Report made one specific recommendation on:

    - Increased risk of harm - a specific risk should be recorded, delegated to the CGC, to capture the clinical implications of Covid19 on waiting times and the associated impact on patient safety, clinical effectiveness and strategic prioritisation.

10. Completed actions from previous ICE and Annual Report recommendations are included under each strand of governance and ongoing recommendations from the 2020/21 ICE are detailed in table 1.

11. In this report, we have provided an update on progress to date and, where appropriate, built on and consolidated previous recommendations to allow refreshed action and completion dates to be agreed. This has culminated in 12 recommendations for which management have agreed

actions to progress by year end. Whilst this appears to be a large number given the overall positive conclusions within the report, these recommendations are primarily suggestions to enhance governance improvement activities already underway within NHS Fife.

12. We recommend that this report is presented to each Standing Committee so that key themes can be discussed and progress against the recommendations can be monitored.

KEY THEMES

13. Our 2020/21 Annual Report noted that a number of the issues highlighted within that year's ICE were being addressed as part of a wide range of governance and strategic initiatives. This continues at pace and we were pleased to see good progress in:

    - Development of an overall Health and Wellbeing Strategy and associated governance arrangements
    - Continuing development of Risk Management arrangements
    - Reflection on Active Governance and adoption of governance and assurance principles within working practises
    - Update of Clinical and Care Governance framework and associated BAF
    - Preparation for development of a workforce strategy
    - Ongoing development of the SPRA process to link with and support the overall and financial strategies
    - Addressing known issues in Information Governance and assurance
    - Agreeing a revised Integration Scheme for submission to the Scottish Government

14. Many of these areas are subject to ongoing Internal Audit review and will not be complete until year-end, when we will be able to provide a final opinion. We are, however, pleased to note the significant progress made to date and the robust processes and principles adopted, as well as the very positive engagement with Internal Audit where we have provided input and advice on a wide range of issues at the outset. It is particularly encouraging that these developments have continued despite the enormous ongoing pressures created by Covid.

15. This report contains a number of recommendations, intended to enhance the processes referred to above, to embed good governance principles and to ensure coherence between Governance Structures, Performance Management, Risk Management and Assurance.

KEY DEVELOPMENTS SINCE THE ISSUE OF THE ANNUAL REPORT INCLUDED:

16. The introduction of the Public Health and Wellbeing Committee, which has developed Terms of Reference and a workplan and has met twice. The Committee will oversee the development of the new Health and Wellbeing Strategy, which will supersede the current Clinical Strategy, and is due to be presented to the Board for approval in March 2022.

17. The fourth iteration of the Remobilisation Plan RMP4 was considered by the Board in September2021, with Scottish G approval received November 2021.

18. An Active Governance Board Development Session was held on 2 November 2021 and an action plan developed.

19. A Risk Management maturity assessment has been undertaken with further risk management development planned including revision of the risk appetite.

20. Overall, there has been good progress on recommendations from the ICE from last year and the Annual Report for 2020/21. Where action is still to be concluded, the Board has been informed of the planned approach and timescales, as well as associated improvement plans.

ACTION

21. The action plan has been agreed with management to address the identified weaknesses. A follow-up of implementation of the agreed actions will be undertaken in accordance with the audit reporting protocol.

ACKNOWLEDGEMENT

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

A Gaskin, Bsc. ACA
Chief Internal Auditor

TABLE 1 - ICE 2020/21 (B08/21) - Update of Progress Against Ongoing Actions since Annual Report		
Agreed Management Actions with Dates	**Management Actions Updates with Dates**	**Assurance Against Progress**
ICE Report 2020/21 – B08/21		
1. Long term Strategy • The EDG should jointly agree how the various strands of work to inform and deliver the long term strategy for NHS Fife will be analysed and translated into a co-ordinated programme, building on the progress already made through the Strategic Planning and Resource Allocation (SPRA) as well as remobilisation planning, considering how best use can be made of existing expertise and data and understanding constraints on resources. • This review should also consider how best to ensure effective governance and oversight of this key area in advance of the Board Development Session • A timetable for development of the new Strategy and supporting strategies should be reported to the NHS Board. Reporting on progress should be clearly assigned to an Assurance Committee or the NHS Board and should include a broad overview of whether Recovery, Remobilisation and strategy development is on track, key achievements, challenges and risks and any significant implications for strategy and priorities. ***Action Owner: Chief Executive***	Not due until 31 March 2022 • Establishment of the Population Health and Wellbeing Portfolio Board to deliver strategic coordination of the emerging strategy, the first meeting was held in November 2021. This Board will report to the Public Health and Wellbeing Committee. • Public Health and Wellbeing Committee has been established to oversee the implementation of the Population Health and Wellbeing Strategy and oversee a number of related areas and held its introductory meeting on 15 October 2021. Wide-ranging Terms of Reference (ToR) and a comprehensive annual workplan have been approved.	 **On track**

2. Governance and Year end Assurances Coordination of the year-end governance reports and statements of assurance is well underway. This will conclude in the normal timeframes – **June 2021,** specifically • Adoption of Assurance Mapping principles **– June 2021** ***Action Owner: Director of Finance and Strategy***	Assurance Mapping Principles were adopted at the September 2021 Audit and Risk Committee and year-end governance reports and statements of assurance were concluded in the required year end timescales. Assurance mapping work continues, and the Board Secretary and Chief Internal Auditor are working together to ensure that local developments are congruent with national initiatives.	 **Completed**
3. Clinical Governance Framework Development of the Clinical Governance Strategy and Clinical Governance Assurance Framework with a focus on risk, informed by Committee Assurance and Integration Principles. ***Action Owner: Medical Director***	• As per internal audit report B19/21 the Clinical Governance Strategy and Framework are being revised. A revised strategy is scheduled to be presented to the Clinical Governance Committee (CGC) and Fife NHS Board towards the end of 2021/22. • The approach to presentation of the BAFs and corporate risks are currently being reviewed by the Director of Finance & Strategy (Executive Lead for RM) with full involvement of EDG. The content of the three BAFs presented to CGC is being reviewed and updated.	 **On track**
4. Whistle Blowing • An annual report from the Whistleblowing Champion (WBC) cannot be provided until a WBC is appointed to NHS Fife. In the absence of a WBC a report is being presented to the Board which includes whistleblowing data. The Staff Governance Committee (SGC) action plan 2021/22 will include the reporting requirement from the Whistleblowing Champion – **March 2021** ***Action Owner: Director of Human Resources***	An update report on NHS Fife's whistleblowing arrangements was presented to the March 2021 Board meeting, detailing NHS Fife's readiness for adopting the new standards from 1 April 2021. A new Non-Executive Director has been appointed whistleblowing champion. They attended the July 2021 SGC meeting and provided an update on their responsibilities to the September 2021 SGC meeting. The 2021/22 SGC workplan includes a report on whistleblowing incidents being presented to the SGC in March 2022. Arrangements are in place to present quarterly whistleblowing reports to the SGC, detailing the number of such incidents occurring within NHS Fife.	 **Completed**

5. Property Management Strategy • Property and Asset Management Strategy (PAMS) is on the Agenda for the NHS Board in March 2021. • We anticipate that there will be a requirement for an East Regional PAMS report in the near future. The data in this document represents NHS Fife position as at 1 April 2020. • The 2020 PAMS document is largely retrospective and represents the pre-Covid19 landscape, the Impact of Covid19 will be further considered as part of the 2021 full PAMS which will be compiled between April and July 2021 by NHS Fife and likely submitted as part of an East Regional PAMS report – August 2021 ***Action Owner: Director of Property and Asset Management***	The PAMs was approved by the FPRC at its November 2021 meeting and emphasises the need for the NHS Fife Property & Asset Management over the next few years to be revised to support the development and deliver the objectives of the Health & Wellbeing Strategy.	 **On Track**
6. Information Governance and Security • Establishment of IG&S Operational Group and Steering Group ToR • Digital and Information (D&I) Board to provide additional support and assurance to IG&S and its alignment to strategy and operational performance **– April 2021** • IG&S Assurance Report and Framework – **March 2021** • Assurance report will be made available for consideration at the next Clinical Governance Meeting, following the IG&S Steering Group meeting on 23 March 2021. • Risk associated with resources and requirement for business cases when delivering the Digital and	The IG&S Operational Group and Steering Group have approved Terms of Reference. Assurance reporting is evolving and the D&I BAF was updated to reflect resources risk regarding implementation of the NHS Fife D&I Strategy 2019-2024.	 **On track**

Information Strategy will be documented within the related BAF – **April 2021** ***Action Owner: Associate Director of Digital***		
Internal Audit Annual Report 2020/21 – B06/22		
6. Increased Risk of Harm • A specific risk should be recorded, delegated to the CGC, to capture the clinical implications of Covid19 on waiting times and the associated impact on patient safety, clinical effectiveness and strategic prioritisation. The risk should include clear controls and assurance sources looking at reducing avoidable harm caused by delays in diagnoses and treatment and should reflect: • The key priorities and aims for 2021/22 within the current remobilisation plan. • Other relevant controls, such as implementation of Royal College of Surgeons guidelines • A description of controls to address the current pressure on scheduled care as a result of imbalance in demand and capacity; additional pressures due to Covid19; possible pent up demand due to reduction in referral rates. • Identified requirements to redesign services.	The CGC agreed that the Quality and Safety BAF Risk should be reworded to reflect short, medium and long term impact of the pandemic on clinical services waiting times and the associated impact on patient safety, clinical effectiveness and strategic prioritisation as well as including new linked risks, related to pandemic impact (Paper 6.1 to 3 November 2021 CGC). Internal Audit have been asked to contribute to this process as part of their Board Assurance work.	 **On Track**

CORPORATE GOVERNANCE

BAF Risks:

- **Risk 1675 - Strategic Planning - There is a risk that the development and the delivery of the new NHS Fife Population Health and Wellbeing strategy is not adequately supported by the required planning and programme management capacity, capability and governance arrangements.**
- **Risk 1676 – Integration Joint Board - There is a risk that the Fife Integration Scheme does not clearly define operational responsibilities of the Health Board, Council and Integration Joint Board (IJB) resulting in a lack of clarity on ownership for risk management, governance and assurance.**

Strategy

Progress with the development of the Population and Wellbeing Strategy (PWS) is positive. The Public Health and Wellbeing Committee has been established to oversee the implementation of the PWS, with an initial meeting held on 15 October 2021. We commend the progress of the establishment of the Population Health and Wellbeing Portfolio Board to deliver strategic coordination of the emerging strategy, with the first meeting taken place in November 2021. Initial work is underway as follows:

- the Public Health and Wellbeing Assessment has been drafted;
- a public survey has been developed as part of the Communication Plan to engage with the citizens of Fife to direct and shape the strategy, this is planned for presentation to the November 2021 Board meeting and thereafter will be released online. The survey is aligned to NHS Fife 4 strategic priorities: Health and Wellbeing; Quality of Clinical Services; Staff experience and Wellbeing and Value and Sustainability, and,
- a review of the existing Clinical Strategy, where the initial meeting has been held on 24 November 2021.

A critical path plan with monthly timelines has been developed for the work on these workstreams. The planned completion date of 31 March 2022, will be challenging, especially given the pressures of Covid. We will review the development of the Strategy in detail within B13/22 - Strategic Planning.

Remobilisation Plans

The draft Remobilisation Plan 4 (RMP4) was considered and approved by the NHS Fife Board in Private session on 28 September 2021 prior to submission to the Scottish Government. The SBAR presented to the November 2021 Board meeting states that the RMP4 is aligned to the strategic planning in Fife and going forward, Annual Delivery Plans will reflect strategic developments including:

- Strategic Planning and Resource Allocation (SPRA) which has commenced for 2022/23, and will align with the development of the Population Health and Wellbeing Strategy;
- The development of NHS Fife's 5-year Population Health and Wellbeing Strategy.

Covid19 & Governance

NHS Fife has continued to monitor the governance arrangements whilst taking account of the pressures on management.
Regular Flu and Covid19 reporting to the Board has continued, the latest update to the November 2021 Board meeting included Covid19 testing, Covid19 cases, Vaccinations and Covid19 deaths.

Committee Assurance

NHS Fife has implemented the NHS Scotland Model Meeting Paper Template for all standing Committee and Board papers, enhanced to include papers for assurance. In particular we noted the comprehensive and informative narrative within the NHS Fife Annual report highlighting 'Key Issues and Risks that could affect the delivery of objectives'.

Standing Committee papers and workplans, demonstrate that Committees receive regular assurances in accordance with their remit and in line with the Committee Assurance Principles, although we noted that the workplans could better highlight and changes or delays to scheduled items and any potential impact on the Committee's ability to provide appropriate assurance.

A Board Development session was held on 2 November 2021 on Active Governance which focussed on improving how data presented to the Board and Standing Committees and explored how insights from intelligence can be used to assure quality and performance. An action plan was agreed following the session and includes a number of actions to improve reporting to Fife NHS Board and its committees, which link well with other developments within the Board.

Assurance Mapping

Internal Audit continue to facilitate the work of the Assurance Mapping group and to liaise with the Board Secretary to consider how the agreed principles can be adapted to the specific needs of NHS Fife and in particular, the actions arising from the November 2021 Active Governance Board Development Event. In addition, we are assisting Board Officers in their review and update of the Quality and Safety BAF and looking at how assurance mapping can be used to provide assurance on Best Value and on assurances required from Directors in accordance with the Scottish Public Finance Manual, as well as ensuring that all work is congruent with national governance initiatives. Whilst Best Value arrangements are in place with assurance statements received from all Standing Committees, there is scope for further improvement by increasing the focus on outcomes and through overt linkage to assurance mapping to avoid duplication.

Integration

The revised Integration Scheme was approved by NHS Fife Board on 28 September 2021 and has been submitted to the Scottish Government (SG) for approval. The revised Integration Scheme, which included input from FTF as the Internal Auditors of both the Health Board and IJB, has much greater clarity around the role of the IJB and that of its partners and now reflects national guidance received.

We previously noted that the Integration BAF was significantly out of date and needed to be reviewed. This has not yet taken place.

Performance

The Integrated Performance Quality Report (IPQR) Executive Summary report informs each meeting of the Board of performance against a range of key measures (Scottish Government and local targets) as well as RMP3 activity. The Board, the Finance, Performance and Resources Committee, the Staff Governance Committee and the Clinical Governance Committee have received regular performance reports to every meeting this year, the latest report presented with the (ESIPQR) at the November 2021 Board meeting highlights:

Cancer 31-Day Diagnostic Decision to first Treatment (DTT) and Antenatal are meeting target, with five indicators not achieving target but performing well above the Scotland average: 4- Hour Emergency Access; Cancer 62 Day RTT; Patient TTG; New Outpatients; Diagnostics. A further four areas are neither meeting the target nor the Scotland average: Smoking Cessation; Detect Cancer early; 18 week RTT; Cancer 62 Day RTT; Delayed Discharge (% bed days lost). However, we recognise that this is a time of exceptional pressure and all Health Boards are facing considerable challenges.

NHS Fife are successfully delivering against the remobilisation plan for New Outpatient Activity; Elective Imaging Activity; Urgent Suspicion of Cancer; CAMHS and Psychological Therapies.

The Board has been less successful with activity against projected activity for TTG Inpatient /Daycase Activity; Elective Scope Activity; A&E Attendance, Emergency Admissions and 31 Day Cancer – First Treatment and the challenges are likely to increase given the ambitions around elective activity and the likely backlog of unrecognised need and higher case mix in relation to both targets.

The SBAR presented with the ESIPQR advised that the activity templates data for RMP4 will be incorporated for governance purposes in future versions of the IPQR.

Actions to improve data reporting to Fife NHS Board and its committees were identified as part of the Active Governance Board Development session on 2 November 2021. These included revising the IPQR to bring in other ways of presenting data and changes are to be made to the format of the IPQR going forward and this is an opportune time to link the corresponding risks to performance to provide a triangulation of assurance.

Risk Management

A review of overall Risk Management arrangements is underway as reported to the Audit and Risk Committee in September 2021 incorporating an externally facilitated risk maturity assessment including a presentation and self-assessment undertaken by the Executive Directors and other EDG members in September 2021. This will inform the development of a risk management improvement plan including revision of the Risk Management Key Performance Indicators reported to the Audit and Risk Committee. We would recommend that the action plan should be presented to the Audit and Risk Committee for approval and monitoring.

We welcome that the newly established Public Health and Strategy Committee is giving consideration to creating a stand-alone BAF, for the areas associated with the work of this Committee.

Committee papers reflected good discussion on the BAFs although this could be further improved. We did note that the risk section of many SBARs was not well completed, often did not reference BAFs or operational risk and did not facilitate discussion of the accuracy of the description and scoring of risks, nor the adequacy and effectiveness of key controls and actions. Some papers did not evidence a serious consideration of risk implications and this area could be improved overall.

B08/21 Internal Control Evaluation report highlighted that whilst a number of BAFs have been updated for Covid19, the Board has not received an overall Covid19 risk, nor have they been informed of how and when Covid19 risks will be incorporated into the BAF. Although we have seen detailed scrutiny of Covid risks at Gold Command, this has still not translated into full revision of the BAFs to reflect the impact of Covid.

Action Point Reference 1 – Board Assurance Framework (BAF)

Finding:

a) Committee papers evidenced discussion on the BAFs and there is further scope to improve the process by overt scrutiny of the accuracy of scoring of risks and the adequacy and effectiveness of key controls and actions which should be mitigating and reducing the risk.

b) In addition, B08/21 Internal Control Evaluation report highlighted that whilst a number of BAFs have been updated for Covid19, the Board has not received an overall Covid19 risk, nor have they been informed of how and when Covid19 risks will be incorporated into the BAF.

c) We have previously recommended the need for the Integration Joint Board BAF to be reviewed and revised once the Integration Scheme has been approved by SG and we reiterate this as a priority, to ensure the NHS Fife Board is apprised and updated of the current risks.

Audit Recommendation:

a) The inclusion of appropriate analysis in each SBAR supporting the BAFs regarding the adequacy and effectiveness of key controls and actions would promote/aid further scrutiny by committee members.

b) The Board Assurance Framework should encompass and link Covid19 risks, to ensure the NHS Board has appropriate oversight and transparency over these risks.

c) Once the revised Integration Scheme has been approved by the Scottish Government, the IJB BAF should be revised to ensure that it adequately describes the risk the mitigating controls and appropriately scored.

Assessment of Risk:

Significant		Weaknesses in control or design in some areas of established controls. Requires action to avoid exposure to significant risks in achieving the objectives for area under review.

Management Response/Action:

The Board is currently reviewing the BAF process and the approach to risk management more generally. There is a planned session of the Audit and Risk Committee and the NHS Fife Board in December to consider this which will include responding to the audit points noted above. From this an action plan will be developed to support a range of improvement activitity which will inform our arrangements in this area.

Action by:	Date of expected completion:
Director of Finance and Strategy	**31 March 2022**

Action Point Reference 2 – Performance Reporting

Finding:

Actions to improve data reporting to Fife NHS Board and its committees were identified as part of the Active Governance Board Development session on 2 November 2021. These included revising the IPQR to bring in other ways of presenting data and changes are to be made to the format of the IPQR going forward.

Our review of Board and Committee papers highlighted that, whilst Board and Committee members are keen to discuss risk, many papers lack adequate, or sometimes any, detail on the associated risks. Where narrative is provided it does not overtly link to BAF or operational risks and does not overtly provide assurance on narrative, scores or the adequacy and effectiveness of key controls and actions.

Audit Recommendation:

As part of this Active Governance action plan, consideration should be given to how Performance Reports can provide overt assurance on the accuracy of the narrative and scores for related strategic (BAF) risks as well as the adequacy and effectiveness of key controls.

The risk section of Board and Committee papers should be given higher priority than at present and should contain basic information to facilitate a focused discussion on the risk implications, be overtly linked to any operational or BAF risks and contain enough information for members to be able to form a conclusion on whether the score narrative and other elements of the related risk are adequately described.

Assessment of Risk:

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

Management Response/Action:

Following discussion at EDG on 2 December 2021, the IPQR will undergo development in a range of areas.

- **Creation of a "System-Wide Summary - Dashboard"/ "Balanced Scorecard" showing the overall position across health and social care**
- **Proposed alternative presentation of aspects of data**
- **Proposed additional content in some areas**
    a. **Workforce**
    b. **Patient Feedback**
    c. **Information Governance**

Proposed section of the IPQR to report on Public Health and Prevention

As agreed with EDG, a review group will be created to lead the IPQR development process.

As a first priority the group will develop a working version of the System-Wide Summary/Balanced Scorecard for the opening section of the report to be used in January 2022.

This will include risk profiling aligned to our performance reporting. The final narrative supporting this will be approved in advance by the Chief Executive. This and all other changes proposed will be reported in an iterative way to EDG by the review group during the final quarter of 2021/22. Progress on the review will also be reported to the governance committees in January and March 2022. **The IPQR reports on the quality of patient care through a number of core targets, the targets are reported individually. The proposal to develop the System-Wide Summary/Balanced Scorecard will draw out the interdependencies across the system which impact on the effectiveness of patient pathways and flow.**	
Action by:	**Date of expected completion:**
Director of Finance and Strategy	**31 March 2022**

CLINICAL GOVERNANCE

BAF Risks:

Risk 1674 – Quality and Safety – High Risk (15)

There is a risk that due to failure of clinical governance, performance and management systems (including information & information systems), NHS Fife may be unable to provide safe, effective, person centred care.

Risk 1675 – Strategic Planning – High Risk (16)

There is a risk that the development and the delivery of the new NHS Fife Population Health and Wellbeing strategy is not adequately supported by the required planning and programme management capacity, capability and governance arrangements.

Clinical Governance Framework

A Clinical Governance Framework, to replace the Clinical and Care Governance Strategy, is currently in development and will be presented to EDG in January 2022 and then the CGC in March 2022 for approval. An associated delivery plan will be developed and its implementation monitored by the Clinical Governance Oversight Group (CGOG) with reports being provided to CGC.

The development of the framework is taking into account previous internal audit recommendations summarised in internal audit report B19/21 - Clinical Governance Strategy and Assurance including: clinical governance reporting routes, services delegated to the IJB, committee assurance principles and integration governance principles. Programmes of work in progress which support the development of the framework include reviews of the Risk Management Framework and Adverse Events Policy and Procedures.

Internal Audit have been consulted in a number of these developments and, we are extremely positive about the direction of travel, the process being adopted, and principles being applied to the development of the Framework.

Our IJB internal audit plan includes a review of Clinical and Care Governance arrangements for the services delegated to the IJB, which is intended to compliment the work undertaken in B19/21 and ensure that whole service assurances are in place with no omissions and no unnecessary duplication.

Clinical Governance Committee

No changes have been made to the CGC Terms of Reference since the period covered by the Internal Audit Annual Report (B06/22) and the CGC Workplan continues to be presented to each meeting of the CGC.

Clinical Risk Management

Following a review of the Quality and Safety (Q&S) BAF by Senior Management CGC were asked to consider proposals to improve the BAF including:

- work to improve the quality of Controls, Gaps in Control and Assurances recorded and to strengthen the assurances provided
- recommendations regarding risks currently linked to the BAF (whether these should continue to be linked or be managed in another way)
- linking new risks, associated with the impacts of the pandemic on the quality and safety of patient care and service delivery to the BAF
- revising the high level risk description for the BAF to reflect the impact of the pandemic on

clinical services (thereby addressing recommendation 1 from our annual report B06/22)

- reviewing all existing high risks related to Clinical Governance to consider which risks should be linked to the Q&S BAF
- engaging with Operational Directors and Senior Leadership Teams to identify key risks to operational delivery and ensure these are reflected on the appropriate risk registers and linked as appropriate to the BAF.

The CGC supported these recommendations and an updated Q&S BAF, will be presented to its January 2022 meeting. We commend this approach and are liaising with management on the revision of the Q&S risk as part of our Assurance Mapping work for 2021/22.

Clinical Performance Reporting

The IPQR was presented to both CGC meetings held since our annual report (September and November 2021). The latest report highlights that 7 of the 10 Clinical Governance targets measured are not currently being achieved and 5 of the 12 activity areas measures relating to NHS Fife's remobilisation plan are worse than predicted. The committee raised concerns regarding these areas and were reassured by the Director of Nursing that work is ongoing to achieve the targets, that the challenges inhibiting progress were recognised and the remobilisation plan will provide more context going forward. We highlight performance against the 4 hour wait target for A&E as an area of potential clinical risk, whilst recognising that Fife is out-performing the Scottish average.

The CGC has also received reports on Health Associated Infection, Complaints, Excellence in Care, Covid19 Testing, Remobilisation and the Covid19 and seasonal flu vaccination programmes.

External Review

An Organisational Learning Group has been established to share learning from incidents, adverse events and positive feedback so that all parts of NHS Fife benefit from lessons learned. This group is in its infancy but has the remit to consider issues identified from external reports to establish why these were not identified by existing internal control mechanisms and to recommend improvements to address issues identified and its terms of reference support this approach.

An unannounced inspection was undertaken by Healthcare Improvement Scotland at Victoria Hospital between 4 & 6 May 2021. The inspection considered compliance with existing Healthcare Associated Infection standards across a sample of wards and departments and found 7 areas of good practice and 2 requirements for improvement. The inspection report was presented to CGOLG in its activity tracker then to CGC on 17 September 2021 when the committee were informed that the 2 requirements for improvement had been addressed.

Significant Adverse Events

The new Adverse Events Lead is undertaking a full review of the Adverse Events Policy and Procedures which will incorporate the recommendations made in internal audit reports on Adverse Events Management (B19/20 and B20/21). We noted that although the CGC receives data on the number and nature of major and extreme adverse events it does not receive KPIs on the Board's performance in resolving these within required timescales.

Duty of Candour

In the Clinical Governance section of our Annual Report B06/22 we stated that due to the unavoidable delay in finalising duty of candour figures the Organisational Duty of Candour report could not be presented to CGC before that Committee's annual assurance statement/report was approved and we recommended that '*In future a short summary report should be provided to the CGC at year-end for consideration when concluding on its Annual Assurance Report and Statement*'. However, no such update on Organisational Duty of Candour has been scheduled for the CGC.

An interim Organisational Duty of Candour Annual Report for 2020/21 was presented to CGC on 3 November 2021 and indicated that between 1 April 2020 and 31 March 2021 there were 15 adverse events where the duty of candour applied with the most common related outcome being an increase to the person's treatment. The report was provided on an interim basis due to the backlog of adverse events reviews as a result of the pandemic meaning that the number is likely to increase. An updated report for 2020/21 is to be provided to the March 2022 CGC, but not, as noted above, a 2021/22 report.

Action Point Reference 3 – Organisational Duty of Candour

Finding:

In the Clinical Governance section of our Annual Report B06/22 we stated that due to the unavoidable delay in finalising duty of candour figures the Organisational Duty of Candour report could not be presented to CGC before that Committee's annual assurance statement/report was approved and we recommended that '*In future a short summary report should be provided to the CGC at year-end for consideration when concluding on its Annual Assurance Report and Statement*'. However, no such update on Organisational Duty of Candour has been scheduled for the CGC.

Audit Recommendation:

An update on the number of instances Organisational Duty of Candour has been applied in NHS Fife in 2021/22 should be scheduled for presentation to CGC prior to it concluding on its Annual Assurance Report and Statement, which should highlight any issues experienced and be sufficient allow it to conclude whether there were adequate and effective Duty of Candour arrangements throughout 2021/22.

The Committee should be informed when it can expect the final report on the year's activity and how arrangements will be developed in future to allow more timely reporting.

Assessment of Risk:

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

Management Response/Action:

An interim Duty of Candour Report was presented to the Clinical Governance Committee (CGC) in November 2021 with a further report presentedin January 2022. The report was issued on an interim basis due to delays resulting from the impact of the pandemic. The report presented included information on 2020/21 activity and also includes a look back at previous years (2018/2019 and 2019/2020). Previous years have been included for completeness as Duty of Candour applied to cases which concluded review after submission of respective annual reports. The review of the Adverse Event Policy and Proceedure will identify actions to improve timely reporting.

The processes involved in collating and finalising the duty of candour compliance information takes time and the report on Duty of Candour for activity in 2021/22 is scheduled for presentation to CGC in November 2022. A statement providing assurance on Duty of Candour, including assurance on 2021/22 activity understood at this time, will be included in the Clinical Governance Committee's Annual Assurance Statement which is due to be considered by CGC at their March 2022 meeting.

Action by:	Date of expected completion:
Medical Director	**31 March 2022**

Action Point Reference 4 – Adverse Events KPIs	
Finding:	
Although the CGC receives data on the number and nature of major and extreme adverse events it does not receive KPIs on the Board's performance in resolving these within required timescales.	
Audit Recommendation:	
The revised approach for Adverse Events should include regular reporting of KPIs to CGC on the completion of adverse events within agreed timescales.	
Assessment of Risk:	
Merits attention  There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**	
Management Response/Action:	
A review of the Adverse Events Policy and Procedure has been initated. The improvement plan to support this review will include action to address visibility of KPIs.	
Action by:	**Date of expected completion:**
Medical Director	**30 April 2022**

STAFF GOVERNANCE

BAF Risk:

Risk 1673 – Workforce Sustainability – High Risk (16)

There is a risk that failure to ensure the right composition of workforce, with the right skills and competencies will adversely affect the provision of services and quality patient care and impact on organisational capability to implement the new clinical and care models and service delivery set out in the Clinical Strategy and the future population Health & Wellbeing Strategy and the challenges and demands associated with the current Covid19 pandemic

Governance Arrangements

The March 2021 meeting of the Staff Governance Committee (SGC) approved a revised Terms of Reference and the changes therein have been formally reflected in the Code of Corporate Governance annual update, which was approved by the Board at its May 2021 meeting. As with other Committees, completion of the 2021/22 SGC workplan is not reported to each SGC meeting.

Covid19

During 2021/22, regular reports on NHS Fife's staff governance arrangements have included information on the impact of the Covid19 pandemic and providing assurance to the SGC on the measures being taken to ensure NHS Fife's workforce is being supported during the pandemic. Examples of this include reports on staff appraisals, health & wellbeing (including attendance management and support for staff shielding and working from home), all of which made specific reference to the impact of Covid19.

Workforce Strategy/Planning

An Interim Joint NHS Fife and Fife Health & Social Care Partnership Workforce Plan for 2021/22 was presented to the April 2021 SGC meeting prior to submission to the Scottish Government (SG). Arrangements are now in place to re-introduce a 3 yearly planning cycle across NHS Scotland with an NHS Fife Workforce Plan 2022-25 currently due to be completed by 31 March 2022. It is being prepared in consultation with the Health & Social Care Partnership and in conjunction with the NHS Fife Population Health & Wellbeing Strategy and its preparation is to take due regard of comments made by the SG on the 2021/22 Interim Joint NHS Fife and Fife Health & Social Care Partnership Workforce Plan. An audit review by Internal Audit of the arrangements for completing the Workforce Plan 2022-25 is ongoing.

Risk Management

The SGC has been presented with an update on the BAF Workforce Sustainability risk at each of its meetings. As part of an overall review of risks being completed by the Executive Directors Group, the SGC approved a number of revisions to the BAF Workforce Sustainability risk at its October 2021 meeting, which, in our view, have improved the quality of the BAF and better reflect workforce challenges and the impact of Covid19. The current risk rating remains high.

The BAF Workforce Sustainability risk is to be further reviewed by management for any workforce pressures identified during the preparation of the Workforce Strategy 2022-25. This risk will be specifically considered by Internal Audit, in our review of the Workforce Strategy 2022-25. Currently, no updates are provided to either the SGC or RC on NHS Fife's succession planning arrangements. There would be benefit in recording and monitoring the Board's approach to mitigating the risks associated with recruiting to key positions.

Staff Governance Action Plan

Guidance is still awaited from the SG review of staff governance standard monitoring arrangements and there is no requirement to prepare a SGAP for 2021/22.

The SGC workplan includes a mid-year and year end review of monitoring compliance with the Staff Governance Standards (SGS). At the September 2021 SGC meeting the Staff Governance Annual Monitoring Return on the application of SGSs was discussed and approved by the committee, with an update on the work underway to locally implement the SGSs provided by the Workforce Leadership team. Further updates on the SGSs are scheduled to be considered at the January and March 2022 SGC meetings to enable the committee to conclude on the implementation of the standards during 2021/22. To enable the SGC to fully ascertain the initiatives introduced during 2021/22 and provide a measure of their success in meeting the requirements of the SGSs, the assurances given at those meetings should give an equivalent level of detail to that previously provided by theStaff Governance Action Plan (SGAP), detailing the measures still to be introduced and the reasons for any delays in doing so.

Staff Experience

The SGC has received regular reports on staff health and wellbeing to highlight the impact of the Covid19 pandemic on staff and provide assurance on the action being taken to support staff. The September 2021 and October 2021 SGC meetings were provided with updates on the Joint Remobilisation Plan (RMP3/RMP4), which has workforce implications. As part of the continuous improvement process relating to staff experience, the results of the recently completed iMatters survey is in the process of being discussed by individual teams and management, with an update due to be given to the January 2022 SGC meeting.

Whistle Blowing

An update on the role of the whistle blowing champion was provided to the September 2021 SGC meeting, along with the a copy of the first quarter's Whistleblowing Quarterly Data Report for 2021/22 (April 2021 – June 2021). No instances of whistleblowing were reported during this period and the Committee discussed the potential reasons for this. The report for the second quarter (July 2021 to September 2021) and is being prepared and will be considered by the relevant fora, before presentation to the SGC. The current arrangements for returns to be considered by different groups is causing timescale issues and these arrangements will be reviewed after this cycle of reports has completed. A review of NHS Fife's whistleblowing arrangements is to be currently scheduled for the draft 2022/23 Annual Internal Audit Plan.

Remuneration Committee

In accordance with the 'Once for Scotland' approach the RC is now a full standing committee of NHS Fife Board. The Remuneration Comittee (RC) terms of reference are now formally reflected in the Code of Corporate Governance and as with other standing committees they will be standardised after the Once for Scotland team issue a new template.

Appraisals

The SGC was advised at its September 2021 meeting that all Executive and Senior Manager appraisals for 2019/20 and 2020/21 had been completed.

To reflect the impact of the Covid19 pandemic, the target for AfC appraisals was reduced from 80% to 55% and as at mid-November 2021, completed KSF/PDP appraisals stood at a 33%.

The Annual Report on Medical Consultant and GP appraisals for 2020/21 was presented to the SGC at its October 2021 meeting. It shows that although, as expected, the Covid19 pandemic did impact the number of appraisals that were completed; 94% of Medical Consultants and 99% of General Practitioners were either appraised or exempt from an appraisal. Apart from the impact of the

Covid19 pandemic, recruiting and retaining NES trained assessors is currently the greatest difficulty faced in completing appraisals, with the number of NHS Fife appraisers having to be supplemented by the use of bank appraisers.

Core Skills Training

Core Skills refers to those common training subject areas which organisations are required to deliver to their workforce, in order to meet either legal training requirements or to comply with key quality standards in accordance with organisational policy and regulatory requirements. The current overall completion rate for mandatory training is 70%. The Workforce Sustainability BAF recognises Core Skills Training as an area requiring improvement. An update on the completion of statutory/mandatory training for 2021/22 will be provided to the March 2022 SGC meeting.

Sickness Reporting

The rate most recently reported to the October 2021 SGC was 6.42% as at 30 September 2021 (5.69% at 30 September 2020,) with Covid19 contributing an additional 1.13% to absence levels, reflecting the trend for Scotland. The Health & Wellbeing Update report provides the committee with a detailed analysis of the causes of absenteeism, along with a summary of the actions being taken to reduce it and the other health and wellbeing initiatives being used. The Workforce Sustainability BAF also recognises sickness absence as an area for improvement and our Internal Audit recommendation in this area is currently outstanding due to the impact of Covid.

Action Point Reference 5 – Succession Planning	
Finding:	
Nationally, recruitment to senior posts have been difficult across NHS Scotland and this trend is likely to be exacerbated by workforce demographics and the impact of Covid. However, we could see no consideration of succession planning for NHS Fife within papers presented to the Staff Governance Committee or Remuneration Committee or in the risk registers.	
Audit Recommendation:	
The Staff Governance Committee and Remuneration Committee should be assured on succession planning arrangements within NHS Fife and of the potential risks associated with this area.	
Assessment of Risk:	
Merits attention 	There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**
Management Response/Action:	
NHS Fife is active in talent management and succession planning and has successfully appointed to all Senior posts over the 2021/22 period. Noting that the challenge to manage future turnover of senior staff is a sector wide issue, an overview paper on our talent management and succession planning arrangements will be outlined to Staff Governance Committee as part of our annual meeting cycle in 2022/23. If this became an issue for Executive Senior Managers then the matter would be considered by the Remuneration Committee. Workforce retention is recognised as risk on our current register and as part of our ongoing review of workforce risks, we will update actions and mitigations to specifically address work on succession planning.	
Action by:	**Date of expected completion:**
Director of Workforce	**October 2022**

Action Point Reference 6 – Staff Governance Standards	
Finding:	
The SGC will receive further updates on implementation of the staff governance standards at its January and March 2022 SGC meetings to enable it to conclude on the implementation of the standards during 2021/22. A review of the assurances provided to it so far during 2021/22 indicates that they have not provided the same level of detail or measurement criteria as the previously maintained SGAP did.	
Audit Recommendation:	
To enable the SGC to fully ascertain the SGS initiatives introduced during 2021/22 and provide a measure of their success in meeting the requirements of the SGSs, the assurances given at those meetings should give an equivalent level of assurance to that previous years, setting out actions and assurances still to be provided and the reasons for any delays.	
Assessment of Risk:	
Merits attention 	There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**
Management Response/Action:	
There have been three elements of review against the staff governance standards in 2021/22; Annual Reports from the Acute & Corporate Services and Health & Social Care Local Partnership Forum and the 2021/22 Staff Governance Monitoring return to Scottish Government which will be repeated for current activity during the 2022/23 cycle. Additionally coverage of standards will be considered through the Staff Governance Committee review of the 2021/22 workplan and the proposals for the 2022/23 workplan at the January and March 2022 meetings respectively.	
Action by:	**Date of expected completion:**
Director of Workforce	**March 2022**

FINANCIAL GOVERNANCE

BAF Risk:

Risk 1671 – Financial Sustainability – High Risk (16)

- There is a risk that the funding required to deliver the current and anticipated future service models, particularly in the context of the COVID 19 pandemic, will not match costs incurred.
- There is a risk that the organisation may not fully identify the level of savings required to achieve recurring financial balance.
- Thereafter there is a risk that failure to implement, monitor and review an effective financial planning, management and performance framework would result in the Board being unable to deliver on its required financial targets.

Risk 1672 – Environmental sustainability – High Risk (20)

There is a risk that Environmental & Sustainability legislation is breached which impacts negatively on the safety and health of patients, staff and the public and the organisation's reputation

Financial Planning 2021/22

The Financial Plan for 2021/22 was a key element of RMP3 which also serves as the Annual Operational Plan for 2021/22. Key financial and Covid assumptions were included as part of the overall financial plan. RMP4 which updates RMP3 and replaces the Annual Operational Plan for 2021/22 was considered by the NHSF Board on 28 September 2021 prior to submission to the SG on 30 September 2021.

In line with national guidance and reflecting difficulties in planning caused by Covid19, a one-year financial plan was provided instead of the intended medium term 3-year plan.

Strategic Planning and Resource Allocation

The Strategic Planning and Resource Allocation (SPRA) process was introduced during 2020/21 to support strategic, financial and organisational planning. It has evolved during 2021/22, learning from last year's iteration and will form the basis of a 3 year medium term financial plan.as well as informing and aligning with the development of the NHS Fife 5 year Population Health and Wellbeing Strategy.

Achievement of recurring savings needed for financial balance, will require both investment and disinvestment to support the delivery of the Population Health and Wellbeing Strategy and the SPRA process recognises the need to disinvest with the aim to further develop plans to achieve savings and efficiency opportunities.

The SPRA highlights the need to further develop the Project Management Office (PMO) to support service transformation and NHS Fife is investing in new posts in this department.

The SPRA process for 2022/23 has commenced with the EDG now reviewing returns, prior to a Board Development Session on 21 December 2021.

Budgetary Control

Each year all budget holders have to provide a signed statement as formal agreement and acceptance of the delegated budget. Budget holders have completed the annual financial 'grip and control' checklist which provides a continuing focus to identify savings opportunities and the way services are delivered due to Covid19.

This budget process provides a clear understanding to budget holders of their role and responsibilities for budgetary control.

Financial Reporting

Finance reporting to Board and FP&RC has been transparent with enhancements made to the IPQR in 2021/22. The content remains the same but the way information is presented has been enhanced. The Director of Finance has consistently and clearly articulated financial challenges and improvement actions. Specific challenges are:

- Achievement of savings;
- the financial impact of Covid in both the short and longer-term, and its impact on both service delivery and financial plans;
- Managing the underlying Acute Services core cost overspend;
- Recruiting to the Corporate PMO.

The Financial Sustainability BAF and the IPQR (Financial Performance) are not overtly linked, with the IPQR making no reference to the BAF. Key challenges are highlighted in the IPQR financial section; however there is no direct correlation to the current controls/gaps in control/mitigation actions within the BAF.

Savings

Savings targets were set out in the 2020/21 Financial Plan, as part of the RMP3. The 2021/22 financial plan reflects an overall savings target of £21.7m and assumes £8m is achievable in-year with £4m on a recurring basis and £4m on a nonrecurring basis. Discussions continue with Scottish Government in relation to supporting the remaining £13.7m this financial year.

For the latest reported figures to August 2021, recurring savings of £3.538m have been achieved, alongside £696k non-recurring. Achievement of financial balance for 2021/22 will be dependent on external funding and we note the ongoing work to identify potential recurring cost saving reduction schemes and programmes for both this year and the next 2 financial years.

Savings is an ongoing issue but with the evolving SPRA process and the development of the PMO capacity and capability, this will further support NHSF to achieve its longer term financial goals and drive service transformation.

BAF – Financial Sustainability – High Risk

The Financial Sustainability BAF, as reported to the FP&RC during 2021/22, recognises the ongoing financial challenges facing the Board, in particular Covid19 funding and savings gaps, which are being discussed with the SG.

The BAF has been developed in-year with the rationale and actions now clearer on the steps required to reduce the overall risk score. Clearer linkages to Strategy, PMO savings programme, and External Audit recommendations would further strengthen the BAF along with greater specificity around current controls.

The BAF has a mitigating action of “relentless pursuit of all opportunities identified through the transformation programme in the context of sustainability & value”; an area should be the subject of specific assurance in future.

Best Value

Internal Audit previously recommended application of the Audit Scotland Best Value Tool Kit. However, given the pressures on officers due to the ongoing Covid19 response, we do not consider this a priority for the Board at this time, especially as best value and effective allocation of resources are a key element of the new SPRA process and Assurance Mapping provide es potentially a more efficient way of achieving Best Value assurance.

Other Areas covered by ICE Fieldwork

We also reviewed the following areas, none of which highlighted any issues of note:

- Standing Financial Instructions
- Standards of Business Conduct
- Anti-Fraud and Corruption Policy and Response Plan
- Financial Operating Procedures
- Control over the Acquisition, Use, Disposal and Safeguarding of Assets

Capital Plan and Property Strategy

Following updates on progress, the November 2021 FP&RC received the PAMS report for the year to 31 March 2021, which is good practice although not mandatory. The PAMs itself was largely retrospective but emphasised the need for a revised NHS Fife Property & Asset Management Strategy to support the development and deliver the objectives of the Health & Wellbeing Strategy.

The PAMS also reported changes to the governance of asset management. The appointment of the Director of Finance as the NHSF Asset Champion, charged with promoting and sustaining of good practice in Asset Management, reflects best practice.

We note the ambition for an NHS Fife PAMS Implementation Action Plan to be developed for 2021/22 which will include actions and outcomes. This Action Plan will be used by the Capital Groups to assess progress in achieving outcomes and objectives that reflect the PAMS requirements of NHS Fife.

Although risks to delivery of the Capital Plan are considered by the Fife Capital Investment Group, and the PAMS, which requires further development, will be essential to support the Health and Wellbeing Strategy, these risks are not recorded on the Risk Register and there is currently no BAF which focuses on Property and Capital.

The FP&RC receive regular updates on current major capital projects. The Elective Orthopaedic Project is on track and due for completion in October 2022with progress regularly reported to the FP&RC.

Environmental Reporting

A paper was presented to the September 2021 FP&RC detailing that NHS Fife is seeking to improve the energy efficiency of its buildings within the Estate, as part of the health sector's drive towards 'net zero carbon' with funding available from the SG as part of the Low Carbon Infrastructure Programme.

A Policy For NHS Scotland on the Climate Emergency and Sustainable Development - DL (2021) 38, was issued on 10 November 2021, with its requirements mandatory and with immediate effect. The DL requirements will almost certainly impact on all NHSF Board decision making.

Action Point Reference 7 – IPQR and Financial Sustainability BAF

Finding:

The Financial Sustainability BAF and the IPQR (Financial Performance) are not overtly linked, with the IPQR making no reference to the BAF. Key challenges are highlighted in the IPQR financial section; however there is no direct correlation to the current controls/gaps in control/mitigation actions within the BAF.

Clearer linkages to Strategy, PMO savings programme, and External Audit recommendations would further strengthen the BAF along with greater specificity around current controls.

Audit Recommendation:

Links between the Financial Sustainability BAF and IPQR should be clear and overtly linked so the controls/mitigations of the BAF provide assurance that challenges within the IPQR is being managed.

The financial sustainability BAF should be updated to include links to Strategy, PMO Savings Programme and relevant External audit recommendations.

Assessment of Risk:

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

Management Response/Action:

The improvement activity outlined in previous recommendations in relation to the BAF and Performance Management/IPQR will address a number of the points made in this finding. Additionally a Financial Improvement/Sustainability Programme was approved recently by the Portfolio Board which underpins the delivery of the new strategy for NHS Fife.

Action by:	Date of expected completion:
Director of Finance and Strategy	**31 March 2022**

Action Point Reference 8 – PAMs	
Finding:	
The PAMs and Capital Programme is a vital part of supporting the future Health and Wellbeing Strategy and delivering its prioritised outcomes. However there is currently no BAF risk or linked operational risk that covers the Capital Programme and Property Strategy.	
Audit Recommendation:	
The risks around delivery of the PAMs and capital programme would benefit from having a BAF or operational risk which would aid and support the delivery of the future Health and Wellbeing Strategy.	
Assessment of Risk:	
Merits attention 	There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**
Management Response/Action:	
The Board is currently reviewing the BAF process and the approach to risk management more generally. There is a planned session of the Audit and Risk Committee and the NHS Fife Board in December to consider this which will include responding to the audit points noted above. **Following this, an appropriate BAF or operational risk around delivery of the PAMs and capital programme will be developed which would aid and support the delivery of the future Health and Wellbeing Strategy**	
Action by:	**Date of expected completion:**
Director of Property & Asset Management	**31 March 2022**

INFORMATION GOVERNANCE

Information Governance

BAF Risk:

Risk 1677 – Digital and Information – High Risk (15)

There is a risk that the organisation will fail to recognise and afford the financial investment necessary to deliver its D&I Strategy and current operational lifecycle commitment to enable transformation across Health and Social Care to deliver sustainable and integrated services that are safe, secure and compliant with governance frameworks and associated legislation.

Governance

The governance arrangements, including terms of reference and reporting lines, for Digital and Information were agreed at the beginning of 2021/22 with the Digital and Information Board (D&IB) and Information Governance and Security Steering Group (IG&SSG) identified as having responsibility for providing assurance to the Clinical Governance Committee (CGC) on Information Governance arrangements including assurance on delivery of the NHS Fife Digital and Information Strategy.

The CGC received an update from the IG&SSG in July 2021 regarding the assurance to be developed on key areas of Information Governance, including an activity tracker with target assurance measures. As the IG&SSG meeting scheduled for September 2021 was cancelled due to service pressures the CGC has not yet received a further assurance report from IG&SSG on progress.

The Information Governance and Security Steering Group (IG&SOG) has met twice in 2021/22 in October 2021 and November 2021 and now meets monthly. It has considered an Information Governance Assurance Dashboard which aims to provide assurance regarding the key areas of IG&S. We provided detailed comment on required improvements to the quality and scope of this assurance and the need for clarity regarding the reporting from this group to the IG&SSG and thence assurance reporting to CGC. Papers to the December IG&SSG show further improvement although there are still a number of areas to be resolved by year-end.

Assurance regarding the delivery of the NHS Fife Digital and Information Strategy has been provided to CGC in accordance with its 2021/22 workplan.

It is important that provision of regular assurances to the CGC on the key aspects of Information Governance are established to ensure that the CGC is in a position to conclude on the adequacy and effectiveness of these arrangements at year-end. This regular reporting should be scheduled in the CGC's workplan for the remainder of 2021/22 and in future year's workplans.

Risk Management

The processes for recording and managing risks related to Digital and Information continue to evolve and we were pleased to see that related risks are to be split so that the component parts of the risk and corresponding mitigations can be better understood. It is important that these processes are sufficient to provide CGC with assurance regarding these risks at year end on the accuracy of risk ratings, and the adequacy and effectiveness of key controls and actions. The impact of the pandemic on Digital and Information risks should be considered and specific assurance on this should be provided to CGC.

The Digital and Information BAF is regularly presented to the CGC, however as previously reported the minutes of its meetings do not record any discussion or assurance regarding whether mitigations, in place and planned, will be sufficient to reduce the risk to a tolerable level within an acceptable timescale.

The reporting on risk management to the Digital and Information Board is to change following the adoption of a new risk framework introducing new profiles and risk categorisation in line with ITIL standards.

The IG&SSG has not met since the publication of our annual report (B06/22). The risk report it received at its 1 June 2021 meeting advised that a full risk process and management review was underway with the support of Corporate and Clinical Governance teams, and we have been advised that this has been completed and a risk management report based on the new process is to be presented to the December 2021 IG&SSG.

Digital and Information Strategy

A report on the alignment of NHS Fife D&I Strategy key ambitions and deliverables to NHS Fife's overall strategy to CGC on 17 September 21 highlighted that prioritisation will required over the remaining term of the strategy through the SPRA process, as not all deliverables will be affordable.

Information Governance Responsibilities

An NHS Fife Senior Information Risk Owner (SIRO) and Data Protection Officer (DPO) are in place and the SIRO is an Executive member of the Board.

Information Governance Policies and Procedures

Assurance provided regarding Information Governance Policies and Procedures since the publication of our annual report (B06/22) has been limited to a brief update provided to the Information Governance and Security Operational Group. This did not list the policies and procedures and their review dates (as historical assurances had done) but highlighted a risk regarding lack of resources for Information Governance and Security Policy Management.

The key Information Governance and Security policies, NHS Fife Information Security Policy [GP/I5] and NHS Fife Data Protection and Confidentiality Policy [GP/D3] both have lapsed review dates (01 November 2017 and 01 June 2021 respectively). It is imperative that these important policies are reviewed at the earliest opportunity. The review should specifically consider the impact of the pandemic and the increase in fraud risk and remote working implications.

Information Governance Incidents and Reporting

At this stage, we cannot be certain that that the CGC will receive appropriate and proportionate assurance on Information Governance Incidents. The assurance route for these needs to be clarified and streamlined and should, as a minimum, include the number of IG incidents reported to the Competent Authority, whether these were reported within the 72-hour deadline, feedback from the competent authority (No Further Action, Enforcement or Pending) and whether any of these should be considered for disclosure in the Board's Governance statement.

Action Point Reference 9 – IG&S Assurance Reporting to CGC

Finding:

The CGC has not received regular assurance reporting on the key aspects of IG&S in 2021/22 to date. Whilst it is accepted that this assurance was at the forming stage at the outset of 2021/22, and pandemic related service pressures have hindered progress, it is important that this regular reporting is established so that the CGC, in 2021/22 and future years, is in a position to conclude on the adequacy and effectiveness of Information Governance arrangements at year end.

Reporting to the IG&S Operational Group to date has not provided the necessary detail or quality of information to allow appropriate assurance reporting to the IG&S Steering Group and CGC.

Audit Recommendation:

Regular assurance reporting from the IG&SSG to CGC should be scheduled in the workplan of CGC for 2021/22 and future years.

This should include a regular Assurance Report as well as IG&SSG minutes.

The Assurance report should include clear, sufficient and reliable assurance on the key aspects of IG&S so that the CGC can conclude on the adequacy and effectiveness of Information Governance arrangements at year end.

Assessment of Risk:

Significant		Weaknesses in control or design in some areas of established controls. **Requires action to avoid exposure to significant risks in achieving the objectives for area under review.**

Management Response/Action:

The Information Governance & Security (IG&S) assurance has been considered within the workplan of the CGC for 2021/22. An assurance report was presented to the July 2021 meeting of the committee with agreement that "a further report will come back to the Committee in due course." This additional report has been scheduled within the 2021/22 workplan for presentation in March 2022, in order to provide further assurance.

The minutes from the IG&S Steering group are consistently presented within the CGC's Linked Committee Minutes section of the agenda.

The provision of the next assurance report, linked committee minutes and annual report 2021/22 will allow the CGC to conclude on the adequacy and effectiveness of Information Governance arrangements.

Action by:	Date of expected completion:
Associate Director of Digital and Information	**28 April 2022**

Action Point Reference 10 – Information Governance and Security Policies

Finding:

The key Information Governance and Security policies, NHS Fife Information Security Policy [GP/I5] and NHS Fife Data Protection and Confidentiality Policy [GP/D3] both have lapsed review dates (01 November 2017 and 01 June 2021 respectively). Lack of resources for IG&S Policy Management was highlighted as a risk to the IG&S Operational Group (28 October 2021).

Audit Recommendation:

Assurance provided regarding Information Governance Policies and Procedures should be improved so that a list of all policies and procedures and their review dates is provided to the IG&S Operational Group and percentage compliance, regarding reviewed within scheduled review date, figures are reported to the IG&S Steering Group.

Progress towards mitigating the risk regarding lack of resources for Information Governance and Security Policy Management should also be reported to the IG&S Steering Group.

The NHS Fife Information Security Policy [GP/I5] and NHS Fife Data Protection and Confidentiality Policy [GP/D3] must be reviewed at the earliest opportunity. The review should specifically consider the impact of the pandemic and the increase in fraud risk and remote working implications.

Assessment of Risk:

Significant  Weaknesses in control or design in some areas of established controls.
Requires action to avoid exposure to significant risks in achieving the objectives for area under review.

Management Response/Action:

The revised list of policies and procedures was reviewed for all Digital and Information items. This work included the identification of all policies and procedures that were presented within NHS Fife, via Stafflink and publicly through the NHS Fife corporate website. Having identified multiple versions of policies and procedures in these two sources a revised process was introduced to identify a single source of truth for policies and procedures and appropriate tracking and remedial actions.

The revised Policy Review group reactivated their work and presented policy GP/I5 – Information Security to the Executive Director Group (EDG) on September 2021, following its review in February 2020. Given the 19 month delay in presenting the policy the Associate Director of Digital and Information requested that the policy be updated to reflect the new management arrangements and change of name within the Digital and Information team.

The Information Security Policy (GP/I5) and the Data Protection & Confidentiality Policy (GP/D3) will be updated and presented to the Policy Review Group.

Action by:	Date of expected completion:
Associate Director of Digital & Information	**14 February 2022**

Action Point Reference 11 – Information Governance Incident Management

Finding:

The agenda of the IG&S Steering Group on 2 June 2021 did not include any reporting on IG related incidents. No further meetings of the IG&S Steering Group have taken place since the publication of our annual report (B06/22). The next meeting is scheduled for 1 Dec 21 and papers for this have just been distributed with the Activity Tracker report recording the latest data on reportable incidents.

The IG&SSG update report presented to CGC on 7 July 2021 did not include any reporting on IG&S incidents. At this stage, we cannot be certain that that the CGC will receive appropriate and proportionate assurance on Information Governance Incidents.

The process of assurance reporting to the IG&S Steering Group is still evolving and we cannot yet fully comment on the appropriateness of the differentiation in roles between this group and the IG&S Operational Group as the IG&S Operational Group only had its first meeting in October 2021.

Audit Recommendation:

The assurance route for reporting of assurances on Information Governance incidents needs to be clarified and streamlined to provide sufficient assurance to CGC. This should, as a minimum, include the number of IG incidents reported to the Competent Authority, whether these were reported within the 72-hour deadline, feedback from the competent authority (No Further Action, Enforcement or Pending) and whether any of these should be considered for disclosure in the Board's Governance statement.

Assessment of Risk:

Significant		Weaknesses in control or design in some areas of established controls. **Requires action to avoid exposure to significant risks in achieving the objectives for area under review.**

Management Response/Action:

The most recent Activity Tracker and associated Quality Control Assurance Measures included a summary set of incidents, per month, for consideration at the December 2021 Information Governance and Security Steering Group. The summary provided, per month:

- **The number of incidents per category**
- **The number of total incidents**
- **The number escalated to SIRO**
- **The number reportable to the competed Authority**
- **The number by service area**

The data items listed will be included as they are contained within the monthly SIRO report.

Action by:	Date of expected completion:
Associate Director of Digital and Information	**31 March 2022**

Action Point Reference 12 – D&I Risk Management

Finding:

The processes for recording and managing risks related to Digital and Information continue to evolve. The Digital and Information BAF is regularly presented to the CGC, however as previously reported the minutes of its meetings do not record any discussion or assurance regarding whether mitigations, in place and planned, would be sufficient to reduce the risk to a tolerable level within an acceptable timescale.

CGC has not been advised regarding whether the impact of the pandemic on Digital and Information risks has been considered.

Audit Recommendation:

It is important that the processes for recording and managing risks related to Digital and Information are sufficient to provide CGC with assurance regarding these risks at year end on the accuracy of risk ratings, and the adequacy and effectiveness of key controls and actions.

The impact of the pandemic on Digital and Information risks should be considered and specific assurance on this should be provided to CGC.

Assessment of Risk:

Significant		Weaknesses in control or design in some areas of established controls. **Requires action to avoid exposure to significant risks in achieving the objectives for area under review.**

Management Response/Action:

Within D&I, a full risk review and revised risk management process has been implement. This review and process has been aligned to NHS Fife's Corporate Risk Management Framework and developing thinking in this area and has considered the impact of the pandemic on Digital and Information Risks.

In addition presentational improvements have been developed to support groups and assurance committees to understand the risks performance, and mitigations for highest rated and emerging risks. The improved presentation outlines the timescale for the delivery of the management actions and the impact on risk rating (both likelihood and consequence) from the successful completion of these mitigations. This, together with the risk proximity assessment, allows consideration to be given to the timelyness of mitigation.

These reports will continue to be presented to the assurance groups and be referenced in assurance reports for the remainder of the year 2021/22 and onwards.

Action by:	Date of expected completion:
Associate Director of Digital and Information	**Ongoing – 31 May 2022**

Assessment of Risk

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

Risk Assessment		Definition	Total
Fundamental		Non Compliance with key controls or evidence of material loss or error. **Action is imperative to ensure that the objectives for the area under review are met.**	None
Significant		Weaknesses in control or design in some areas of established controls. **Requires action to avoid exposure to significant risks in achieving the objectives for area under review.**	Five
Merits attention		There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**	Seven