NHS Fife Audit & Risk Committee

Thu 16 May 2024, 13:30 - 15:40

MS Teams

Agenda

13:30 - 14:00
30 min

1. MEMBERS' TRAINING SESSION – THE ANNUAL ACCOUNTS: THE ROLE & FUNCTION OF THE AUDIT & RISK COMMITTEE

Presentation *Azets*

1.1. Presentation

1.2. Questions & Answers

14:00 - 14:20
20 min

2. Apologies for Absence

Alastair Grant

14:20 - 14:20
0 min

3. Declaration of Members' Interests

Alastair Grant

14:20 - 14:20
0 min

4. Minutes of Previous Meeting held on Thursday 14 March 2024

Enclosed *Alastair Grant*

Approval

- Item 4 - Unconfirmed Audit & Risk Committee Minutes (unconfirmed) 20240314.pdf (9 pages)

14:20 - 14:20
0 min

5. Matters Arising / Action List

Enclosed *Alastair Grant*

Assurance

- Item 5 - Audit & Risk Committee Action List 20240516.pdf (1 pages)

14:20 - 14:30
10 min

6. ANNUAL ACCOUNTS

6.1. Annual Accounts Preparation Timeline – Follow Up

Enclosed *Kevin Booth*

Assurance

- Item 6.1 - SBAR Annual Accounts Preparation Timeline – Follow Up.pdf (3 pages)
- Item 6.1 - Appendix 1 Annual Accounts Timetable 2023-24.pdf (1 pages)

6.2. External Auditors Annual Accounts Progress Update

Verbal *Chris Brown*

Assurance

14:30 - 14:50
20 min

7. INTERNAL AUDIT

7.1. Internal Audit Progress Report

Enclosed *Barry Hudson*

Assurance

- Item 7.1 - SBAR Internal Audit Progress Report + Appendices.pdf (15 pages)

7.2. Internal Audit – Follow Up Report on Audit Recommendations 2023/24

Enclosed *Andy Brown*

Decision

- Item 7.2 - SBAR Internal Audit – Follow Up Report on Audit Recommendations 2023-24 + Appendices.pdf (23 pages)

14:50 - 15:15
25 min

8. RISK

8.1. Corporate Risk Register

Enclosed *Shirley-Anne Savage*

Assurance

- Item 8.1 - SBAR Corporate Risk Register.pdf (6 pages)
- Item 8.1 - Appendix 1 NHS Fife Corporate Risk Register as at 300424.pdf (20 pages)
- Item 8.1 - Appendix 2 Assurance Principles.pdf (1 pages)
- Item 8.1 - Appendix 3 Risk Matrix.pdf (2 pages)

8.2. Draft Annual Risk Management Report 2023/24

Enclosed *Shirley-Anne Savage*

Assurance

- Item 8.2 - SBAR Annual Risk Management Report 2023-24.pdf (3 pages)
- Item 8.2 - Appendix 1 Annual Risk Management Report 2023-24 Final Draft.pdf (13 pages)

8.3. Risk Management Key Performance Indicators 2023/24

Enclosed *Shirley-Anne Savage*

Assurance

- Item 8.3 - SBAR Risk Management Key Performance Indicators 2023-24.pdf (3 pages)
- Item 8.3 - Appendix 1 Risk Management Key Performance Indicators 2023-24.pdf (8 pages)

8.4. Risks & Opportunities Group Annual Statement of Assurance

Enclosed *Shirley-Anne Savage*

- Item 8.4 - SBAR Risks & Opportunities Group Statement of Assurance 2023-24.pdf (3 pages)
- Item 8.4 - Appendix 1 Annual Statement of Assurance for Risks and Opportunities Group 2023 -24.pdf (8 pages)

15:15 - 15:40
25 min

9. GOVERNANCE MATTERS

9.1. Update to Scheme of Delegation

Enclosed *Kevin Booth*

Assurance

- Item 9.1 - SBAR Update to Scheme of Delegation.pdf (5 pages)

9.2. Annual Review of Code of Corporate Governance

Enclosed *Dr Gillian MacIntosh*

Decision

- Item 9.2 - SBAR Annual Review of Code of Corporate Governance.pdf (3 pages)

9.3. Draft Audit & Risk Committee Annual Statement of Assurance 2023/24

Enclosed *Dr Gillian MacIntosh*

Approval

- Item 9.3 - SBAR Draft Audit & Risk Committee Annual Assurance Statement 2023-24.pdf (3 pages)
- Item 9.3 - Appendix 1 A&R Annual Statement of Assurance 2023-24.pdf (18 pages)

9.4. Draft Governance Statement

Enclosed *Dr Gillian MacIntosh*

Discussion

- Item 9.4 - SBAR Draft Governance Statement.pdf (3 pages)
- Item 9.4 - Appendix 1 Draft Governance Statement.pdf (20 pages)

9.5. Losses & Special Payments Quarter 4

Enclosed *Kevin Booth*

Assurance

- Item 9.5 - SBAR Losses & Special Payments Quarter 4.pdf (4 pages)
- Item 9.5 - Appendix 1 Summary of Losses and Special Payments 010124 – 310324.pdf (1 pages)
- Item 9.5 - Appendix 2 Previous 6 Years Comparison.pdf (1 pages)

9.6. Procurement Tender Waivers Compliance Quarter 4

Enclosed *Kevin Booth*

Assurance

- Item 9.6 - SBAR Procurement Tender Waivers Compliance Quarter 4.pdf (3 pages)

9.7. Delivery of Annual Workplan 2024/25

Enclosed *Dr Gillian MacIntosh*

Assurance

- Item 9.7 - Delivery of Annual Workplan 2024-25.pdf (4 pages)

15:40 - 15:40
0 min

10. ESCALATION OF ISSUES TO NHS FIFE BOARD

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

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15:40 - 15:40
0 min

11. ANY OTHER BUSINESS

15:40 - 15:40
0 min

12. DATE OF NEXT MEETING (ANNUAL ACCOUNTS) - THURSDAY 20 JUNE 2024 FROM 2PM - 4PM VIA MS TEAMS

Fife NHS Board

Unconfirmed

MINUTE OF THE AUDIT & RISK COMMITTEE MEETING HELD ON THURSDAY 14 MARCH 2024 AT 2PM VIA MS TEAMS

Present:
Alastair Grant, Non-Executive Member (Chair)
Cllr Graeme Downie, Non-Executive Member
Anne Haston, Non-Executive Member
Aileen Lawrie, Non-Executive Member

In Attendance:
Kevin Booth, Head of Financial Services & Procurement
Andy Brown, Principal Auditor
Chris Brown, Head of Public Sector Audit (UK), Azets
Alan Mitchell, Thomson Cooper *(item 5.1 only)*
Pauline Cumming, Risk Manager
Alistair Graham, Associate Director of Digital & Information *(item 8.2 only)*
Barry Hudson, Regional Audit Manager
Amy Hughes, Senior Auditor, Azets
Jocelyn Lyall, Chief Internal Auditor
Dr Gillian MacIntosh, Head of Corporate Governance & Board Secretary
Carol Potter, Chief Executive *(part)*
Dr Joy Tomlinson, Director of Public Health *(item 7.5 only)*
Hazel Thomson, Board Committee Support Officer (Minutes)

Chair's Opening Remarks

The Chair welcomed everyone to the meeting.

The Chair advised that Dr Shirley-Anne Savage has joined the Committee as a regular attendee in her new role as the Associate Director of Risk & Professional Standards. She was, however, not able to attend this meeting due to scheduled annual leave.

The Chair congratulated Pauline Cumming, Risk Manager, who retires in May, and advised members that this is her last Audit & Risk Committee meeting.

A welcome was extended to Maxine Michie, Deputy Director of Finance, who is deputising for Margo McGurk; to Alan Mitchell, from Thomson Cooper, who joined the meeting to speak to item 5.1 Patients' Private Funds - Audit Planning Memorandum; to Joy Tomlinson, Director of Public Health, who joined the meeting to speak to item 7.4 Business Continuity Arrangements Internal Audit Report; and to Alistair Graham, Associate Director of Digital & Information, who joined the meeting to speak to item 8.2 Risks & Opportunities Progress Report.

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

1. Apologies for Absence

Apologies were received from member Kirstie MacDonald, Non-Executive Member, and routine attendees Margo McGurk and Shirley-Anne Savage.

2. Declaration of Members' Interests

There were no declarations of interest made by members.

3. Minute of the last Meeting held on 13 December 2024

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

4. Action List / Matters Arising

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

5. EXTERNAL AUDIT

5.1 Patients' Private Funds - Audit Planning Memorandum

Alan Mitchell from Thomson Cooper joined the meeting and presented an overview of the assignment and advised that a risk-based approach would be taken for the audit, and that four key risks have been identified: updates to the financial operating procedures (where an internal audit was also carried out); security of the patients' private funds; and two risks regarding management override, in relation to managing the procedures in place for the Annual Accounts and risks of fraud.

The timeline for completion of the audit work was provided and it was confirmed that this aligns to the NHS Fife Annual Accounts timetable, with the requirement for the accounts to be consolidated with.

The Committee took **assurance** from the report and the plans in place for the audit.

6. ANNUAL ACCOUNTS

6.1 Initial Annual Accounts Preparation Timeline

The Head of Financial Services & Procurement presented the initial Annual Accounts preparation timeline, which has been shared widely with the Finance Team. It was agreed to add in an additional column to monitor progress, for members' oversight. It was noted that the timeline for the draft Annual Accounts to be provided to Azets is by 6 May 2024.The planned process for the provision of components of the accounts in stages in order to provide information as early as possible to the External Auditors was explained. The Board Secretary provided assurance that the narrative section of the Annual Accounts will meet the timeline. It was also advised that the timetable incorporates the external components.

Action: Head of Financial Services & Procurement

It was noted that the Annual Accounts guidance manuals have not been issued, to date, and is currently being concluded by the Scottish Government. The Head of Financial Services & Procurement will issue these as soon as they are made available by Scottish Government to prevent any delay to the timetable.

An overview was provided on the ongoing negotiation between the Directors of Finance Group and Audit Scotland in relation to the 2023/24 expected level of audit fees.

The Deputy Director of Finance emphasised that the end of June 2024 deadline for submitting the Annual Accounts to the Scottish Government must be met, and assurance was provided that the deadline date will be achieved.

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

6.2 External Auditors' Annual Accounts Progress Update

The Head of Public Sector Audit for Azets provided a progress update and advised that progress was on track in relation to the planned work carried out during the interim audit to date. Conformation was given that there was only one audit area which was not able to be completed in relation to the application of IFRS16 to the PFI agreements. The Head of Financial Services & Procurement advised that this delay was due to the timing of Scottish Government providing central guidance to all Boards who operated such schemes. It was confirmed that this guidance has recently just been provided and was being interpreted at this time to allow the audit area to be progressed. It was noted that a key area of audit work for the 2023/24 audit will centre around financial sustainability.

Questions followed, and it was advised that no significant areas for improvement have been identified to date, and that any areas for improvement will be built into the reporting of the final audit.

It was advised that there is a two-way process, between Azets and NHS Fife management, in terms of identifying areas of key significant risks, and an explanation was provided on the audit process involved and how the audit work aims to support improvements.

A brief overview of Intangible assets was provided to the committee, and it was explained that the two potential intangible assets are currently being discussed between the Finance Team and Azets to ensure that the correct treatment is applied in the draft Accounts.

The Committee took **assurance** from the progress update.

7. INTERNAL AUDIT

7.1 Internal Audit Progress Report

The Regional Audit Manager advised of recent changes within the Internal Audit Team, noting a number of staff leaving, and provided assurance that timelines will be met

ahead year-end. The completion of the mid-year work in the Internal Controls Evaluation Report and the revised audit plan, which is now progressing was noted. In addition it was noted that an update will be provided to the Committee on the External Quality Assessment in May 2024. The detail and delivery of key items in the report was highlighted, and it was noted further detail was provided within the appendix.

Additional detail was provided in relation to the strategic planning audit, and it was advised that the next step would be to carry out an audit in relation to the delivery plans associated with the Population Health & Wellbeing Strategy. It was noted that this will be carried out in tandem with the operational planning for 2024/25.

Conformation was given that a planned Board Development Session on Risk Appetite will also support this work, providing ongoing assurance to the Board that the strategic priorities and risk appetite are aligned. The importance of the financial and workforce plans supporting the strategy was highlighted.

The Committee:

- Took **assurance** on the progress on the delivery of the Internal Audit Plan(s)
- **Noted** an update will be provided on the External Quality Assessment to the May 2024 Audit and Risk Committee
- **Noted** the approval of the revised 2023/24 Internal Audit Plan, which had been circulated prior to the meeting to members for their input.

7.2 Internal Audit – Follow Up Report on Audit Recommendations

The Principal Auditor reported that progress continues to be made by management and implementing actions to address the recommendations within the report. An update was provided on progress of the audit recommendations, and assurance was provided that the remaining six actions, which have not been completed within one year of the report publication, are on track for completion by the revised implementation target dates.

It was highlighted that the remaining actions from the Internal Control Evaluation Report and Annual Report have not surpassed the 12-month target that was applied.

The Committee took **assurance** and **considered** the status of Internal Audit recommendations recorded within the Audit Follow Up system.

7.3 Internal Audit Framework

The Chief Internal Auditor advised that the Internal Audit Framework has been approved by the FTF Partnership Board. It was noted that the FTF Audit Charter is included within the framework and is required to be approved on an annual basis, in line with public sector internal audit standards, and that it also includes the service specification and reporting protocol. The amendments to the Internal Audit Framework were outlined and are highlighted within the tracked changes version of the document. In addition, a 'clean' version of the document was also provided for ease of members' review.

It was noted that the hyperlink to the audit follow-up protocol within appendix C will be added to the final version.

The Committee:

- **Noted** the NHS Fife Specification for Internal Audit Services
- **Approved** the Internal Audit Charter
- **Approved** the NHS Fife Internal Audit Reporting Protocol

7.4 Business Continuity Arrangements Internal Audit Report

The Director of Public Health joined the meeting for this agenda item. She provided background detail, advising that that the report was commissioned in recognition of the recommendations from the previous internal audit report and through informal discussions at a national level.

Assurance was provided that sampled plans all showed that a business impact assessment and risk assessment had been carried out, however, it was noted that there were gaps in what is being held in local areas, in the majority of the plans. It was noted that a lot of training has been undertaken, to date, and an overview on work that has been carried out and is underway was provided, as detailed in the paper. It was recognised that further work is still required, and an improvement plan will be put in place by June 2024. As part of the improvement plan, raising awareness of the process will be refreshed.

An overview was provided around the development of action cards, and it was reported that there was a complexity around the implementation of the action cards overlapping with the audit process, which resulted in the action cards not being fully utilised by teams. Assurance was provided that the Resilience Team are actively testing business continuity plans with teams, and that physical plans are held locally, and available on the staff intranet as an extra means of accessing.

Further detail was provided on the risk associated to introduce a new Business Continuity Management System, and it was reported that a new risk descriptor, around business continuity not being fully embedded within the organisation, will be developed, and added to the corporate risk register.

It was reported that progress and evidence gathering will be monitored by Internal Audit.

The Committee **considered** the findings of the Business Continuity Arrangements Internal Audit B13/23 Report and **endorsed** the action plan set out within Section 2 of the report.

8. RISK

8.1 Corporate Risk Register

The Risk Manager highlighted the key changes to the Corporate Risk Register and advised that the Covid pandemic risk has now been closed, following extensive discussions and due diligence, and that any potential new variants will remain carefully monitored but will be treated moving forward in line with similar respiratory infections. It was advised that preparation for implementing the legislation around the Health & Care Staffing (Scotland) Act is being developed as a new corporate risk, and a new corporate risk around pandemic preparedness and biological threats is being developed

and will be presented to the Clinical Governance Committee in May 2024. It was advised that a new risk around capital funding service sustainability is being worked through and will be progressed through the various governance routes. An improvement to the quality & safety risk was highlighted, with it being noted that the risk target was no longer realistic and has now been increased. An explanation was provided on the review of the wording to the workforce planning and delivery risk, which had been approved at the last Staff Governance Committee meeting.

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

8.2 Risks & Opportunities Group Progress Report

The Director of Digital & Information joined the meeting for discussion on this agenda item. He provided an update on progress of the Risks & Opportunities Group, who continue to meet to support implementation and development of our risk management framework. It was advised that work is ongoing in relation to the ongoing development of the framework, which is focussing on a risk assessment matrix, in line with the work that is underway at a national level with Health Improvement Scotland. It was reported that work continues to be ongoing in relation to the implementation of the summary dashboard and will this include key performance indicators related to risk.

The approach to deep dives reviews was outlined.

It was advised an update on the risk management framework will come to the May 2024 Committee meeting and will detail the single approach to risk management. A Risk & Opportunities Annual Assurance Statement will also be provided to the Committee at the next meeting. It was noted that a Board Development Session on Risk Appetite is scheduled for 8 April 2024, and it is expected that elements of the Risk & Opportunities Group work will be informed through the Board's discussions at that session. Furthermore, it was advised that the action plan for the Blueprint for Good Governance will also be discussed at the session, in relation to reflecting on processes and strengthening the assurance mapping approach.

A request was made for further detail around realistic medicines, given the high risk. It was advised that there is an action plan in place, and measures are being considered, and a position statement will be brought back to the relevant Board Committee meeting in May 2024

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

9. GOVERNANCE MATTERS

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

The Board Secretary advised that a self-assessment is carried out for all the Board's Standing Governance Committees on an annual basis. This paper provides the feedback given by members and attendees for the Audit & Risk Committee.

An overview on the themes of the self-assessment was provided, and it was noted that there were some common themes identified across all the Board's Standing Governance Committees self-assessment outcomes. Work in the next year will attempt to address members' comments as part of a continuous improvement exercise.

In relation to the comments around enhanced training for members, the Board Secretary encouraged members to carry out the Board Development Training available online covering finance, effective audit & risk, and how to be an effective Board member. A reminder of the links to these courses would be circulated.

Discussion took place on the importance of the SBAR capturing the main points and assurance elements, and of reducing the length of papers in the meeting pack. The Board Secretary agreed to take these points forward for further consideration and noted that a common approach across all of the Standing Governance Committees would be beneficial.

Action: Board Secretary

Members made comment in relation to the usefulness of Development Sessions in relation to the role of the Standing Governance Committees.

9.2 Annual Review of Audit & Risk Committee Terms of Reference

The Board Secretary advised that a review of the Terms of Reference is carried out for all the Board's Standing Governance Committees on an annual basis, and any updates are reflected in the annual publication of the Code of Corporate Governance. An overview of the main changes was provided, which were largely to updates to the Internal Audit section, and to reflect the movement of Freedom of Information and Whistleblowing performance monitoring to other committees of the Board.

The Committee **approved** the Terms of Reference, for further consideration by the Board.

9.3 Losses & Special Payments Quarter 3

The Head of Financial Services & Procurement advised that there were 235 losses in quarter 3, which is in line with the previous quarter. The total cost of losses in quarter 3 has increased to £1.3m, which is a result of a significant increase to the ex-gratia payments. Conformation was given that Losses and Special Payments had also increased out with any ex gratia payments and this could be attributed to the Debtors review which was not carried out in quarter 2. It was confirmed that at the end of quarter 3 the total losses and special payments are below the 12 month figure reported to the Scottish Government in 2022/23. Assurance was provided that regular analytical reviews are carried out to look for any developing trends for losses, and that any areas or risk would be highlighted to the applicable senior management and escalated through the Finance, Performance & Resources Committee if necessary. Following a question in relation to the ex-gratia payments for clinical negligence it was noted that the Clinical Governance committee has oversight for the detail and outcomes associated. It was also confirmed that the Central Legal Office provide legal advice to the Board including the recommendations on settlements, which are signed off by both the Chief Executive

and Director of Finance on behalf of the Board.

The Committee took **assurance** from the visibility of the Board's losses and special payments in the quarter to 31 December 2023.

9.4 Waiver of Competitive Tenders Quarter 3

The Head of Financial Services & Procurement reported that there were no Procurement contracts awarded over £50k in quarter 3, and, as such, no tender waivers were required to be put in place.

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

9.5 Final Annual Workplan 2024/25

The Board Secretary advised that the workplan outlines the work that will come forward to Committee in 2024/25 to ensure that the Committee's role and remit is fulfilled, and that the document will be iterative with new and emerging items of business added on as appropriate.

The Committee considered and **approved** the proposed workplan for 2024/25; and approved the approach to ensure that the workplan remains current.

10. FOR ASSURANCE

10.1 Audit Scotland Technical Bulletin 2023/4

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

10.2 NHS in Scotland 2023 Audit Scotland Report

Following a query, it was advised that the inpatient/day case waiting list indicators are scrutinised by the Finance, Performance & Resources Committee via the Integrated Performance & Quality Report.

The Committee **noted** the conclusions of the report.

10.3 Delivery of Annual Workplan 2023/24

The Board Secretary highlighted that the Counter Frauds Standards update, and the risk management key performance indicators, had been deferred but will both come forward to the Committee in May 2024.

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

11. ESCALATION OF ISSUES TO NHS FIFE BOARD

There were no issues to highlight to the Board.

12. ANY OTHER BUSINESS

There was no other business.

Date of Next Meeting - Thursday 16 May 2024 from 2pm – 4pm via MS Teams.

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

AUDIT & RISK COMMITTEE – ACTION LIST
Meeting Date: Thursday 16 May 2024

NO.	DATE OF MEETING	AGENDA ITEM / TOPIC	ACTION	LEAD	COMMENTS / PROGRESS	RAG
1.	31/08/23	**National Risk Management System**	Exploratory discussions are ongoing at a national level around procurement of risk management systems. Currently, the local preference is for Datix Cloud IQ. The outcome of national discussions is awaited.	**PC**	17/03/22 - A business case is being developed in April 2022 for NHS Fife, and the preferred upgrade package is Datix Cloud IQ. A verbal update was provided at the September 2022 meeting.	On hold - An update will be brought back to the Committee on developments as the business case is finalised.
2.	13/12/23	**October 2023 Risk Management Development Session Outputs**	To add specific actions from the session to the Committee action list.	**MM/HT**	HT to follow up with the Chair.	May 2024
3.	14/03/24	**Audit & Risk Committee Self-Assessment Report 2023/24**	To take forward the comments made, for further consideration, in relation to the importance of the SBAR capturing the main points and assurance elements, and of reducing the length of papers in the meeting pack.	**GM**	Further update to SBAR template due shortly, to support assurance levels work. Ongoing efforts to reduce size of paper packs through usage of links rather than full document submission.	May 2024
4.	14/03/24	**Initial Annual Accounts Preparation Timeline**	To add in an additional column to the Annual Accounts preparation timeline, to monitor progress, for members' oversight.	**KB**		May 2024

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**16 May 2024**
Title:	**Annual Accounts Preparation Timeline – Follow Up**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Kevin Booth, Head of Financial Services & Procurement**

1 Purpose

This is presented to the Committee for:
- Assurance

This report relates to a:
- Government policy/directive
- Legal requirement

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

2 Report summary

2.1 Situation

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

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

2.2 Background

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

In order to support the External Auditors assignment and with the objective of requiring to have the Annual Accounts approved by the Board and presented to the Scottish Government by 30th June 2024 an internal timetable was produced to manage components and ensure key milestones are understood and met across the finance team. The internal timetable was presented to the Audit & Risk committee at the previous meeting on 14th March 2024 to provide oversight of the key dates and assurance that a sufficient plan was in place and that progress remained on track.

2.3 Assessment

The timetable was shared with the External Auditors for their awareness on 29th February and regular progress updates, along with any supplementary information requests have been provided to them during the Annual Accounts process.

The Draft Annual Accounts incorporating the Front-End Narrative section, the Remuneration Report and the Consolidated Financial Template have all been completed and have been approved by the Director of Finance & Strategy. The full set of Draft Accounts were then provided to Azets on Friday 3rd May 2023, in line with the External Audit Annual Plan 2023/24

In addition, the component parts being the Fife Health Charity Accounts and the Patient's Private Funds which have been incorporated into the Consolidated Accounts were provided to the auditors (Thomson Cooper) on time and the assignments for each of these is progressing on schedule.

Following the submission of the draft accounts to Azets, the Finance Team will continue to support the External Audit process to ensure that the final clearance meeting in June can be held prior to the following Audit & Risk Committee on 20th June 2023.

The final version of the internal Annual Accounts timetable (appendix1) is provided to confirm all actions have been completed with the exception of the working papers which will continue to be provided throughout the audit assignment.

2.3.1 Quality, Patient and Value-Based Health & Care

N/A

2.3.2 Workforce

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

2.3.3 Financial

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

2.3.4 Risk Assessment/Management

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

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

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

2.3.6 Climate Emergency and Sustainability Impact

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

2.3.7 Communication, involvement, engagement and consultation

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

2.3.8 Route to the Meeting

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

2.4 Recommendation

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

3 List of appendices

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

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

NHS Fife
Annual Accounts Timetable 2023/24

Task	Owner	Day	Target Date	Completed	
Distribute approved Templates & clarify Working Papers responsibility	KB	Friday	08/03/2024		
Distribute Annual Accounts Manual & Capital accounting Manual	KB	Friday	08/03/2024		
NHS Scotland bodies - Final date for purchase invoice authorisation and PECOS receipting, for payment by 22nd March	**AMH**	**Wednesday 3pm**	**20/03/2024**		
Final Inter account cash transfer (Endowment - Exchequer)	IP	Wednesday	20/03/2024		
Final date for payments to Scottish NHS Scotland bodies without agreement of the recipient	AMH	Friday	22/03/2024		
Final date for purchase invoice authorisation and PECOS receipting, for payment by 31st March	**All**	**Wednesday 3pm**	**27/03/2024**		
Final creditors payment before 31 March (BACS file produced)	AMH/IH	Thursday	28/03/2024		
Final date for sales invoices to NHS Scotland bodies to be included in SFR30 balances agreed	**IH**	**Thursday**	**28/03/2024**		
Purchase ledger close (month 12)	AMH/Zendesk	Sunday 8pm	31/03/2024		
Registered Invoices Excel Report run	Ledger Control	Tuesday 9am	02/04/2024		
Final creditors payment before 31 March credited to bank accounts	AMH/IH	Wednesday	03/04/2024		
Petty Cash Certificates returned	IH/AW	Wednesday	03/04/2024		
Injury benefit / Early Retirement provision	KB	Thursday	04/04/2024		
Upload Year End Stock Entries to eFin	**IH**	**Thursday**	**04/04/2024**		
Financial Accounts ledger entries complete	**Fin A/c's**	**Thursday 5pm**	**04/04/2024**		
Date first creditor payment after 31 Mar credited to bank accounts	AMH/IH	Friday	05/04/2024		
Registered Invoices year end coded & uploaded to eFin	**IH**	**Friday 9am**	**05/04/2024**		
Sales ledger close (month 12)	**IH/Zendesk**	**Friday**	**05/04/2024**		
Return of Draft Front End Narrative sections	KB	Friday	05/04/2024		Still awaiting FM Figures (Mmi) Q4 Performance figures (SF)
Clinical/medical negligence provision - Figures to SG	RM	Monday	08/04/2024		
Front End Narrative to DOF for Review	KB	Monday	08/04/2024		
Remuneration Report data reports from Payroll	TC/DK	Monday	08/04/2024		
Capital entries complete	**TG & GM**	**Wednesday**	**10/04/2024**		
Financial Management ledger entries complete	**FM**	**Wednesday**	**10/04/2024**		
Primary Care entries complete	**CS**	**Wednesday**	**10/04/2024**		
SG to provide NHS Fife share of Cnoris Provision	KB	Friday	12/04/2024		
Final date for notifying other NHS Bodies of amounts to be charged in current Financial Year	FM	Monday	15/04/2024		
Front End Narrative submitted to Auditors	**KB**	**Monday**	**15/04/2024**		Sent 16/04/2024 - Less FM/PM figures
Control account reconciliations complete	Ledger Control	Tuesday	16/04/2024		
Primary Care control accounts reconciled	IH	Tuesday	16/04/2024		
Remuneration Report complete	KB	Tuesday	16/04/2024		Still awaiting SPPA information
Remuneration Report to DOF/Chief Executive for review	KB	Wednesday	17/04/2024		
Agree and obtain reassurance from Fife Health & Social Care IJB on balances for consolidation	RR	Monday	19/04/2024		
Agreement of Earmarked Reserves & Direction Letter	AH/RR	Tuesday	19/04/2024		
Finalise FPR Return cashflow	IH/KB	Friday	19/04/2024		
Agree Debtors, creditors, income and expenditure balances with NHS Scotland bodies for SFR30	**IH**	**Friday**	**19/04/2024**		
General ledger close (month 12)	**Zendesk**	**Monday**	**22/04/2024**		
Remuneration Report issued to Auditors	**KB**	**Monday**	**22/04/2024**		Sent 22/04/2024 less SPPA figures
FPR Return to SGHSCD (Month 12)	RR	Monday (Noon)	22/04/2024		
Analysis of debtors & creditors	IH	Wednesday	24/04/2024		
Draft Charity Accounts/Patient Funds Accounts complete	**IP/IH/CS**	**Monday**	**25/04/2024**		Provided 25/04/2024
Revaluation figures processed in eFin	TG & GM	Thursday	25/04/2024		
All working papers & draft Notes to be completed and available in AA folder	All	Thursday	25/04/2024		
Working papers ready for auditors, confirmed to KB	**All**	**Friday**	**26/04/2024**		Ongoing process
General ledger close (month 13)	**Zendesk**	**Monday 4pm**	**29/04/2024**		
Annual Accounts Excel Template to DOF/Chief Executive for review	**KB**	**Friday**	**03/05/2024**		
FPR Return to SGHSCD (Month 13)	RR	Friday (Noon)	03/05/2024		
Draft accounts (Excel Template/Word Document) ready for auditors	**KB**	**Monday**	**06/05/2024**		Provided 03/05/24

Complete
Overdue

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**16 May 2024**
Title:	**Internal Audit Progress Report**
Report Author:	**Barry Hudson, Regional Audit Manager /**
	Jocelyn Lyall, Chief Internal Auditor

1 Purpose

This is presented for:

- Assurance

This report relates to a:

- Local policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this report is to:

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

2.2 Background

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

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

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

2.3 Assessment

For the period from December to March 2024, FTF was fully staffed. Since our last progress report was presented to the Audit and Risk Committee on 14 March, further progress has been made with the delivery of the revised Annual Internal Audit Plan.

We have previously reported that planned audit days were not delivered due to sickness absence and delays in staff recruitment. The recruitment process commenced in March 2024 for the two vacant Principal Auditor posts within the FTF consortium (one within the NHS Fife team) with the expectation that it could take a minimum of four months for replacement staff to commence employment. The recruitment process has not identified appointable candidates and the FTF Partnership Board has been consulted to agree the next steps to recruit appropriate resource.

Taking account of these factors, the year-end audit work has been prioritised and fieldwork is nearing completion. This will allow the Chief Internal Auditor to provide the necessary assurances prior to the signing of the Annual Accounts. Internal Audit will continue to engage with the Director of Finance and Strategy to prioritise completion of the highest risk audits within the NHS Fife plan and to ensure adequate year end assurance is provided through the outputs of the Internal Control Evaluation and Annual Reports, and through completion of individual audits.

In addition to completing year end work the team remains focused on delivering audits within the expected timescales.

An internal audit External Quality Assessment is due for completion during 2024/25, with the Partnership Board to consider at its meeting on 8 May 2024 the format of that review.

Progress on implementation by management of agreed internal audit actions is monitored by Internal Audit through the Audit Follow-Up System and is reported regularly to the Audit and Risk Committee and Executive Directors Group.

Work has commenced on the development of the Strategic Audit Plan 2024/25 to 2026/27 and the 2024/25 Operational Plan. The Director of Finance and Strategy is considering the initial risk scoring and the views of the Executive Directors Group will be considered thereafter. The final plan will be presented to the June 2024 Audit and Risk Committee meeting for consideration and approval.

2.3.1 Quality/ Patient Care

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

2.3.2 Workforce

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

2.3.3 Financial

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

2.3.4 Risk Assessment/Management

The process to produce the Annual Internal Audit Plan takes into account inherent and control risk for all aspects of the Internal Audit Universe. Individual internal audit assignments identify the key risks at the planning stage and our work is designed to evaluate whether appropriate systems are in place and operating effectively to mitigate the risks identified. Legislative requirements are a core consideration in planning all internal audit reviews.

As detailed in the assessment section, the requirement to recruit to two vacant Principal Auditor posts is likely to impact on delivery of FTF annual internal audit plans.

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

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

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

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

To mitigate this risk, as noted in the assessment section of this report, audit work related to the delivery of the Annual Internal Audit Report to support the Chief Internal Auditor's annual opinion has been prioritised.

2.3.5 Equality and Diversity, including health inequalities

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

2.3.6 Other impacts

N/A

2.3.7 Communication, involvement, engagement and consultation

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

2.3.8 Route to the Meeting

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

2.4 Recommendation

The Audit and Risk Committee is asked to:

- Note that the Internal Audit Progress Report provides **Reasonable Assurance.**

3 List of appendices

The following appendices are included with this report:

Appendix A – Internal Audit Progress Report highlighting:

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

FTF Internal Audit Service
Internal Audit Progress Report

Introduction

This report presents the progress of internal audit activity to 7 May 2024.

Internal Audit Activity

The following audit products, with the audit opinion shown, have been issued since the last Audit and Risk Committee on 14 March 2024. Each review has been categorised within one of the five strands of corporate governance. A summary of each report is included for information within the 'Summary of Audit findings' section.

NHS Fife Completed Audit Work

Audit 2022/23 and 2023/24	Opinion on Assurance	Recommendations	Draft issued	Finalised
Corporate Governance				
B01/24 Audit Risk Assessment & Operational Planning	N/A	N/A	N/A	Year-end statement
B02/24 Audit Management & Liaison with Directors	N/A	N/A	N/A	Year-end statement
B03/24 Liaison with External Auditors	N/A	N/A	N/A	Year-end statement
B04/24 Audit and Risk Committee	N/A	N/A	N/A	Year-end statement
B09/24 Audit Follow Up	N/A	N/A	N/A	Throughout year and year-end statement
B10/24 Attendance and input / provision of advice	N/A	N/A	N/A	Year-end statement

at Standing Committees and other Groups.				
B11/24 Assurance Mapping	N/A	N/A	N/A	Year-end statement
B12/24 Implementation of Governance Blueprint	Substantial	N/A	17 April 2024	1 May 2024
B14/24 Risk Management	N/A	N/A	N/A	Year-end statement
Clinical Governance				
B20A/24 Follow-up of B21/20 – Transport of Medicines	Reasonable	One Moderate Four Merits Attention	18 April 2024	7 May 2024
B20B/24 Medicines Assurance Audit Programme - Short Life Working Group	N/A	None	17 April 2024	7 May 2024
Staff Governance				
B17/23 Workforce Planning	Reasonable	Three Significant Three Moderate	11 December 2023	7 May 2024
Financial Governance				
B24/24 Patients' Funds	Reasonable	Four Moderate Two Merits Attention	5 March 2024	7 May 2024

Fife IJB Completed Audit Work

Audit 2022/23 and 2023/24	Opinion on Assurance	Recommendations	Draft issued	Finalised
F06/24 Fife IJB – Resilience and Business Continuity Arrangements	Reasonable	One Moderate Two Merits Attention	26 February 2024	9 April 2024

NHS Fife Work in Progress and Planned:

		Status	Target Audit and Risk Committee
Remaining Audits from revised 2023/24 Internal Audit Plan			
B15/24	Environmental Management [1]	Planning	~~May 2024~~ September 2024
B21/24	Efficiency, effectiveness and timeliness of retention and recruitment systems [1]	Planning	~~May 2024~~ September 2024
B23/24 (incorporating B20/23)	Financial Process Compliance [2]	WIP	~~May 2024~~ September 2024

[1] Audit fieldwork paused to accommodate pressures within the audit team and focusing on year-end work.

[2] Fieldwork complete. Issue of draft report delayed due to Internal Audit staff absence.

Fife IJB Work in Progress and Planned:

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

Summary of Audit Findings

This section provides a summary of the findings of internal audit reviews concluded since the March 2024 Audit and Risk Committee.

B01/24 Audit Risk Assessment & Operational Planning	Level of assurance: N/A
Annual plan for 2023-24 was approved at the June 2023 Audit and Risk Committee meeting.	

B02/24 Audit Management & Liaison with Directors	Level of assurance: N/A
Regular meetings were held with the Director of Finance and Strategy, Deputy Director of Finance and Head of Financial Services and Procurement and meetings were held with other Directors to discuss audit issues throughout the year.	

B03/24 Liaison with External Audit	Level of assurance: N/A
Ongoing liaison and sharing of audit reports with Azets.	

B04/24 Audit and Risk Committee	Level of assurance: N/A
Internal Audit attended all Audit and Risk Committees and prepared required papers.	

B09/24 Audit Follow Up	Level of assurance: N/A
Internal Audit provided reports detailing the Audit Follow Up Position to the Audit and Risk Committee on four occasions throughout 2022/23. Throughout the year, we liaised with officers to obtain meaningful updates on ongoing audit recommendations; obtained evidence to support the reported progress and completed validation checks to ensure the information provided to the Audit and Risk Committee is accurate and to provide assurance that appropriate action has been taken. We have updated our report style to reflect the requirements of the recent update to the Governance Blueprint. Audit Follow Up reporting includes progress on Annual and Internal Control Evaluation reports.	

B10/24 Attendance and input / provision of advice at Standing Committees and other	Level of assurance: N/A

Groups.	

Internal Audit have provided advice and assistance to officers and Board members on the following areas during 2023-24, including:

- Input into Board and non-executive development events
- Assurance mapping and risk advice
- Attendee at the Risk and Opportunities Group and provision of advice
- Attendee to Information Governance and Security Steering Group and the Digital & Information Board and provision of advice.

B11/24 Assurance Mapping	Level of assurance: N/A

The Chief Internal Auditor facilitates the Assurance Mapping Group, which coordinates consideration of assurance issues and updates, dissemination and implementation of the Committee Assurance Principles across NHS Fife, Forth Valley, Tayside and Lanarkshire.

The Chief Internal Auditor contributed to a presentation on Scrutiny and Assurance to Non-Executive Directors in May 2024.

We continue to provide advice to Senior Management on the application of assurance mapping and risk management principles. The Regional Audit Manager has provided input and advice on the current deep dive reporting process.

B12/24 Implementation of Governance Blueprint	Level of assurance: Substantial

We reviewed NHS Fife's compliance with the required Scottish Government (SG) timeline to confirm that the Blueprint for Good governance guidance has been followed, evidence appropriately recorded, and an appropriate action plan produced to improve NHS Fife's Governance arrangements with actions timebound within financial year 2024/25.

The self-assessment process was completed by the deadline, a Board Development session was held to analyse and discuss the results and an appropriate improvement plan was developed and submitted to the SG.

B14/24 Risk Management	Level of assurance: N/A

Independent evaluation of the development of risk management arrangements was provided through the Internal Control Evaluation and will be further reported through the Internal Audit Annual Report 2023/24. We attend the Risk and Opportunities Group and have provided advice and feedback as the Risk Management Framework evolves, including advice on deep dives, Corporate Risk Register, risk descriptions, current risk exposure ratings and review of target risks. The Chief Internal Auditor attended the April

2024 Risk Appetite Board Development Event.

B20A/24 Follow-up of B21/20 – Transport of Medicines	**Level of assurance: Reasonable**

Internal Audit Report B21/20 Transport of Medicines focused on medicine deliveries to community hospitals by hospital transport and taxis. The audit evaluated how the controls, related to the transportation of medicines included in the Safe and Secure Use of Medicines Policy and Procedures (SSUMPP), were operating to mitigate risks for the delivery of medicines to these locations by checking a sample of Medicines Uplift and Delivery Forms and collating responses to questionnaires completed by staff involved in the preparation, delivery and receipt of medicines.

We assessed whether the actions to address the significant findings from our previous review have been implemented as agreed. We visited pharmacy stores at Victoria and Queen Margaret hospitals and a sample of clinical areas at these hospitals and Stratheden, Adamson and St Andrews hospitals to determine whether the following issues have been addressed:

- Medicines Uplift and Delivery Forms not being signed by pharmacy staff to acknowledge responsibility for releasing the medicines and not being signed by clinical staff to acknowledge responsibility for receipt of the medicines
- Medicines Uplift and Delivery Forms recording the stages of the uplift and delivery of medicines not being returned to Pharmacy as they should be
- Issues related to preserving the cold chain for medicines that require refrigeration.

Overall, we found that there has been significant improvement in the recording of acknowledgement of responsibility for medicines when releasing and receiving medicines, and in the understanding of these controls and the controls related to preserving the cold chain by pharmacy and clinical staff.

B20B/24 Medicines Assurance Audit Programme - Short Life Working Group	**Level of assurance: N/A**

In October 2023 the Safe Use of Medicines Group (now known as the Medicines Safety and Policy Group) approved the establishment of a Short Life Working Group (SLWG) to review and revise the Medicines Assurance Audit Programme to reflect the current risk environment and the current iteration of the Safe and Secure Use of Medicines Policy and Procedures (SSUMPP). Internal Audit facilitated three meetings of the SLWG to undertake this work.

The outcome from the MAAP SLWG was the proposed revised Medicines Assurance Audit Programme which was presented to the Medicines Safety and Policy Group along with a paper describing the work of the MAAP SLWG.

During the latter stages of the SLWG review of the MAAP it became apparent that it would be beneficial to review the current audits, the five-year audit plan maintained by the Pharmacy Governance Team and the topic descriptions of the MAAP. This would

ensure there is a common understanding of how the audits relate to the MAAP topics and would also potentially inform changes to topic descriptions on the MAAP and/or additions to the topic list. Including cross references to the relevant sections of the SSUMPP in the MAAP would also be beneficial. A potential gap in audit activity was also identified in that the Movement of Medicines topic does not currently include an audit of the transfer of medicines between wards.

The work of the MAAP SLWG was discussed at the Medicines Safety and Policy Group on 1 May 2024 and it was agreed that the Medicines Safety and Policy Group should further review the proposed MAAP to ensure that audits are focussed on the areas that will result in most value in terms of improvement activity being identified and to provide assurance to the organisation in relation to compliance with the SSUMPP.

B17/23 Workforce Planning	**Level of assurance: Reasonable**

The Staff Governance Committee will consider this report in full at its May 2024 meeting.

The Workforce Plan 2022-25 was agreed by the NHS Fife Board on 26 July 2022 for submission to the Scottish Government by 31 July 2022 published following presentation of SG feedback to the SGC in November 2022. Key stakeholders were consulted and engaged throughout the development of the draft workforce plan, and the SGC endorsed the plan before Board approval and submission to SG. Regular updates on the development of the Workforce Plan were presented to the SGC.

Staff in functions delegated to the IJB are not included in the Workforce Plan, and it therefore does not provide a holistic, integrated overview of workforce planning for all NHS Fife staff. The Workforce Plan does however clearly state that it sits alongside the Fife Health & Social Care Workforce Plan for 2022 to 2025. However, the data in the report references HSCP staff, which could create false expectations in that the reader may expect that staff working in delegated functions are included, and that the Workforce Plan covers all NHS Fife staff.

When the draft Workforce Plan was presented to Fife NHS Board in July 2022 the cover paper clearly signposted that the plan focuses specifically on the range of services delivered by the Acute Services Division and Corporate functions. The Director of Workforce highlighted that the HSCP three-year Workforce Plan and Strategy will cover delegated services and was being developed by HSCP colleagues in collaboration with NHS Fife.

Management have agreed the following actions to address the findings identified during the review:

- **Risk Management** – Internal Audit recommended that a deep dive is undertaken with regular review and assessment of the risk score for Workforce Planning and Delivery. Management actions - *'the Workforce Planning risk is subject to regular review in line with the Corporate Risk cycle and revised risk wording was agreed at the March 2024 SGC. The landscape has now changed with the commencement of the Reform Transform Perform Programme (RTP). A Deep Dive into aspects of Workforce Planning and the application of the NES Modelling Tool was provided at the January 2024 Staff Governance Committee meeting and a more detailed presentation will be provided at a future SGC Development session'.*
- **Information to assess the capacity and capability to effectively deliver**

services - The Workforce Plan does not contain sufficient data to quantify the gap between future staffing requirements and likely staff availability. Management actions – *'an update on the NHS Fife and HSCP action plans and NES modelling data was presented to 9 September 2023 and 6 March 2024 SGC meeting and is now in use to inform RTP workstreams. Output of the RTP workstreams, plus the Reduced Working Week group will be used to determine future size and composition of the workforce, with the NES modelling tool being utilised to identify potential gaps'.*

- **Oversight and assurance over delegated functions** – Internal Audit recommended that the full implications of the arrangement over the delegated functions are outlined in a paper to the SGC including which partner body is responsible for the workforce risk of the delegated staff. Appropriate arrangements should be made for the SGC to receive assurances over the monitoring and oversight of the Health & Social Care Workforce Plan and Action Plan for the delegated services. Management actions – '*A paper covering the Audit Report will be presented to May 2024 SGC and at regular intervals in line with the SGC Annual Workplan. We will ensure that appropriate references to the NHS Fife Workforce Plan and HSCP Workforce Strategy and associated workforce related risks are covered in future updates, but given previous discussions at SGC, we do not consider that a separate paper is required at this time'.*
- **Workforce Action Plan** – Internal Audit highlighted that detailed short and medium-term actions from the Workforce Plan Action Plan under the Five Pillars of Workforce do not contain measurable objectives and will be difficult if not impossible to monitor and therefore provide assurance on progress. Management actions – '*Updated NHS Fife and HSCP action plans and NES modelling data presented to 6 March 2024 SGC and at regular intervals, in line with the SGC Annual Workplan. Service Workforce Planning activity is to be aligned to Annual Delivery Plan reporting, with any output from the RTP and/or Reduced Working Week group factored into projections and matrix indicators'.*
- **SGC Remit and Workforce Plan** – Internal Audit highlighted that the Terms of Reference, and more importantly the work of the SGC, are mostly focused on staff governance rather than workforce risks and workforce planning and delivery. Management action – '*The Terms of Reference, have been amended to include oversight of Workforce Planning actions. Assurance on workforce planning is provided to SGC via regular updates on Workforce Plans and actions agreed via the SGC Annual Workplan and considered via the SGC Annual Report. The Corporate Workforce Risks are also reviewed at every SGC meeting'.*

B24/24 Patients Funds	Level of assurance: Reasonable
The Patients' Funds Financial Management System records the receipt and lodgement of cash and valuables, payments for and on behalf of patients, accrual of interest to patients' accounts and the investment of funds. This system only applies to transactions processed through the cashier's office. The annual independent external audit of patients' funds provides assurance on the operation of this system. As requested by the Chair of the Audit and Risk Committee, this audit followed up the issues highlighted within the external audit report dated 31 March 2023. The objective	

was to ensure that there is now compliance with SFI section 16 – Patients' Property and Funds and FOP 18 – Patients' Funds at the wards previously visited. These specific issues were also be checked at an additional sample of wards.

No instances of inappropriate use of patients' income were detected, with the majority of transactions processed in compliance with guidance, using the correct standard documentation. We did however identify instances from our sample of transactions tested that some requirements of FOP 18 were not always adhered to. The action plan to the report includes specific recommendations for individual wards with robust management responses agreed. Examples of weaknesses identified across the sample of wards includes documentation that was not correctly completed or signed in relation to patients' valuables and the lack of recording of supervisory checks being undertaken.

F06/24 Fife IJB – Resilience and Business Continuity Arrangements	**Level of assurance: Reasonable**

Internal Audit reviewed whether the necessary arrangements are in place to meet the requirements of the Civil Contingencies Act 2004 as applicable to Category 1 responders, as well as checking alignment and coordination with partners. The IJB's Strategic risk register as presented to the 19 January 2024 Audit and Assurance Committee meeting included the following risk: '*There is a risk that the IJB is unable to fulfil its statutory role as a Category 1 responder under the Civil Contingencies Act 2004 and link appropriately with partner bodies and multi-agency partners to ensure the ability to maintain critical HSCP services and provide support to the wider Fife Community*'. It is currently classified as a medium risk.

The Resilience Framework provides details of the IJB's responsibilities as a Category 1 responder, and in meeting this legislation, provides a description of the approach to planning, responding, and recovering from incidents occurring within or impacting on the delivery of health and social care services in Fife.

The Resilience Framework demonstrates that the IJB has made substantial progress in developing internal management and governance arrangements to implement the requirements of the Civil Contingencies Act.

One moderate and two merits attention recommendations were agreed with management and appropriate responses were provided to the following findings:

- Internal Audit finding - the governance arrangements in place to meet the IJB Category 1 Responder responsibilities have not been incorporated into its governance structure as detailed in the IJB Governance Manual. Management Action – "*The suggested changes will be presented within an SBAR to Audit and Assurance Committee and then on to IJB for final approval. Cross reference will be made to the Resilience Framework and the IJB's role as a Category 1 responder under the Civil Contingencies Act 2004.*"
- Internal Audit finding - A small number of additions could be made to the 2024/25 Resilience Assurance Group (RAG) workplan, including reminders to complete tasks that evidence the completeness of the RAG remit. Management action – "*The 2024/25 RAG workplan will note the tasks to provide a regular assurance report to SLT and an annual report to the IJB. The minutes from the Fife Local Resilience*

Partnership and East of Scotland Regional Resilience Partnership will be circulated for noting as part of the RAG agendas'.

- Internal Audit finding - The most recent HSCP management information available on the completeness of the Business Continuity Plans (BCPs) for wards and departments delegated to the HSCP indicated that 25% were out of date and were due their annual review. For a further 5%, BCPs had not been entered on the central repository maintained by NHS Fife, making it unclear whether a BCP exists. Internal Audit's review of NHS Fife's BCP arrangements, reported in B13/23, identified certain aspects of BCP completion that were not being fully undertaken. Although not separately identified within that report, the sample selected consisted of some HSCP wards, and therefore the aspects of non-completion identified may apply to HSCP BCPs. This audit did not cover a review of Fife Council BCP arrangements for the services that were delegated from it to the HSCP. It was confirmed with management that BCP arrangements for these services are reported to the Fife Council Resilience Team. Management action – '*All BCPs relating to HSCP NHS Services that are overdue for review will be updated and added to the NHS Fife Central repository. For future reviews matters raised within audit report B13/23 will be checked against the BC plans to ensure these have been fully completed. All BCPs relating to HSCP Fife Council services that are overdue for review will be updated and shared with the Fife Council Resilience Team'.*

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**16 May 2024**
Title:	**Internal Audit – Follow Up Report on Audit Recommendations 2023/24**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Report Author:	**Barry Hudson, Regional Audit Manager** **Andy Brown, Principal Auditor**

1 Purpose

This is presented for:

- Assurance
- Discussion
- Decision

This report relates to the:

- Audit Follow up Protocol

This aligns to the following NHSScotland quality ambition:

- Effective

2 Report summary

2.1 Situation

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

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

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

2.2 Background

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

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

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

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

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

A revised AFU Protocol is included at appendix G and the Committee is asked to review and approve the document. The main changes to the protocol are:

- Documentation of the process for requests made by Internal Audit for updates on action status in the period ahead of reporting of these to Audit and Risk Committee.
- The updated reporting on actions with extended implementation dates which was agreed at the Audit & Risk Committee on 13 December 2023. Reasons for extensions granted for recommendations more than 12 months old and extended recommendations rated as fundamental or significant that are less than 12 months old is now reported.

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

2.3 Assessment

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

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

	Apr 2024			Feb 2024		
Remaining Actions	**5**			**7**		
	Ext	O/S	NYD	Ext	O/S	NYD
Recommendations more than 1 year (*Appendix C)*	1	0	0	6	0	0
Recommendations less than 1 year	1	0	3	0	0	1

The table below shows the status of all remaining ICE and Annual Report recommendations at 30 April 2024, with comparable figures from the last Audit Follow-Up (AFU) report at 29 February 2024.

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

Progress summary

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

Report Removed	Reason
B19/21 - Clinical Governance Strategy and Assurance	All actions completed and validated.
B21/21 - Medical Equipment and Devices	All actions completed and validated.
B16/22 - Prescription Stationery Security	All actions completed and validated.

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

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

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

AFU Report Content

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

2.3.1 Quality, Patient and Value-Based Health & Care

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

2.3.2 Workforce

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

2.3.3 Financial

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

2.3.4 Risk Assessment/Management

The internal audit follow-up process mitigates against the risk of control weaknesses remaining because appropriate action hasn't been taken to address IA recommendations.

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

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

2.3.6 Climate Emergency & Sustainability Impact

Not applicable

2.3.7 Communication, involvement, engagement and consultation

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

2.3.8 Route to the Meeting

Not applicable

2.4 Recommendation

- **Assurance**
- **Note** and consider the status of Internal Audit recommendations recorded within the AFU system.
- **Approve** the updated AFU protocol at Appendix G.

3. List of appendices

The following appendices are included with this report:

Appendix A:	Extended and Outstanding Graphs	Page 1
Appendix B:	Table - Detailed Action Status by Report	Page 3
Appendix C:	Recommendations More Than 1 Year – Action Status	Page 4
Appendix D:	Recommendations Less Than 1 Year – Action Status	Page 6
Appendix E:	Internal Audit Validation	Page 8
Appendix F:	Definitions	Page 9
Appendix G	Revised AFU Protocol	Page 10

Report Contact

Barry Hudson

Regional Audit Manager

Email: barry.hudson@nhs.scot

Recommendations More Than 1 Year

As there was only one action remaining to address recommendations made in reports published more than a year ago graphs are not necessary.

The single action falling into this category was to address a recommendation made in report B13/21 Risk Management Strategy, Standards and Operations. This was assigned to the Health and Social Care Partnership and relates to the revision of the NHS Fife risk appetite and for this to take cognisance of the risk appetite of the Integrated Joint Board. This was rated as ‘Significant’ and we have graded the action required to complete this as ‘Green’ meaning that ‘*Good progress is being made and completion of updated actions will achieve objectives and mitigate identified risks’*.

Recommendations Less Than 1 Year

As there was only one action remaining to address recommendations made in reports published less than a year ago graphs are not necessary.

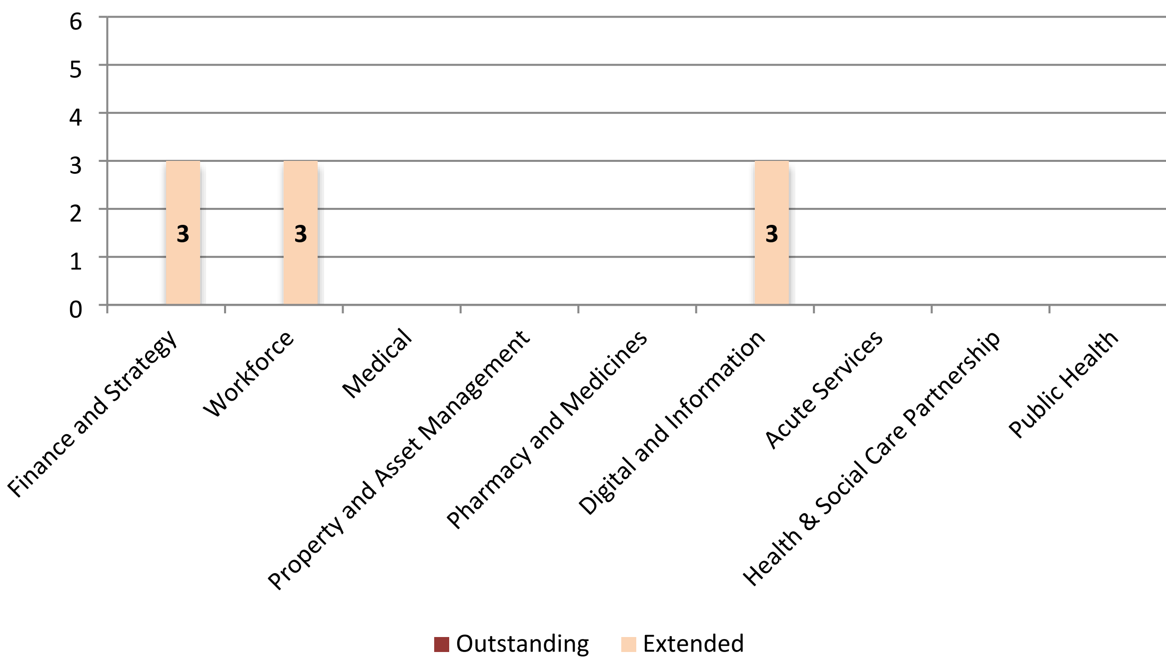
The single action falling into this category was to address a recommendation made in report B14/23 Strategic Planning Development. This was assigned to the Finance and Strategy Directorate and relates to reviewing the scoring of corporate risks 1 and 2 to take account of the findings in our report. This was rated as ‘Merits Attention’ and we have graded the action required to complete this as ‘Green’ meaning that ‘*Good progress is being made and completion of updated actions will achieve objectives and mitigate identified risks’*.

ICE/IAAR Recommendations More Than 1 Year

There are no remaining actions to address recommendations made in ICE/IAARs that are more than one year old.

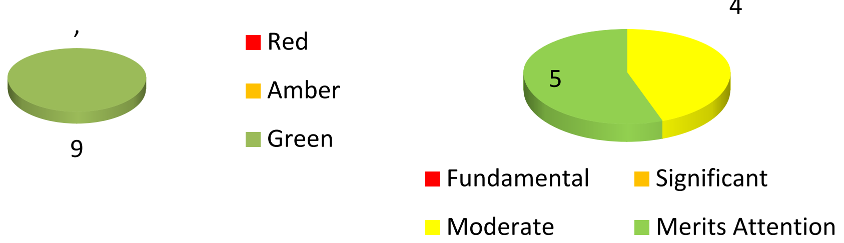
ICE/IAR Recommendations Less Than 1 Year

Outstanding and Extended by Directorate



ICE/IAAR Extended Recommendations RAG Status and Priority

RAG Status **Priority**



Internal Audit Reports with Remaining Actions	**Date of Issue**	**Total Recs.**	**Complete**	**Superseded**	**Remaining**	**Extended**	**Outstanding**	**Not Yet Due**	**Not Validated**
2020/21									
B13/21 Risk Management Strategy	Sep 21	5	4	0	1	1	0	0	-
2020/21 Totals		**5**	**4**	**0**	**1**	**1**	**0**	**0**	**0**
2022/23									
B13/23 Business Continuity Arrangements	Feb-24	5	2	0	3	0	0	3	-
B14/23 Strategic Planning - Development	Jan-24	1	0	0	1	1	0	0	-
2022/23 Totals		**6**	**2**	**0**	**4**	**1**	**0**	**3**	**0**
Overall Totals (Actions from reports where recommendations remain unaddressed)		**11**	**6**	**0**	**5**	**2**	**0**	**3**	**0**

Previous ICE and Annual Reports with Remaining Actions	**Date of Issue**	**Total Recs.**	**Complete**	**Superseded**	**Remaining**	**Extended**	**Outstanding**	**Not Yet Due**	**Not Validated**
2023/24									
B06/24 Annual Report – 2022-23	Jun-23	11	5	0	6	6	0	0	-
B08/24 ICE – 2023-24	Dec-23	6	3	0	3	3	0	0	
2023/24 Totals		**17**	**8**	**0**	**9**	**9**	**0**	**0**	**-**
Overall Totals (Actions from reports where recommendations remain unaddressed)		**17**	**8**	**0**	**9**	**9**	**0**	**0**	**-**

Recommendations More than 1 Year at 30 April 2024

Report	Rec Number	Priority	Brief Description	Responsible Officer & Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
2020/21 - Extended							
B13/21 Risk Management Strategy	3	S	Now that there is clarity around responsibility for operations, an Integration Joint Board (IJB) Risk Management Strategy should be produced and formally agreed with the parties as soon as possible and incorporated into the NHS Fife Framework. More detailed aspects of the risk management arrangements between NHS Fife and Fife IJB should be included in GP/R7 - Risk Register and Risk Assessment policy.	**Director of Health & Social Care**	~~31 Mar 22~~ ~~30 Sep 22~~ ~~31 Dec 22~~ ~~31 Aug 23~~ ~~31 Dec 23~~ 30 Sep 24		The remaining part of this action is for the NHS Fife Risk Appetite to be reviewed taking into account the risk appetite of the IJB and this will be undertaken by 30 September 2024 as part of the overall review of NHS Fife's Risk Appetite. A Fife NHS Board development session focussed on risk appetite was held on the 8th April 2024. The session included consideration of the IJB risk appetite statement and levels and these are to be considered when finalising NHS Fife's Risk Appetite.
20/21 Extended	**1**						
Total > 1 Year	**1**						

Recommendations More than 1 Year at 30 April 2024

ANNUAL and ICE REPORTS Report	Rec Number	Priority	Brief Description	Responsible Executive Director	Original and Extended Due Dates	RAG Status	Reason for Extension from Responsible Officer
There are no actions more than 1 year old from Internal Audit Annual Reports or Internal Control Evaluation (ICE) Reports that have extended target implementation dates.							

Recommendations Less than 1 Year at 30 April 2024

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

Recommendations Less than 1 Year at 30 April 2024

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

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

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

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

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

NHS FIFE AUDIT FOLLOW-UP PROTOCOL

INTERNAL AND EXTERNAL AUDIT REPORT ACTION PLANS AND RECOMMENDATIONS

1. INTRODUCTION

1.1. As Accountable Officer, the Chief Executive is ultimately responsible for ensuring that the organisation has effective management systems in place to safeguard public funds.

1.2. The Audit and Assurance Committee Handbook (February 2023) includes the following good practice requirements for the audit follow up of recommendations:

- ***'holding managers within the organisation to account for the implementation of audit recommendations***
- ***to advise the Board and Accountable Officer on the adequacy of management response to audit recommendations***
- ***key lines of enquiry include obtaining assurance that:***
  - ***Internal Audit recommendations that have been agreed by management are timeously implemented***
  - ***any issues arising from line management not accepting Internal Audit recommendations are appropriately escalated for consideration***
  - ***the implementation of recommendations is monitored and followed up***
- ***output from follow-up audits by Internal Audit is monitored by the committee and the committee considers the adequacy of implementation of recommendations'***

1.3. The revised Blueprint for Good Governance in NHS Scotland (2nd Edition) states that *'it is important that the Audit and Risk Committee adopt a robust approach to the oversight of the completion of actions identified in the audit reports. Where possible, actions should be dealt with in the current financial year rather than being carried forward from one financial year to the next. Any exceptions to this should be closely scrutinised by the Audit and Risk Committee who should seek assurance that the timeline proposed for addressing the risks or issues identified by the auditors is both reasonable and achievable'*.

1.4. We have interpreted this guidance as follows:

Actions should be implemented within 1 year of the recommendation having been made. This is calculated from the date the final report was issued.

2. FOLLOW-UP ON INTERNAL AUDIT REPORTS

Status Update Process

2.1. Internal Audit send a Status Update Request (SUR) Form (see Annex 1) to the Responsible Officer two weeks prior to the due date for the relevant actions requesting a response confirming, by no later than the due date, the completion or otherwise of the actions.

2.2. If the action is reported by the Responsible Officer as completed, appropriate evidence to demonstrate that the required action has been taken and has been effective must be provided to support this.

2.3. If the action is reported by the Responsible Officer as no longer relevant or superseded a valid reason supporting this status must be provided.

2.4. Internal Audit will highlight any responses which do not appear adequate to address the control weakness identified in the original report, or where the evidence does not fully support the conclusion drawn. In such situations further evidence will be requested from the Responsible Officer.

2.5. If the action is reported by the Responsible Officer as delayed, an extension to the original due date must be requested along with provision of a valid reason for the delay. The approval of extensions will be subject to consideration based on the context of the impact of risk as follows:

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

2.6. The agreement of the new target implementation date will always be subject to consideration as to whether it is reasonable and achievable. The expectation is that all recommendations will be addressed within 12 months of the final report issue date.

2.7. If approval of the proposed extended review date is not granted it is expected that the action will be addressed promptly.

Reminder Process

2.8. Updates are requested in the period prior to Internal Audit compiling their Audit Follow-up Report so that an up to date and accurate status can be reported for all remaining actions. If no response is received from the Responsible Officer by the due date, Internal Audit will issue a reminder.

2.9. Where there is significant inaction or no response is provided by a Responsible Officer, Internal Audit will discuss this initially with the relevant Director/Senior Manager. Where the matter remains unresolved, it will be escalated to the Director of Finance and Strategy and, ultimately, the Chief Executive.

Validation

2.10. All actions notified as completed are checked by Internal Audit to confirm that the evidence supplied is sufficient. Internal Audit will highlight any responses which do not appear adequate to address the control weakness identified in the original report, or, where the evidence does not fully support the conclusion drawn. In these situations further evidence will be requested from the Responsible Officer.

Monitoring

2.11. The Status Update Request Forms will be held as a complete record of the implementation of actions to address recommendations in Internal Audit reports. This includes:

- Reference of the recommendations arising from each Action Plan for reports that have actions remaining to be addresses
- Level of priority given to each recommendation (assessment of risk)
- Dates by which the actions are due to be completed

- Responsible Officer for each recommendation
- Suggested evidence required to allow action to be recorded as completed and validated
- Evidence of completion or updates on progress
- Details or requests for extensions to action by dates and their approval by the appropriate officer
- Validation assessment by Internal Audit

Reporting

2.12. Internal Audit will be responsible for presenting regular reports on Audit Follow-Up to each Audit and Risk Committee. The report will provide the most recent position on progress in addressing remaining actions from internal audit reports by reporting on:

- Reports that have been removed from the follow-up process since the last report as all actions have been completed and validated or superseded by actions in another report
- action status by report for all remaining actions
- reasons for extensions granted for all extended recommendations that are more than 12 months old and on extended recommendations rated as fundamental or significant that are less than 12 months old. For extended actions a RAG status is recorded giving an indication of how much still needs to be done to fully address the recommendation to aid prioritisation
- outstanding recommendations
- internal audit validation details where an action has been reported as completed but further information is required to evidence this

Definitions of action status, recommendation priorities and RAG status are provided at Annex 2.

2.13. Following each Audit and Risk Committee meeting, the report will be presented to the Executive Directors Group. This is for consideration of any long outstanding responses, repeated extensions to due by dates, actions not completed, and those which did not fully address the identified control weakness, either because of the content or the accuracy of the response. The expectation is that these actions will be addressed before the next Audit and Risk Committee meeting.

2.14. The information from Responsible Officers recorded within the appendices to the report are updates as provided by officers of NHS Fife. Internal Audit will validate updates **only** at the stated completion of an action.

3. FOLLOW-UP OF EXTERNAL AUDIT REPORTS

3.1. The follow up of External Audit reports remains the responsibility of the Director of Finance and Strategy. External Audit reports are far fewer in number and generally speaking will identify a Director as being responsible for the action to be taken. Internal Audit will only review progress against external audit recommendations where relevant to internal audit fieldwork.

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

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

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

BARRY HUDSON

Regional Audit Manager

DATE OF ISSUE: May 2024

REVIEW DATE: May 2025

ANNEX 1

INTERNAL AUDIT FOLLOW UP SYSTEM – STATUS UPDATE REQUEST - B??/?? Assignment Title

Please indicate in the table below the status of the actions to address the indicated recommendations from report B??/?? Assignment Title which were assigned to you.

The suggested **evidence required** to allow actions to be recorded as completed and validated is recorded at **Appendix 1**.

If the action to address recommendation(s) has not been implemented by the agreed implementation date please state the reason for this and, if appropriate, request an **extension** to the implementation date on the **form at Appendix 2**.

The original wording, from the audit report, of the Findings, Recommendations and Management Responses related to these recommendations is included at **Appendix 3**.

B??/?? Assignment Title – Responsible Officer – Name – Job Title									
Ref.	**Original Action by Date**	**Pty**	**Brief Description *2**	**Status *1**	**Evidence of Completion/Progress Update (See appendix 1 for required evidence to be provided)**	**Validated (Yes/No)**	**Validated By**	**Validation Outcome Reason**	**Extension Requested? *3**
1									
2									
3									

*1 Please record status as Completed (C), In Progress (IP), Not Started (NS), No Longer Applicable (NLA) or Superseded (S)

*2 Full Description is at Appendix 3 below

*3 Please record extension request details at Appendix 2

ANNEX 1

INTERNAL AUDIT FOLLOW UP SYSTEM – STATUS UPDATE REQUEST **B??/?? Assignment Title** **APPENDIX 1**

Evidence to be Provided to Show Completion

Ref.	Evidence Required	Evidence Obtained/Provided
1		
2		
3		

INTERNAL AUDIT FOLLOW UP SYSTEM – STATUS UPDATE REQUEST B??/?? Assignment Title APPENDIX 2

Extension Requests

As per the Follow-up Protocol the first extension request can be approved by Internal Audit, the second request by the relevant Executive Director and the third and any subsequent requests requiring the approval of the Director of Finance and Strategy or the Chief Executive.

Ref.	Original Action by Date	First Extension					Second Extension				
		Date Requested	Reason for Request	Proposed New Date	Approved by	Date Approved	Date Requested	Reason for Request	Proposed New Date	Approved by	Date Approved
1											
2											
3											

Ref.	Original Action by Date	Third Extension					Fourth Extension				
		Date Requested	Reason for Request	Proposed New Date	Approved by	Date Approved	Date Requested	Reason for Request	Proposed New Date	Approved by	Date Approved

INTERNAL AUDIT FOLLOW UP SYSTEM – STATUS UPDATE REQUEST **B??/?? Assignment Title** **APPENDIX 3**

Findings, Recommendations, Management Response

Ref.	Pty	Finding	Recommendation	Management Response
1				
2				
3				

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

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

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

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**16 May 2024**
Title:	**Corporate Risk Register**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy, NHS Fife**
Report Author:	**Pauline Cumming, Risk Manager, NHS Fife**

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Annual Delivery Plan
- Emerging issue
- Local policy
- NHS Board / IJB Strategy or Direction / Plan for Fife

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This paper provides an update on the Corporate Risk Register since the last report to the Committee on 14 March 2024. The information reflects the risks being reported through the May 2024 round of governance committee meetings.

Members are invited to:

- review the corporate risks as at 30 April 2024 set out at Appendix 1;
- consider the information against the Assurance Principles and Risk Matrix at Appendix 2 and 3 respectively;
- conclude and comment on the assurance derived from the report.

2.2 Background

The Corporate Risk Register aligns to the 4 strategic priorities. The format is intended to prompt scrutiny and discussion around the level of assurance provided on the risks and their management, including the effectiveness of mitigations in terms of:

- relevance
- proportionality
- reliability
- sufficiency

2.3 Assessment

NHS Fife Strategic Risk Profile

The Strategic Risk Profile as at 31/03/24 is provided at Table 1 below.

Table 1: Strategic Risk Profile

Strategic Priority	Total Risks	Current Strategic Risk Profile				Risk Movement	Risk Appetite
To improve health and wellbeing	4	2	2	-	-	◄►	High
To improve the quality of health and care services	6	4	2	-	-	◄►	Moderate
To improve staff experience and wellbeing	2	2	-	-	-	◄►	Moderate
To deliver value and sustainability	6	4	2	-	-	◄►	Moderate
Total	**18**	**12**	**6**	**0**	**0**		

Summary Statement on Risk Profile

The current assessment indicates that delivery against 3 of the 4 strategic priorities continues to face a risk profile in excess of risk appetite.

Mitigations are in place to support management of risk over time with some risks requiring daily assessment.

Assessment of corporate risk performance and improvement trajectory remains in place.

Risk Key		Movement Key	
High Risk	15 - 25	▲	Improved - Risk Decreased
Moderate Risk	8 - 12	◄►	No Change
Low Risk	4 - 6	▼	Deteriorated - Risk Increased
Very Low Risk	1 - 3		

- The risk level breakdown is as previously reported - 12 high and 6) moderate.

Key Updates

Risk 2 - Health Inequalities
In the Corporate Risk report to the May 2024 Public Health and Wellbeing Committee, the Director of Public Health advises there is no recommended change to the current or target risk levels at this point, though wishes to signal that it is likely this will be necessary later in the year. While there is a clear commitment within NHS Fife to address inequalities, some actions are less likely to be achieved given budgetary pressures impacting on both health and social care and it is anticipated this will increase the likelihood of increasing healthcare inequalities. The risk will be reviewed in early summer as the Reform, Transform, Perform Programme becomes established.

Risk 4 - Optimal Clinical Outcomes
As previously reported, following consideration of the updated Deep Dive review at the Clinical Governance Committee on 1 March 2024, there is to be further discussion through the Risks and Opportunities Group on whether this risk should close and a revised risk or risks be developed. The Associate Director for Risk & Professional Standards advises that pending the outcome of those deliberations, the target timescale has been adjusted from 31/03/24 to 31/03/25.This may change depending on developments.

Risk 6 - Whole System Capacity
The Director of Acute Services advises that this risk is to be discussed at the Executive Directors Group (EDG) on 2 May 2024, where consideration will be given as to whether it remains a risk or has materialised into an issue. The outcome will be shared with the Finance, Performance & Resources Committee at its meeting on 7 May 2024.

Risk 9 - Quality and Safety
The Associate Director of Quality & Clinical Governance advises that one of the root causes of this risk is that there are "no effective systems of supporting effective organisational learning". A paper setting out a proposed approach to refreshing the work of the Organisational Learning Group was shared with the Clinical Governance Oversight Group on 16 April 2024, with a formal update scheduled to the EDG in July 2024. The paper includes a workplan for 2024/2025 and outlines a number of activities the group will progress. The target timescale has accordingly been adjusted from 31/03/24 to 31/03/25.

Risk 11 - Workforce Planning and Delivery
The previous report to this Committee signalled the intention to propose to the Staff Governance Committee on 6 March 2024, that the risk description for the above risk, be amended to more accurately reflect the specific nature of the workforce challenges facing the Board. The Committee endorsed the proposal at that meeting. The revised wording is reflected in Appendix 1.

Risk 13 - Delivery of a balanced in-year financial position
Further to the previous update to this Committee, members are advised that the year-end outturn is currently being finalised and will be subject to audit review. The Director of Finance & Strategy will propose further clarification on the description of the risk for 2024/25 once the 2023/24 position is finalised.

Risk 14 - Delivery of recurring financial balance over the medium term
Further to the previous update to this Committee, the Director of Finance & Strategy advises that the medium-term financial plan was approved by the NHS Fife Board in March 2024 however discussion remains ongoing with Scottish Government in relation to a number of key planning assumptions and is currently not approved. The plan indicates a 3-year time period is required to enable delivery of sustainable cost reduction and service change to deliver recurring financial balance.

Risk 19 - Implementation of Health and Care (Staffing) (Scotland) Act 2019 (HCSA)
Work continues on HCSA implementation. This includes preparing to be in a position to formally report on progress to Scottish Government (SG) from 1 April 2025. A separate update on HCSA preparations is on the agenda for the SGC meeting on 14 May 2024. The target timescale has been adjusted from 01/04/24 to 22/07/24 by which point the Board will have received final SG feedback on progress to date.

Potential New Corporate Risks

Pandemic Preparedness/Biological Threat
Preparation of the above risk continues, however the Director of Public Health advises that further time is needed for a Deep Dive review. An SBAR will be tabled at the meeting of the Clinical Governance Committee on 12 July.2024. Following initial scoping, the Public Health Assurance Committee has recommended progressing the development of two risks in line with the approach set out in the UK national risk register. These risks are (i) Pandemic Preparedness and (ii) Emerging Infectious Disease. A paper relating will be tabled with the EDG on 3 June 2024. This will allow EDG to consider the risk descriptors for the two risks, consider inclusion on the Corporate Risk Register, and also to which committee each risk is best aligned.

Capital Funding - Service Sustainability
The Head of Capital Planning & Project Director has drafted a risk and a supporting SBAR for discussion at EDG on 2 May 2024. This will allow Directors to consider if they support the new risk being included on the Corporate Risk Register, and if so, to recommend to which committee it should be aligned. The outcome of these deliberations will be provided to the Finance, Performance & Resources Committee on 7 May 2024.

Details of all risks are contained within Appendix No. 1.

Deep Dive Reviews
Members are advised that a Pharmacy Workforce Review, in the form of a Deep Dive, will be provided as a presentation to the Staff Governance Committee on 14 May 2024.

Next Steps
The Corporate Risk Register will continue to evolve in response to feedback from this Committee and other stakeholders, including via Internal Audit recommendations. The Register will require to adapt to reflect the current operating landscape, and our risk appetite in relation to changes in the internal and external environment including developments associated with the Reform, Transform, Perform Programme.

A Board Development session on risk appetite was held on the 8 April 2024. The session included consideration of the Integration Joint Board (IJB) risk appetite statement which has 4 levels of .risk appetite against NHS Fife's current 3 level model. The Associate Director for Risk & Professional Standards and the Director of Digital & Information who facilitated the session, are in the process of pulling together themes from the meeting to inform recommendations for consideration by the Board.

The Risks and Opportunities Group will seek to enhance its role in the identification and assessment of emergent risks and opportunities and make recommendations on the potential impact to the Board's Risk Appetite position. The Group will also contribute to the development of the process and content of Deep Dive Reviews as part of a broader consideration of the Board's assurance framework.

2.3.1 Quality, Patient and Value-Based Health & Care

Effective management of risks to quality and patient care will support delivery of our strategic priorities. It is expected that the application of realistic medicine principles will ensure a more co - ordinated and holistic focus on patients' needs, and the outcomes and experiences that matter to them, and their families and carers.

2.3.2 Workforce

Effective management of workforce risks will support delivery of our strategic priorities, to support staff health and wellbeing, and the quality of health and care services.

2.3.3 Financial

This paper does not raise, directly, financial impacts, but these do present significant elements of risk for NHS Fife to consider and manage in pursuit of our strategic priorities.

2.3.4 Risk Assessment / Management

Management and oversight of the corporate risks continue to be maintained, with risk reporting provided regularly to the relevant groups and committees.

The majority of risks remain above risk appetite, reflecting the ongoing the ongoing level of demand across all services within an increasingly challenging financial environment. The appetite status is as follows:

Above - 10
Within - 6
Below - 2

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

An Equality Impact Assessment (Stage 1) was carried out to identify if any items of significance need to be highlighted to EDG. The outcome of that assessment concluded that no further action was required.

2.3.6 Climate Emergency & Sustainability Impact

This paper does not raise, directly, issues relating to climate emergency and sustainability. These items do form elements of risk for NHS Fife to manage.

2.3.7 Communication, involvement, engagement and consultation

This paper reflects engagement with Executive and Non - Executive Directors, the Director of Digital & Information, the Associate Director for Risk & Professional Standards and discussions within the Risks and Opportunities Group.

2.3.8 Route to the Meeting

- Margo McGurk, Director of Finance & Strategy on 30 April 2024

2.4 Recommendation

This report provides the latest position in relation to the management of corporate risks. Members are asked to take a **“reasonable” level of assurance** that, all actions, within the control of the organisation, are being taken to mitigate the risks as far as is possible to do so.

3 List of appendices

Appendix 1 - NHS Fife Corporate Risk Register as at 30 April 2024
Appendix 2 - Assurance Principles
Appendix 3 - Risk Matrix

Report Contact
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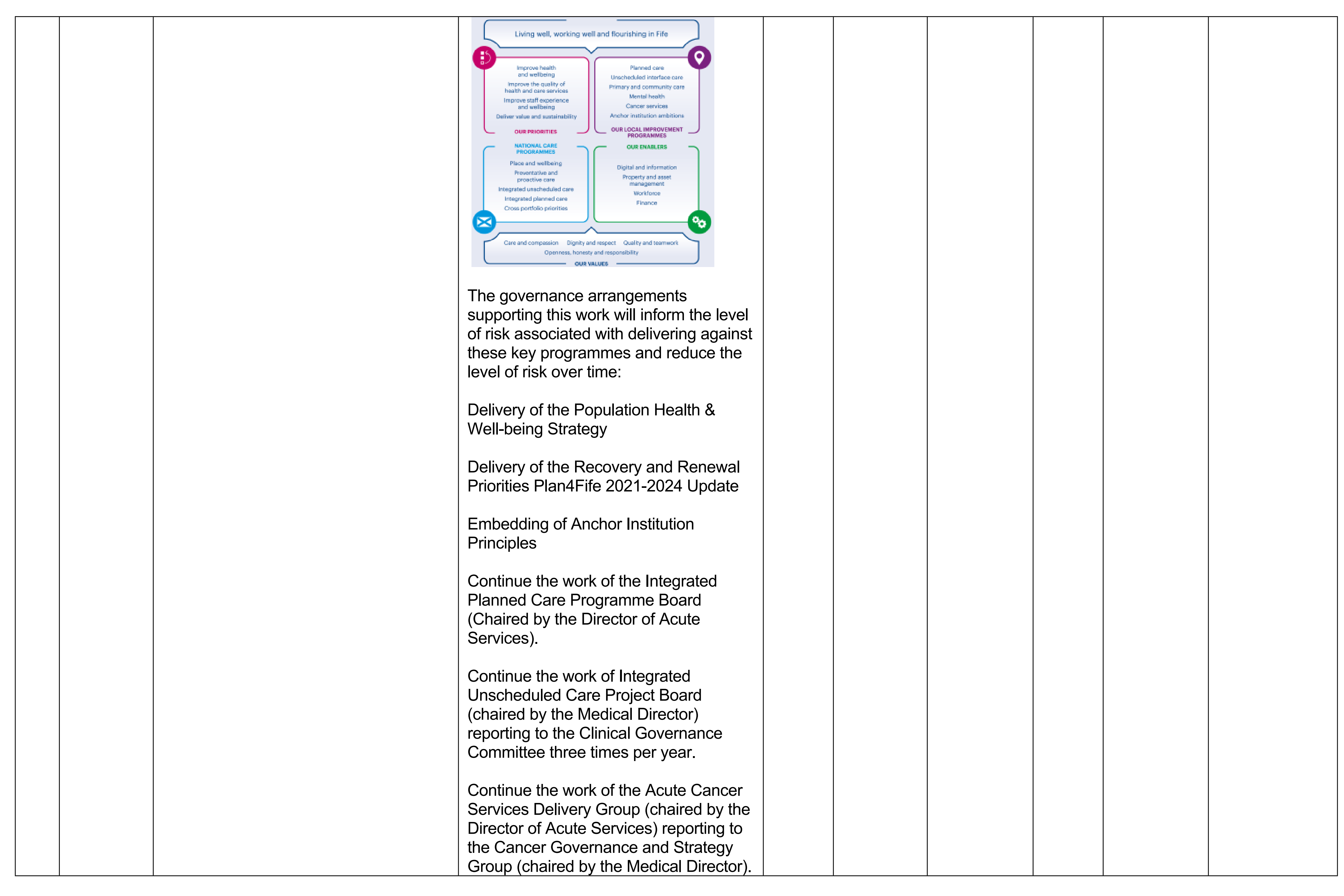
NHS Fife Corporate Risk Register as at 30/04/24									
No	Strategic Priority and Risk Appetite	Risk Title and Description	Mitigation	Risk Appetite Status	Current Risk Level/ Rating	Target Risk level & rating by dd/mm/yy	Current Risk Level Trend	Risk Owner	Primary Committee
1	HIGH	**Population Health and Wellbeing Strategy** There is a risk that the ambitions and delivery of the new organisational Strategy do not deliver the most effective health and wellbeing and clinical services for the population of Fife.	The strategy was approved by the NHS Fife Board in March 2023. This is in the context that the management of this specific risk will span a number of financial years. NHS Fife's 3-year Medium Term Plan was submitted to Scottish Government in July 2023 which flows from our strategy and is based on the same principles and values. An update on the deep dive review was provided to the PHWC in Sept 2023 which reported that structures and processes are being put in place to allow ongoing assessment on delivery of the strategy. Progress against delivery of the strategy has been documented in the PHW Strategy Mid Year Report approved in January 2024 by NHS Fife Board. The Annual Report 23/24 will describe progress made during 2023/24 against the strategy outcomes as well as the proposed actions for 2024/25. This will be aligned to the medium term financial plan.	Below	Mod 12	Mod 12 by 31/03/24	◄►	Chief Executive	Public Health & Wellbeing (PHWC)
2	HIGH	**Health Inequalities** There is a risk that if NHS Fife does not develop and implement an effective strategic approach to contribute to reducing health inequalities and their causes, health and wellbeing outcomes will continue to be poorer, and lives cut	Public Health and Wellbeing Committee established, with the aim of providing assurance that NHS Fife is fully engaged in supporting wider population health and wellbeing for the local population. The Population Health and Wellbeing	Within	High 20	High 15 by 31/05/24	◄►	Director of Public Health	Public Health & Wellbeing (PHWC)

		short in the most deprived areas of Fife compared to the least deprived areas, representing huge disparities in health and wellbeing between Fife communities.	Strategy is monitoring actions which will contribute to reducing health inequalities. Consideration of Health Inequalities within all Board and Committee papers. Leadership and partnership working to influence policies to 'undo' the causes of health inequalities in Fife. Public Health working on approach to ensure that financial decisions under RTP take into account impacts on protected characteristics and inequalities. Development of Anchors strategic plan. Key achievements to date: - Real Living Wage accreditation achieved - 100% of newly awarded contracts of 50K and over are with Real Living Wage accredited businesses - Eight employability programmes in place and engaging with Local Employability partnership - Baseline reporting in place to track spend on local businesses within Fife						
4	**HIGH**	**Policy obligations in relation to environmental management and climate change** There is a risk that if we do not put in place robust management arrangements and the necessary resources, we will not meet the requirements of the 'Policy for NHS Scotland on the Global Climate Emergency and Sustainable Development, Nov 2021.'	Robust governance arrangements remain in place including an Executive Lead and a Board Champion. Regional working group and representation on the National Board ongoing. Active participation in Plan 4 Fife continues. The NHS Fife Climate Emergency Report and Action Plan have been developed. These form part of the Annual Delivery Plan (ADP). The Action	Below	Mod 12	Mod 10 by 01/04/2025	◄►	Director of Property & Asset Management	Public Health & Wellbeing (PHWC)

			Plan includes mechanics and timescales. The Board's Climate Change Annual Report was prepared for submission to PHWC in January 2024 and thereafter to Scottish Government (SG) and has been published as per the requirements of the policy DL38. Resource in the sustainability team has increased to 4 FTE's in total including an energy manager who will be key in supporting the requirements of the strategy and policy. The Head of Sustainability has been seconded from the Estates initially for 18 months to drive delivery of the Climate Emergency Action Plan. A partnership plan for Fife Council, Fife College and University of St Andrews is being prepared for submission to the Fife Partnership board in May 2024. This will set out the agreed actions discussed in the 'addressing the climate emergency working group' and formally create joint actions we will work on as part of the climate emergency in Fife. The deliverables associated with climate change, will be monitored through the Annual Delivery Plan.						
5	**HIGH**	**Optimal Clinical Outcomes** There is a risk that recovering from the legacy impact of the ongoing pandemic, combined with the impact of the cost-of-living crisis on citizens, will increase the level of challenge in meeting the health and care needs of the population both in the immediate and medium-term.	The Board has agreed a suite of local improvement programmes, as detailed in the diagram below and related activities, to frame and plan our approach to meeting the challenges associated with this risk.	Within	High 15	Mod 10 by 31/03/25	◄►	Medical Director	Clinical Governance (CGC)



The governance arrangements supporting this work will inform the level of risk associated with delivering against these key programmes and reduce the level of risk over time:

Delivery of the Population Health & Well-being Strategy

Delivery of the Recovery and Renewal Priorities Plan4Fife 2021-2024 Update

Embedding of Anchor Institution Principles

Continue the work of the Integrated Planned Care Programme Board (Chaired by the Director of Acute Services).

Continue the work of Integrated Unscheduled Care Project Board (chaired by the Medical Director) reporting to the Clinical Governance Committee three times per year.

Continue the work of the Acute Cancer Services Delivery Group (chaired by the Director of Acute Services) reporting to the Cancer Governance and Strategy Group (chaired by the Medical Director).

			Continue to develop and implement Annual Delivery Plans for the Cancer Framework. Continue the work of the Primary Care Strategy Group Continue work on the Mental Health Redesign Programme Continue the work of the Scheduled Care Group Review the Scottish Government (SG) Value Based Health & Care. A Vision for Scotland, December 2022 document against our local plans. Continue escalation of issues through Senior Leadership Teams to Executive Director's Group then through to Clinical Governance Committee and other committees as appropriate Implement the Fife H&SCP Strategic Plan for Fife 2023-26 Implement the Cancer Framework Delivery Plan 2024/25 Ensure the NHS Fife Realistic Medicine/Value Based Health Care Delivery Plan aligns with the Scottish Government (SG) Value Based Health & Care. Action Plan 2023.						

6	**MODERATE**	**Whole System Capacity** There is a risk that significant and sustained admission activity to acute services, combined with challenges in achieving timely discharge to downstream wards and/or provision of social care packages, that the management of Acute hospital capacity and flow will be severely compromised.	The combination of application of our OPEL process on a daily basis and the improvement work through our Integrated Unscheduled Care and Planned Care programmes provides the operational and strategic response to the challenges posed through this risk. A Whole System Winter Plan 23/24 has been produced as well as a report from the Whole System Winter Planning Workshop held in Sept 2023. This will include a response to surge and demand for an increase in capacity and flow through Acute, Community and Social Care. The System Flow Operational Group meets weekly with senior operational managers to review and plan capacity and flow across the Fife health and care system with escalation to the Integrated Unscheduled Care Board. Whole System Essential Flow Verification provides assurance that all patients identified as clinically fit or with a Planned Date of Discharge are reviewed daily. Weekly ASD Long Length of Stay (LoS) verification group to review and action LoS. Weekend verification group reviews the number of discharges and staffing ahead of weekend.	Above	High 20	Mod 9 by 30/04/24	◄►	Director of Acute Services	Finance, Performance & Resources (F,P&RC)

			Living well, working well and flourishing in Fife Improve health and wellbeing Improve the quality of health and care services Improve staff experience and wellbeing Deliver value and sustainability OUR PRIORITIES Planned care Unscheduled interface care Primary and community care Mental health Cancer services Anchor institution ambitions OUR LOCAL IMPROVEMENT PROGRAMMES NATIONAL CARE PROGRAMMES Place and wellbeing Preventative and proactive care Integrated unscheduled care Integrated planned care Cross portfolio priorities OUR ENABLERS Digital and information Property and asset management Workforce Finance Care and compassion Dignity and respect Quality and teamwork Openness, honesty and responsibility OUR VALUES						
7	**MODERATE**	**Access to outpatient, diagnostic and treatment services** There is a risk that due to demand exceeding capacity, compounded by unscheduled care pressures, NHS Fife will see deterioration in achieving waiting time standards. This time delay will impact clinical outcomes for the population of Fife.	Planning for 2024/25 has been completed in line with planning guidance letter received on 24/01/24. Confirmed funding 1M less than committed staff costs. Paper has been prepared for discussion by EDG outlining the impact of the reduction in funding in addition to the ongoing gap between capacity and demand which is driving an increase in waiting list size and waiting times The Integrated Planned Care Programme Board continues to oversee the productive opportunities work and this along with ongoing waiting list validation seeks to maximise available capacity. Speciality level plans in place outlining local actions to mitigate the most significant areas of risk. Focus remains on urgent and urgent suspicious of cancer patients however routine long waiting times will increase. Weekly waiting times meetings to review and action long waits. Monthly meeting to review and develop longer	Above	High 20	It is still not possible to provide a target risk and date given the uncertainty over level of funding		Director of Acute Services	Finance, Performance & Resources (F,P&RC)

			term plans to improve waiting times. Monthly meetings with Scottish Government to monitor delivery against the annual plan. The governance arrangements supporting this work continue to inform the level of risk associated with delivering against these key programmes and mitigate the level of risk over time. Discussions continue with Scottish Government around the need for additional funding to help reduce the waiting times for long waiting routine patients.							
8	MODERATE	**Cancer Waiting Times (CWT)** There is a risk that due to increasing patient referrals and complex cancer pathways, NHS Fife will see further deterioration of Cancer Waiting Times 62-day performance, and 31 day performance, resulting in poor patient experience, impact on clinical outcomes and failure to achieve the Cancer Waiting Times Standards.	The prostate project group continues with actions identified to improve steps in the pathway. The nurse-led model went live in August 23. 240 patients have been seen in this clinic to date. There will be a focus to look at the waits to TP biopsy, post MDT part of the pathway and review robotic surgery capacity. Fortnightly meetings with Scottish Government (SG) and quarterly monitoring of the Effective Cancer Management Framework continue. Single Point of Contact Hub (SPOCH) continues to effectively support initiation of the Optimal Lung Cancer support the negative qFIT pathway. To remove patients from the lung pathway in a timely manner the Hub advises patients of 'good news'. The Cancer Framework and delivery plan has been launched and priorities for 2023 -24 are being reconciled. Work is underway to develop actions for	Above	High 15	Mod 12 by 30/04/24	◄►	Director of Acute Services	Finance, Performance & Resources (F,P&RC)

			2024-25. The governance arrangements supporting this work will inform the level of risk associated with delivering against these key programmes and reduce the level of risk over time. Cancer Waiting Times funding is expected to be provided on a recurring basis from 2024-25. Bids have been prioritised to support improvement ADP Actions for 2024/25 have been reviewed.						
9	**MODERATE**	**Quality & Safety** There is a risk that if our governance, arrangements are ineffective, we may be unable to recognise a risk to the quality of services provided, thereby being unable to provide adequate assurance and possible impact to the quality of care delivered to the population of Fife.	Effective governance is in place and operating through the Clinical Governance Oversight Group (CGOG) providing the mechanism for assurance and escalation of clinical governance (CG) issues to Clinical Governance Committee (CGC). There are also effective systems & processes to ensure oversight and monitoring of national & local strategy / framework / policy /audit implementation and impact. One of the root causes of this risk is that there are "no effective system of supporting effective organisational learning". A paper setting out a proposed approach to refreshing the work of the Organisational Learning Group has been shared with the Clinical Governance Oversight Group in April 24 with a formal update scheduled to the Executive Directors in July 24. The paper includes a workplan for 2024/2025 and outlines a number of activities the group will progress.	Within	Moderate 12	Low 6 by 31/03/25	◄►	Medical Director	Clinical Governance (CGC)

10	**MODERATE**	**Primary Care Services** There is a risk that due to a combination of unmet need across health and social care as a result of the pandemic, increasing demand on services, workforce availability, funding challenges, adequate sufficient premises and overall resourcing of Primary Care services, it may not be possible to deliver sustainable quality services to the population of Fife for the short, medium and longer term.	A Primary Care Governance and Strategy Oversight Group (PCGSOG) is in place. A Primary Care Strategy was developed following a strategic needs analysis and wide stakeholder engagement. This was approved at IJB in July 2023 and is now moving to implementation. This is a 3 year strategy focused on recovery, quality and sustainability. Development of a Performance and Assurance Framework covering qualitative and quantitative performance will provide robust reporting, monitoring and oversight of implementation and impact of the Primary Care Strategy to committees quarterly. This is due by end of January 2024.**Completed** – this will go to the Primary Care Governance and Strategic Oversight Group for ratification. Following approval of the Performance and Assurance Framework an annual report will be presented to Committee / IJB. A Primary Care Improvement Plan (PCIP) is in place; subject to regular monitoring and reporting to General Medical Services (GMS) Board, Quality & Communities (Q&C) Committee, IJB and Scottish Government. A workshop took place in January 2023 to review and refresh the current PCIP to ensure it is contemporary and based on current position and known risks to ensure a realistic and feasible PCIP. This will be progressed via committees for approval by	Above	High 16	Mod 12 by 31/03/25	◄►	Director of Health & Social Care	Public Health & Wellbeing (PHWC)

			April 2024, following a further workshop to be convened by March 24. Local negotiations in relation to MOU2 transitionary payments are complete and agreement has been reached and implemented for 23/24. The review of leadership, management and governance structure which has been jointly commissioned by Deputy Medical Director (DMD) and Head of Service (HOS) for Primary & Preventative Care (P&PC) is now complete and is to be ratified by PCGSOG when it next convenes early 2024. Memorandum of Understanding 2 (MOU2) - in line with the direction of MOU2, the focus for the PCIP remains to be delivery of a complete CTAC and Pharmacotherapy, This programme of work will be underpinned by the PCIP 2023-2024 with regular monitoring and oversight by the GMS groups and the governance structures of the IJB. This will be reviewed - April 2024. The PCIP 2023-2024 will focus on consistency, continuity of service and communication to develop a 52 week model of service delivery for the priorities of MOU2 and continue to sustain service delivery in line with the priorities of MOU including MSK, mental health practitioners, urgent care in hours and community link workers - March 2024. Pharmacotherapy and CTAC models for care continue to be shaped and developed. The anticipated date for completion is April 2024.						

19	MODERATE	**Implementation of Health and Care (Staffing) (Scotland) Act 2019 [HCSA]** Taking account of ongoing preparatory work, there is a risk that the current supply and availability of trained workforce nationally, will influence the level of compliance with HCSA requirements. While the consequences of not meeting full compliance have not been specified, this could result in additional Board monitoring / measures.	NHS Fife Local HCSA Reference Group, with Fife wide, multi-disciplinary and staff representation, is now well established. Frequency of meetings increased to monthly from September 2023. Nationally led Chapter Guidance testing and monthly national Chapter Testing Group and fortnightly monitoring meetings have now concluded. Five SWOT Analyses have been presented so far both at local and national level, to share knowledge and increase awareness, three remaining SWOTs to be shared and logged with national team. N&M Workforce Lead in post since March 2021, with SG funding provided. HCSA resources continue to be shared widely within NHS Fife. Active MS Teams Channel used to share information outwith meetings. Quarterly progress returns submitted to SG. Enhanced local engagement and reporting achieved via introduction of MS Forms to capture latest activity in respect of Act requirements. Feedback informs local action plan. Regular updates provided to APF, EDG and SGC. Board participation in national SG /HIS event on 12 March 2024, Speech & Language Therapy service recorded HIS podcast to support shared learning. This risk on the preparations for HCSA implementation is monitored via the NHS Fife HCSA Local Reference Group.	Within	Moderate 12	Mod 9 by 22/07/24	◄►	Director of Workforce	Staff Governance (SGC)

11	MODERATE	**Workforce Planning and Delivery** There is a risk that the current supply of a trained workforce is insufficient to meet the anticipated Whole System capacity challenges, or the aspirations set out within the Population Health & Wellbeing Strategy, which may impact on service delivery	Continued development of the workforce elements of the Annual Delivery Plan, Population Health & Wellbeing Strategy and Strategic Framework; alongside the Workforce Plan for 2022 to 2025 and aligned service based workforce plans and now aligning to new RTP Programme. Implementation of the Health & Social Care Workforce Strategy and Plan for 2022 to 2025 to support the Health & Social Care Strategic Plan for 2023 to 2026 and the integration agenda. Implementation of the NHS Fife Board Strategic and Corporate Objectives, particularly the "exemplar employer / employer of choice" and the associated values and behaviours and aligned to the ambitions of an Anchor Institution, e.g. Employability agenda / Modern Apprenticeships and new EMERGE programme in conjunction with Levenmouth Academy, Fife College and NES, offering up to 15 places for pupils interested in health related careers. Continued development of Service Level Workforce Plans, taking account of the 2024/2025 ADP submissions to establish the projected workforce gap between supply, demand, the financial envelope and identifying workforce and non workforce solutions services are progressing to mitigate workforce risks and balance service delivery. Quarterly Workforce Planning updates have been built into the governance cycle for 2024/2025. Consideration of impact of planned reduction in Agenda for Change staffs' full time working week from 37.5 hours to 36 hours per week on workforce numbers and service capacity, with modelling being undertaken in line with	Above	High 16	Mod 8 by 31/03/25	◄►	Director of Workforce	Staff Governance (SGC)

			National implementation plans. Consideration of impact of non pay elements of Agenda for Change staff pay award for 2023/2024 in respect of Band 5 review. Consideration of impact of non pay elements of Agenda for Change staff pay award for 2023/2024 in respect of protected learning time. Progression of Bank and Agency Programme of Work and Nursing & Midwifery Workforce actions, to improve workforce sustainability, e.g. introduction of Assistant Practitioner roles and new Registrant recruitment. Recruitment of 104 Registered Nurses and Radiographers as part of International recruitment initiative to support workforce resilience. The Fife Care Academy held a recruitment event in November 2023 to support workforce sustainability. The event was attended by over 20 providers including NHS Fife nursing, Fife Council, independent and third sectors. A further event is planned for 21 February 2024, with 24 employers represented. The Care Academy Strategic Group is arranging tracking of all HSC learning activity to support mapping of course progression to inform future programme capacity. A HSCP reference group has also been established, with multi service representation including named CI registered managers. Sector leads from Third and Independent sector are included. A Teams channel and self-assessment tool have been created and work on compiling the findings is advanced. Engagement sessions for the managers / supervisors are						

			underway in two of the three services and a communication plan is being developed.						
12	MODERATE	**Staff Health and Wellbeing** There is a risk that if due to a limited workforce supply and system pressure, we are unable to maintain the health and wellbeing of our existing staff we will fail to retain and develop a skilled and sustainable workforce to deliver services now and in the future.	Working in partnership with staff side and professional organisations across all sectors of NHS Fife to ensure staff health and wellbeing opportunities are maximised, to support attraction, development and retention of staff. The Staff Health & Wellbeing Framework for 2022 to 2025, setting out NHS Fife's ambitions, approaches and commitments to staff health and wellbeing, was published in December 2022 and complementary Action Plan for 2023 to 2025 now approved, in order to deliver these commitments. Consideration and review of staff support priorities for 2022-2025 being progressed via Staff Health & Wellbeing Group and other fora, aligned to Action Plan. Work progressing on Promoting Attendance improvement actions to support reductions in staff absence and promote staff wellbeing. This includes commencing multifactorial reviews within targeted areas to develop bespoke support to both staff and managers in these areas as part of the 2024 / 2025 initiatives, overseen by a new Board wide assurance group.	Above	High 16	Mod 8 by 31/03/25	◄►	Director of Workforce	Staff Governance (SGC)
13	MODERATE	**Delivery of a balanced in-year financial position** There is a risk that due to the ongoing impact of the pandemic combined with the very challenging financial context both locally and nationally, the Board will not achieve its statutory financial revenue budget target in 2023/24	During February 2024, all Boards received from the Scottish Government, a portion of UK consequentials funding to support a break even position. Despite this funding and the intensified measures and commitment to reduce costs and avoid any additional investment in our services, including	Above	High 16	Mod 12 by 31/03/24	◄►	Director of Finance & Strategy	Finance, Performance & Resources (F,P&RC)

		without further planned brokerage from Scottish Government.	implementation of the Reform, Transform, Perform (RTP) programme, a large deficit remains and it is highly likely that the Board will require significant financial brokerage from Scottish Government to break-even.						
14	MODERATE	**Delivery of recurring financial balance over the medium-term** There is a risk that NHS Fife will not deliver the financial improvement and sustainability programme actions required to ensure sustainable financial balance over the medium-term.	Our financial improvement plan will be delivered through our Reform, Transform and Perform (RTP) Framework working collaboratively with our partners. Reform will necessitate immediate changes in our working practices across the organisation, Transform will focus on evolving our services, structures, and care delivery, and Perform will be pivotal in driving sustainable improvements throughout the organisation. We are currently refreshing our Medium-Term Financial Plan (MTFP) to reflect funding announcements presented in the Scottish Government's budget for 2024/25. The MTFP identifies significant cost savings across all years covered by the financial plan. Work is underway through the RTP programme to support the change required across the organisation to deliver financial balance The Board will maintain its focus on reaching the full National Resource Allocation (NRAC) allocation over the medium- term.	Above	High 16	Mod 12 by 31/03/24	◄►	Director of Finance & Strategy	Finance, Performance & Resources (F,P&RC)
15		**Prioritisation & Management of Capital funding** There is a risk that lack of prioritisation	Ongoing governance through FCIG with capital plan being submitted through FP&R and the Board.	Within	Mod 12	Mod 8 (by 01/04/26 at	◄►	Director of Property & Asset Manageme	Finance, Performance & Resources (F,P&RC)

	MODERATE	and control around the utilisation of limited capital and staffing resources will affect our ability to deliver the PAMS and to support the developing Population Health and Wellbeing Strategy.	Annual Property and Asset Management Strategy (PAMS) updates to provide strategic direction now being replaced with the Whole System Initial Agreement development over the next 2 years. Rolling 5-year equipment programme and implementation of medical devices database. Implementation of medical devices database. Rolling 5-year Digital & Information programme linked to D&I strategy. Ongoing management of estate risks using the Estate Asset Management System (EAMS). Use of Business Case template to present new schemes for consideration. Future consideration/development of prioritisation investment tool. Fleet and sustainability requests will be linked to plans/strategy and presented through SBARs to Fife Capital Investment Group (FCIG).			next SG funding review)		nt	
16	**MODERATE**	**Off-Site Area Sterilisation and Disinfection Unit Service** There is a risk that by continuing to use a single off-site service Area Sterilisation Disinfection Unit (ASDU), our ability to control the supply and standard of equipment required to deliver a safe and effective service will deteriorate.	Monitoring and review continues through the NHS Fife Decontamination Group. Establishment of local SSD for robotics is progressing with an indicative date of 31/12/23. Health Facilities Scotland (HFS) has agreed the design and the unit at St Andrews Community Hospital (SACH); the timescale to become operational has been revised from December 2023 to possibly June 2024. Work is underway to meet this target.	Within	Mod 12	Low 6 (by 01/04/2026 at next SG funding review)		Director of Property & Asset Manageme nt	Clinical Governance (CGC)

			An option appraisal for delivery of the service is being explored. Ensure that mitigations are in place to ensure that no trays are damaged while they are handled and stored in NHS Fife to include new racking and training Staff have received training in the safe handling of trays. Training is being repeated on a yearly basis. Staff must inspect each tray prior to loading on to storage system. New racking system installed early March 2022 costing £27,000 and prevents the stacking of trays. Tins purchased in early 2022 costing £29,000 in use to protect our heavy trauma and orthopaedic trays A trial of foam corners has been instigated by Tayside. Ensure that contingency stock has been procured to mitigate the effects of any down-time on the service to include: - •At least 3 Days of Trauma trays •At least 3 days of obstetric trays Consideration being given to increasing stock to 7 days for Trauma and Obstetric trays. Manage the SLA appropriately and consider changes to allow quality issues to be identified and treated seriously and in a timely manner. Regular Liaison meetings to discuss issues with the service have been taking place since 2021. Discussions are taking place about						

			changing some of the terms in the SLA to allow defective trays to be identified at point of use rather than at point of delivery (July 2023). Consideration of alternative providers to determine whether value for money is being provided and whether increased resilience can be provided continues. Involvement and influencing the National group looking at capacity and resilience in CDU provision across Scotland. This group, facilitated by National Services Scotland (NSS) will make recommendations to the Scottish Government (SG) about how best to increase capacity and resilience within NHS Scotland. This Group was convened in 2021. The Decontamination Collaborative Programme Board (DCPB) is now chaired by the Director of Property & Asset Management and has been briefing SG through regular meetings. Work with Regional partners to identify synergies in service delivery including the developing business plan for re-provision of CDU capacity within NHS Lothian. Raise the profile of this issue at National Estates and Facilities Fora including National Strategic Facilities Group which includes key representatives from NSS and SG.						
17	**MODERATE**	**Cyber Resilience** There is a risk that NHS Fife will be overcome by a targeted and sustained cyber attack that may impact the availability and / or integrity of digital and information required to operate a full health service.	The Network Information System Directive (NISD) and now Cyber Resilience Framework Audit has concluded. The compliance rate has increased to 87%, up from 76% from the previous year. The action plan for improvement has	Above	High 16	Mod 12 by Sept 2024	◄►	Medical Director	Clinical Governance (CGC)

			been presented to the Information Governance and Security Steering Group. The Deep Dive review for this risk was presented to Clinical Governance Committee in January 2024. Management actions detailed continue to be progressed.						
18	MODERATE	**Digital & Information** There is a risk that the organisation maybe unable to sustain the financial investment necessary to deliver its D&I Strategy and as a result this will affect our ability to enable transformation across Health and Social Care and adversely impact on the availability of systems that support clinical services, in their treatment and management of patients.	Consistent alignment of the D&I Strategy with the NHS Fife Corporate Objectives and the Population Health & Wellbeing Strategy. Active review of the current digital programmes against current strategic objectives is complete and has governed by the Digital and Information Board. The annual delivery plan for 2024/25 will demonstrate a reduced level of activity to match the resource availability and limited levels of finance. (Capital and revenue) The revised strategy will include, financial and workforce planning, to support the mitigation of this risk. D&I Board have established new prioritisation and authorisation processes with ongoing review.	Above	High 15	Mod 8 by April 2025	◄►	Medical Director	Clinical Governance (CGC)

Risk Movement Key

▲ Improved - Risk Decreased
◄► No Change
▼ Deteriorated - Risk Increased

Assurance Principles

Risk Assurance Principles:

Board

- Ensuring efficient, effective and accountable governance

Standing Committees of the Board

- Detailed scrutiny
- Providing assurance to Board
- Escalating key issues to the Board

Committee Agenda

- Agenda Items should relate to risk (where relevant)

Seek Assurance of Effectiveness of Risk Mitigation

- Relevance
- Proportionality
- Reliable
- Sufficient

Chairs Assurance Report

- Consider issues for disclosure
- Emergent risks or Escalation / Recording
- Scrutiny or risk delegated to Committee

Year End Report

- Highlight change in movement of risks aligned to the Committee, including areas where there is no change
- Conclude on assurance of mitigation of risks
- Consider relevant reports for the workplan in the year ahead related to risks and concerns

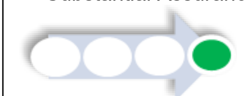
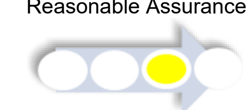
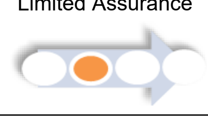
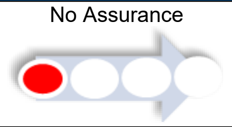
General Questions:

- Does the risk description fully explain the nature and impact of the risk?
- Do the current controls match the stated risk?
- How weak or strong are the controls? Ae they both well-designed and effective i.e., implemented properly?
- Will further actions bring the risk down to the planned/target level?
- Does the assurance you receive tell you how controls are performing?
- Are we investing in areas of high risk instead of those that are already well-controlled?
- Do Committee papers identify risk clearly and explicitly link the strategic priorities and objectives/corporate risk?

Specific Questions when analysing a risk delegated to the committee in detail:

- History of the risk (when was it opened) – has it moved towards target at any point?
- Is there a valid reason given for the current score?
- Is the target score:
  - In line with the organisation's defined risk appetite?
  - Realistic/achievable or does the risk require to be tolerated at a higher level?
  - Sensible/worthwhile?
- Is there an appropriate split between:
  - Controls – processes already in place which take the score down from its initial/inherent position to where it is now?
  - Actions – planned initiatives which should take it from its current to target?
  - Assurances – which monitor the application of controls/actions?
- Assessing Controls
  - Are the controls "Key" i.e., are they what actually reduces the risk to its current level (not an extensive list of processes which happen but don't actually have any substantive impact)?
  - Overall, do the controls look as if they are applying the level of risk mitigation stated?
  - Is their adequacy assessed by the risk owner? If so, is it reasonable based on the evidence provided?
- Assessing Actions – as controls but accepting that there is necessarily more uncertainty
  - Are they on track to be delivered?
  - Are the actions achievable or does the necessary investment outweigh the benefit of reducing the risk?
  - Are they likely to be sufficient to bring the risk down to the target score?
- Assess Assurances:
  - Do they actually relate to the listed controls and actions (surprisingly often they don't)?
  - Do they provide relevant, reliable and sufficient evidence either individually or in composite?
  - Do the assurance sources listed actually provide a conclusion on whether:
    - the control is working
    - action is being implemented
    - the risk is being mitigated effectively overall (e.g. performance reports look at the overall objective which is separate from assurances over individual controls) and is on course to achieve the target level
  - What level of assurance can be given or can be concluded and how does this compare to the required level of defence (commensurate with the nature or scale of the risk):
    - 1st line – management/performance/data trends?
    - 2nd line – oversight / compliance / audits?
    - 3rd line – internal audit and/or external audit reports/external assessments?

Level of Assurance:

Substantial Assurance	Reasonable Assurance	Limited Assurance	No Assurance
			

Document developed from diagram produced by NHS Lanarkshire based on principles compiled by the Assurance Mapping Group of members of Boards covered by the FTF Internal Audit Service, 2022

Risk Assessment Matrix

A risk is assessed as **Likelihood x Consequence**

Likelihood is assessed as Remote, Unlikely, Possible, Likely or Almost Certain

Figure 1 Likelihood Definitions

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

Consequence is assessed as, Negligible, Minor, Moderate, Major or Extreme.

Risk Level is determined using the 5 x 5 matrix below based on the AUS/NZ Standard. The risk levels are:

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

Figure 2 Risk Matrix

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

Risks once identified, must be categorised against the following consequence definitions

Figure 3 Consequence Definitions

Descriptor	Negligible	Minor	Moderate	Major	Extreme
Patient Experience	Reduced quality of patient experience / clinical outcome not directly related to delivery of clinical care.	Unsatisfactory patient experience / clinical outcome **directly related to care provision** – **readily resolvable.**	Unsatisfactory patient experience / clinical outcome, short term effects – expect recovery <1wk.	Unsatisfactory patient experience / clinical outcome, long term effects – expect recovery - >1wk.	Unsatisfactory patient experience / clinical outcome, continued ongoing long term effects.
Objectives / Project	Barely noticeable reduction in scope / quality / schedule.	Minor reduction in scope / quality / schedule.	Reduction in scope or quality, project objectives or schedule.	Significant project over-run.	Inability to meet project objectives, reputation of the organisation seriously damaged.
Injury (Physical and psychological) to patient / visitor / staff.	Adverse event leading to minor injury not requiring first aid.	Minor injury or illness, first aid treatment required.	Agency reportable, e.g. Police (violent and aggressive acts). Significant injury requiring medical treatment and/or counselling.	Major injuries/long term incapacity or disability (loss of limb) requiring medical treatment and/or counselling.	Incident leading to death or major permanent incapacity.
Complaints / Claims	Locally resolved verbal complaint.	Justified written complaint peripheral to clinical care.	Below excess claim. Justified complaint involving lack of appropriate care.	Claim above excess level. Multiple justified complaints.	Multiple claims or single major claim/. Complex justified complaint
Service / Business Interruption	Interruption in a service which does not impact on the delivery of patient care or the ability to continue to provide service.	Short term disruption to service with minor impact on patient care.	Some disruption in service with unacceptable impact on patient care. Temporary loss of ability to provide service.	Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked.	Permanent loss of core service or facility. Disruption to facility leading to significant “knock on” effect
Staffing and Competence	Short term low staffing level temporarily reduces service quality (less than 1 day. Short term low staffing level (>1 day), where there is no disruption to patient care.	Ongoing low staffing level reduces service quality. **Minor error** due to ineffective training / implementation of training.	Late delivery of key objective / service due to lack of staff. **Moderate error** due to ineffective training / implementation of training. Ongoing problems with staffing levels.	Uncertain delivery of key objective / service due to lack of staff. **Major error** due to ineffective training / implementation of training.	Non-delivery of key objective / service due to lack of staff. Loss of key staff. **Critical error** due to ineffective training / implementation of training.
Financial (including damage / loss / fraud)	Negligible organisational / personal financial loss (£<10k)	Minor organisational / personal financial loss (£10k-100k)	Significant organisational / personal financial loss (£100k-250k)	Major organisational / personal financial loss (£250 k-1m)	Severe organisational / personal financial loss (£>1m)
Inspection / Audit	Small number of recommendations which focus on minor quality improvement issues.	Recommendations made which can be addressed by low level of management action.	Challenging recommendations that can be addressed with appropriate action plan.	Enforcement action. Low rating Critical report.	Prosecution. Zero rating Severely critical report.
Adverse Publicity / Reputation	Rumours, no media coverage. Little effect on staff morale.	Local media coverage – short term. Some public embarrassment. Minor effect on staff morale / public attitudes.	Local media – long-term adverse publicity. Significant effect on staff morale and public perception of the organisation.	National media / adverse publicity, less than 3 days. Public confidence in the organisation undermined Use of services affected	National / International media / adverse publicity, more than 3 days. MSP / MP concern (Questions in Parliament). Court Enforcement Public Enquiry, FAI

Based on NHS Quality Improvement Scotland (February 2008) sourced AS/NZS 4360:2004: Making it Work: (2004) and Healthcare Improvement Scotland, Learning from Adverse Events: A national framework (4th Edition) (December 2019)

NHS Fife

Meeting:	Audit and Risk Committee
Meeting date:	16 May 2024
Title:	Draft Annual Risk Management Report 2023/24
Responsible Executive:	Margo McGurk, Director of Finance & Strategy, NHS Fife
Report Author:	Pauline Cumming, Risk Manager, NHS Fife

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Annual Delivery Plan
- Emerging issue
- Local policy
- NHS Board / IJB Strategy or Direction / Plan for Fife

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This report provides the Committee with an overview of the risk management activity undertaken during the period 2023-2024 and outlines the focus for 2024-2025.

2.2 Background

The report forms a component of the governance reporting arrangements for risk management in accordance with the NHS Fife Code of Corporate Governance.

2.3 Assessment

The report confirms that adequate and effective risk management arrangements were in place throughout the year. It describes progress against key deliverables within the risk management improvement programme approved in 2022, intended to enhance the effectiveness of our risk management framework arrangements. In summary:

Continual improvement of the operational risk management approach including:

- Completing the refresh of the Risk Management Framework - achieved
- Refining risk management processes - achieved
- Reviewing and updating of the Board risk appetite statement - commenced
- Updating risk key performance indicators - achieved
- Improving the content and presentation of risk management reports - achieved
- Supporting the continuing development of assurance reporting - achieved
- Devising and delivering a risk management training programme - achieved
- Reviewing the Board Strategic Risk Profile - achieved

Next Steps

Our risk management arrangements will continue to evolve in response to feedback from this Committee and other stakeholders, including via Internal Audit recommendations. The Corporate Risk Register will continue to adapt to reflect the current operating landscape, and our risk appetite in relation to changes in the internal and external environment including developments associated with the Reform, Transform, Perform Framework. The ROG will seek to further develop its contribution to the identification and assessment of emergent risks and opportunities and make appropriate recommendations on the potential impact upon the Board's Risk Appetite position. The Group will also contribute to the development of the process and content of the Board's assurance framework.

2.3.1 Quality, Patient and Value-Based Health & Care

Elevating the profile of risk management in NHS Fife will further support delivery of our strategic priorities through improved operational governance and better alignment with the Population Health and Wellbeing Strategy and associated work streams.

2.3.2 Workforce

Effective management of workforce risks will support staff health and wellbeing, and the quality of health and care services.

2.3.3 Financial

This paper does not raise, directly, financial impacts, but these do present significant elements of risk for NHS Fife to consider and manage in pursuit of our strategic priorities.

2.3.4 Risk Assessment / Management

Focus of the paper.

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

An Equality and Diversity (E&D) assessment has not been conducted but there are not considered to be direct E&D implications associated with this report.

2.3.6 Climate Emergency & Sustainability Impact

This paper does not raise, directly, issues relating to climate emergency and sustainability. These items do form elements of risk for NHS Fife to manage.

2.3.7 Communication, involvement, engagement and consultation

The report reflects the results of engagement in 2023/24 including with the following:

- Director of Finance and Strategy
- Executive Directors Group
- Governance Committees
- Fife NHS Board
- Internal Audit Team
- Risks and Opportunities Group
- Senior Leadership Teams
- Operational Teams

2.3.8 Route to the Meeting

- Margo McGurk, Director of Finance & Strategy on 2 May 2024
- Alistair Graham, Director of Digital and Information on 2 May 2024
- Shirley- Anne Savage, Associate Director for Risk and Professional Standards on 2 May 2024

2.4 Recommendation

Members are asked to:

- **Consider** and **take assurance** from the content of the report

3 List of appendices

Appendix 1 - Draft Annual Risk Management Report 2023-2024

Report Contact
Pauline Cumming
Risk Manager, NHS Fife
Email pauline.cumming@nhs.scot

Annual Risk Management Report

2023-2024

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File Name: NHS Fife Annual Risk Management Report 2023- 2024	V 0.1	Date: 02/05/24
Author: Pauline Cumming, Risk Manager, NHS Fife	Page 1 of 13	

1. RECOMMENDATION

The Audit and Risk Committee is asked to note and take assurance from the risk management activity undertaken during the period, 1 April 2023 to 31 March 2024.

2. INTRODUCTION

2.1 NHS Fife is committed to embracing and further developing an organisational culture which recognises the role and contribution of risk management in supporting decision making, strategic planning, and capitalising on opportunities to change in line with our ambitions, aspirations and capabilities.

2.2 This commitment is based on our core values of care, compassion, dignity and respect, openness, honesty and responsibility quality and teamwork.

2.3 In March 2022, Fife NHS Board endorsed a risk management improvement programme to provide the mechanics for a refreshed and more effective risk management framework which included:

- Reviewing and revalidating the current Board Risk Appetite
- Reviewing the Board Strategic Risk Profile
- Creating a Corporate Risk Register to replace the current Board Assurance Framework
- Developing a Risk dashboard to complement the updated Integrated Performance and Quality Report (IPQR) and to support effective performance management
- Agreeing an updated process to support the escalation, oversight, and governance of risks; and
- Creating a Risks and Opportunities Group

2.4 During 2023- 2024, several initiatives have been undertaken to progress elements of this programme. This report provides the Committee with a summary of the activities undertaken and confirms that adequate and effective risk management arrangements were in place throughout the year.

3. RISK MANAGEMENT IN 2023 / 2024

3.1 The Director of Finance and Strategy provides strategic leadership and direction for risk management in NHS Fife.

3.2 The Audit & Risk Committee has responsibility for evaluating the overall effectiveness of the risk management arrangements, and reviews and challenges how these are operating across the organisation.

3.3 During 2023/24, Internal Audit have continued to support the development of the risk management arrangements through constructive challenge and recommendations on specific elements of this work. The Internal Control

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Evaluation (ICE) 2023/24 Report noted that the Board continues to progress its Risk Management Framework Improvement Programme.

4. RISK MANAGEMENT FRAMEWORK

The updated Risk Management Framework was approved by the NHS Fife Board in September 2023. This reaffirms the Board's commitment to embed an effective risk management framework and culture to support the achievement of the strategic priorities, and the ambitions of the Population Health and Wellbeing Strategy. The updated framework reflects the clarification and formalisation of the risk management arrangements with the Fife Integration Joint Board.

The intention was to also update the related Risk Register / Risk Assessment Policy GP/R7. In re-- drafting the policy, there was considerable duplication with the Framework and following consultation with Internal Audit, and other key stakeholders, it was determined that a separate policy is not required as key elements of the policy not already covered will be added to the Framework. This approach was supported by the ROG on 5 December 2023 and endorsed by the Audit and Risk Committee on 13 December 2023.

The revised Framework and a Delivery Plan to support implementation have been finalised with the intention of submitting to the Audit and Risk Committee and the Board in May 2024, but in light of developments underway in relation to our risk appetite, it has been agreed to defer submission until that work is concluded.

5. RISK APPETITE

5.1 A risk appetite statement details the amount of risk the organisation is willing to take and underpins an effective risk management culture which enables the organisation to achieve its strategic priorities.

5.2 The Board's Risk Appetite was set in July 2022, and considered as part of the update to the Risk Management Framework in September 2023. It is recognised that risk appetite is not static and must be reviewed and adjusted periodically to reflect changes in the internal and external environment that may affect our risk profile or strategy. To this end, the Board began re-assessing its risk appetite at a dedicated Development Session held on 8 April 2024. The session was developed and co -facilitated by the Director of Digital and Information and the Associate Director for Risk and Professional Standards.

The discussion included consideration of risk appetite in the current operating landscape, and the Re-form, Transform and Perform (RTP) Framework and the Corporate Risk Register to reflect our risk appetite and consider making amendments where consensus is built.

Consideration was given to the Integration Joint Board (IJB) risk appetite statement as previously recommended by Internal Audit and a review of NHS Fife's current 3 level risk appetite against a 4 level risk appetite more in line with that of the IJB. The session did not conclude on a revised version and further work is underway to pull together the themes from the meeting and put forward

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recommendations for consideration by the Board. It is anticipated this work will be completed early in the 2024/25 reporting year.

5.3 Corporate Risk papers presented to each standing committee currently state if risks are within or outwith risk appetite and the reason for that position. The majority of the corporate risks are outwith risk appetite which reflects the ongoing level of demand across all services within the increasingly challenging financial environment. In line with the focussed work on risk appetite described above, consideration will be given in the year ahead to the Internal Audit recommendation on how to capture greater detail on how the risk appetite will affect strategy, decision-making, prioritisation, budget setting and organisational focus.

6. STRATEGIC RISK PROFILE

6.1 A Strategic Risk Profile as a dashboard set in the context of the Board's risk appetite, continues to form a component of the monthly Integrated Performance & Quality Report (IPQR). The full Profile is part of the introductory Corporate Risk Summary section; with extracts related to specific strategic priorities within the Assessment section against areas of performance including clinical governance, operational, finance, staff governance and public health and wellbeing.

6.2 Figure 1 below provides a breakdown of the Strategic Risk Profile as at 31/03/24.

Figure 1 Strategic Risk Profile

Strategic Priority	Total Risks	Current Strategic Risk Profile				Risk Movement	Risk Appetite
To improve health and wellbeing	4	2	2	-	-	◀▶	High
To improve the quality of health and care services	6	4	2	-	-	◀▶	Moderate
To improve staff experience and wellbeing	2	2	-	-	-	◀▶	Moderate
To deliver value and sustainability	6	4	2	-	-	◀▶	Moderate
Total	**18**	**12**	**6**	**0**	**0**		

Summary Statement on Risk Profile

The current assessment indicates that delivery against 3 of the 4 strategic priorities continues to face a risk profile in excess of risk appetite.
Mitigations are in place to support management of risk over time with some risks requiring daily assessment.
Assessment of corporate risk performance and improvement trajectory remains in place.

Risk Key		Movement Key	
High Risk	15 - 25	▲	Improved - Risk Decreased
Moderate Risk	8 - 12	◀▶	No Change
Low Risk	4 - 6	▼	Deteriorated - Risk Increased
Very Low Risk	1 - 3		

7. CORPORATE RISK REPORTING

7.1 From 1 April 2023 to 31 March 2024, the high-level risks identified as having the potential to impact on the delivery of NHS Fife's strategic priorities, and related operational high-level risks, were reported the delivery of NHS Fife's strategic priorities, and related operational high-level risks, were reported bi-monthly through the Corporate Risk Register to the governance committees, and subsequently to the Audit & Risk Committee and the Board. Appendix 1 provides a summary of the risks, their score in April 2023, September 2023 and at the end of March 2024. It allows a comparison of the overall risk level and should be considered against progress of the Population Health and Wellbeing Strategy. This analysis shows that our risk profile has not significantly changed since the beginning of the financial year.

The Covid-19 Pandemic risk was removed from the Corporate Risk Register following extensive discussions and due diligence over several months, reflecting its transition to business-as-usual activity, and monitoring through the Public Health Assurance Committee. A related potential new corporate risk on preparedness for potential future pandemics and biological threats is being developed, and a potential new corporate risk around capital funding constraints and impacts on service sustainability is also being developed. A new corporate risk on the preparation for implementing the legislation around the Health & Care Staffing (Scotland) Act 2019 was approved in late 2023.

7.2 The Corporate Risk Register report was presented to the full NHS Board at the November 2023 meeting for scrutiny, and Board members were provided with the necessary levels of assurance on the effectiveness of mitigating actions. The Committee were informed of a new approach to reviewing corporate risks, with some risks moving to a triannual reporting schedule. Furthermore, the Committee held a Development Session in October 2023 to review the effectiveness of the new Corporate Risk Register process and explored members' understanding of their risk management responsibilities.

The corporate risk reporting schedule is set out at Appendix 2.

7.3 Our approach to corporate risk reporting has evolved in the past year. The Risks and Opportunities Group (ROG) has been instrumental in progressing several key developments, in response to feedback from the governance committees and other stakeholders, taking forward considerations and recommendations on the corporate risk register. These are summarised below.

7.4 In Year Risk Rating Improvement

During the year, the use of a time-limited improvement target for the corporate risk ratings was reviewed. Given the complexity of corporate risks, system volatility and scale of current external challenges, and the levels of inherent risk associated with some of the risks, it was agreed to remove the current in-year prediction and match the overarching risk target rating with a more meaningful and realistic metric i.e. an

expected date of achievement. It was felt this would lessen the confusion of changing current risk rating targets for the in-year target.

7.5 **Corporate Risk Review Cycle**

In seeking to provide a balance of effective Corporate Risk review, with a standard frequency that recognised the need for Committee assurance on both the regularity of risk review and timely risk updates, we revised our approach. As the governance committees meet six times a year, there was an opportunity to rotate the corporate risk review frequency over these six meetings to provide assurance, while supporting the requirement for efficiency. It was agreed that while Corporate Risk owners can review and update risks at any time, they would review and update where necessary their total set of risks at least every four months.

7.6 The corporate risks collectively outline the organisational risks associated with the delivery of our strategy. It is recognised that the regular review of these risks and monitoring of the internal and external environment, are essential to ensure the risks represent the organisation's contemporary risk profile, clearly reflect the relationship between current and target risk scores and risk appetite, and that the current and target scores are realistic.

8. ASSURANCE FRAMEWORK

8.1 In 2023, the standing committees requested a specific review on the use of the "level of assurance" listed within the Committee Assurance Principles routinely provided with the Corporate Risk Register reports. Following agreement at EDG and endorsement by the Audit and Risk Committee in June 2023, the 4 - level assurance model, used by Internal Audit, was incorporated within the Assurance Principles. The Deep Dive review template was also updated to incorporate the assurance levels, requiring the risk owner to provide a level of assurance to the Committee as part of the deep dive's creation or review of a previous deep dive.

These developments were implemented from July 2023 and have added consistency to our reporting. The use of the assurance levels continues to evolve, as we further seek to enhance the evidence to substantiate the level of assurance being offered.

8.2 **Deep Dive Reviews**

Corporate Risk Deep Dive reviews continue to be an important component of our risk assurance reporting arrangements. Deep dives were carried out across all the Board's committees, allowing greater scrutiny of the root causes of risks, and providing an opportunity for discussion on the effectiveness of management actions in place to reduce risk levels. At 31/03/24, 14 of the current 18 Corporate Risks had undergone at least one deep dive and the Staff Governance Committee had commissioned reviews of non -corporate risks which are otherwise significant and aligned to staff governance.

The exceptions are:

- Risk 6 - Whole System Capacity
- Risks 11 and 12 - Workforce Planning & Delivery, and Staff Health and Wellbeing - deep dives reviews have been carried out on related topics
- Risk 19 - Preparation for the Implementation of the Health and Care (Staffing) (Scotland) Act 2019 - The risk was only added to the Corporate Risk Register in November 2023.

One characteristic of a deep dive review is that it should be carried out at specific points during the life-cycle of the risk. Based on our learning over the last year, and following discussion at the Audit and Risk Committee Development Session in October 2023, and recommendations to the EDG in November 2023 and the other standing committees in January 2024, it was agreed that going forward, the requirement for a deep dive review will continue to be determined through routes including EDG and the Risks and Opportunities Group. Decisions will be informed by intelligence within operational teams, as well as consideration of triggers including: the creation of a new corporate risk, materially deteriorating risks, or the proposed de-escalation / closure of a corporate risk. The refreshed approach to commissioning a deep dive will be implemented during Quarter 2, 2024 - 2025.

It has been agreed that to enhance the assurance that can be taken from deep dives, and in response to recommendations from Internal Audit, the following improvements to deep dive reviews should be considered in 2024/2025.

- an assessment as to the impact of management actions on the target score;
- a focus on controls, with explicit assurance and conclusion on their effectiveness;
- an assessment of the proportionality of proposed actions; and
- external and internal factors associated with risks and their potential influence

The deep dive review schedule as at 31/03/24 is set out in Appendix 3.

9. RISKS AND OPPORTUNITIES GROUP

9.1 The Risks and Opportunities Group (ROG) which was established in September 2022, continues to meet to provide leadership and promote and embed an effective risk management framework and culture. To deliver on its annual work plan, the Group divides its time between the Corporate Risk Register and in supporting operational risk management practice.

9.2 The Group met on 6 occasions during the financial year to 31 March 2024, on the undernoted dates:

- 6 April 2023
- 8 June 2023
- 5 August 2023
- 3 October 2023
- 5 December 2023
- 6 February 2024

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9.3 A Terms of Reference was reviewed and updated in August 2023; to date, the Group's focus has included:

- Reviewing the Corporate Risk Register with a focus on realistic risk scoring, particularly current and target risk scores, and risk appetite;
- Considering governance committees' feedback on Corporate Risk assurance reports including deep dive reviews;
- Identifying potential improvements to the design and content of assurance reports,
- Considering potential developments to the Risk Assessment Matrix in terms of the scope of descriptors and associated terminology. The matrix is based on a national matrix. Similar considerations have taken place in other NHS Boards. Following a national meeting with Healthcare Improvement Scotland (HIS) in February 2024 in which NHS Fife took part, a short life working group will be set up to review the national matrix and take forward any developments. The ROG has agreed to let the national work emerge and conclude, after which it will reflect on the NHS Fife matrix.
- Contributing to the development of a Risk Summary Dashboard - in seeking to fulfil its remit to support operational risk management and enhance the value of the data within Datix, over the last year, the ROG has considered and contributed to the development of a Risk Summary Dashboard with the D&I team. The dashboard is designed to guide risk owners through a series of activities to facilitate effective risk management. The implementation approach for the ROG to take this forward was agreed by the EDG.

9.4 The Audit and Risk Committee and EDG received demonstrations of the Dashboard in October and November 2023 respectively.

9.5 The ROG has recommended that the Dashboard be made available and its use promoted to support our operational risk management approach, and align with the Risk Management Framework. A plan to support Dashboard implementation will be taken forward through the remit of the ROG during 2024.

9.6 Key Performance Indicators (KPIs) - The Group has considered a set of KPIs associated with operational risks, which demonstrate active risk management. An initial report on these indicators will be provided to the Audit and Risk Committee in May 2024. These will continue to be refined as part of the ROG agenda.

9.7 Horizon Scanning - The ROG continues to consider opportunities, particularly in relation to delivery of the NHS Fife Population Health and Wellbeing Strategy. Realistic Medicine principles have been identified as an area of focus for the year ahead.

9.8 The ROG has developed a work plan for 2024-25 which will drive efforts to further develop and embed a positive and proactive approach to risk management across the organisation.

9.9 Members have been invited to contribute to identifying the possible opportunities or developments that should form longer term planning horizons in the Population Health and Wellbeing Strategy Annual Report - now and in 5 years time.

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9.10 The Group has produced an annual statement of assurance, which includes a self-assessment of the Group's effectiveness. This will be reported to EDG for consideration and decision on areas identified for development or improvement and provided for information to the Audit and Risk Committee.

10. DATIX RISK MANAGEMENT SYSTEM

10.1 Datix remains the repository for risks, incidents (adverse events), safety alerts, complaints and claims within NHS Fife. It was previously reported that Datix Cloud IQ was the preferred upgrade path from DatixWeb and that a business case was being developed for NHS Fife. The development of the business case was suspended following a request to all NHS Boards from National Procurement to pause, pending the outcome of a tendering exercise which may lead to a Once for Scotland digital system. The outcome of that exercise was that a new system called Inphase has been awarded the national tender and work is underway within NHS Fife to assess the new system with a view to its adoption.

10.2 **Risk Register Module**

Pending a system upgrade, work continues to refine the system as required to support risk management processes.

11. RISK MANAGEMENT LEARNING AND DEVELOPMENT

11.1 An Audit & Risk Committee Development Session on the Review of the Effectiveness of the new Corporate Risk Register process was held on 12 October 2023 and also explored members' understanding of their risk management responsibilities.

11.2 During 2023/24, a range of risk management training was undertaken including on a customised basis in response to requests from individuals, services and directorates. An initial risk management training programme has been developed for 2024/25 in response to staff feedback and consultation with the Risks and Opportunities Group.

12. RISK MANAGEMENT OBJECTIVES 2024/25

12.1 During 2023/24 there was the introduction of a new post of Associate Director for Risk and Professional Standards to help drive forward the risk agenda. The Associate Director for Risk and Professional Standards will engage with the Executive Directors, Committee Chairs and the Board, and consider the support requirements to develop our risk management arrangements in order to enhance organisational risk maturity.

12.2 Developments for the forthcoming year will focus on continual improvement of the operational risk management approach informed by Internal Audit recommendations. This will include:

- Completing the update of the Risk Management Framework to include the detail of the updated risk appetite statement
- Continuing to refine risk management processes;
- Implementing risk management key performance indicators;
- Continuing to enhance the content and presentation of risk reports;
- Supporting the continuing development of assurance reporting;
- Further develop a risk management training programme for staff according to their roles and responsibilities

Appendix 1

Corporate Risk Register Summary

Risk title (taken from risk register)	Score April 2023	Score Sept 2023	Score March 2024	Target Risk Level	Trend[1]
1. Population Health and Wellbeing Strategy	Mod 12	Mod 12	Mod 12	Mod 12 by 31/03/24	=
2. Health Inequalities	High 20	High 20	High 20	Mod 12 by 31/05/24	=
3. COVID 19 Pandemic	Mod 12	Mod 9	N/A closed	Mod 12 by October	↓
4. Policy obligations in relation to environmental management and climate change	Mod 12	Mod 12	Mod 12	Mod 10 by 01/04/25	=
5. Optimal Clinical Outcomes	High 15	High 15	High 15	Mod 10 by 31/03/24	=
6. Whole System Capacity	High 20	High 20	High 20	Mod 9 by 30/04/24	=
7. Access to outpatient, diagnostic and treatment services	High 20	High 20	High 20	- [2]	=
8. Cancer Waiting Times (CWT)	High 15	High 15	High 15	Mod 12 by 30/04/24	=
9. Quality & Safety	High 15	High 15	Mod 12	Low 6 by 31/03/24	↓
10. Primary Care Services	High 16	High 16	High 16	Mod 12 by 31/03/25	=
11. Workforce Planning and Delivery	High 16	High 16	High 16	Mod 8 by 31/3/25	=
12. Staff Health and Wellbeing	High 16	High 16	High 16	Mod 8 by 31/03/25	=
13. Delivery of a balanced in-year financial position	High 16	High 16	High 16	Mod 12 by 31/03/24	=
14. Delivery of recurring financial balance over the medium-term	High 16	High 16	High 16	Mod 12by 31/03/24	=
15. Prioritisation & Management of Capital funding	Mod 12	Mod 12	Mod 12	Mod 8 by 01/04/26	=
16. Off-Site Area Sterilisation and Disinfection Unit Service	Mod 12	Mod 12	Mod 12	Low 6 by 01/04/26	=
17. Cyber Resilience	High 16	High 16	High 16	Mod 12 by Sept 2024	=
18. Digital & Information	High 15	High 15	High 16	Mod 8 by April 2025	=
19. Implementation of the Health and Care (Staffing) (Scotland) Act 2019 [HCSA]	N/A	N/A	Mod 12 - New	Mod 9 by 01/04/2024	-

[1] = risk stayed the same, ↓ risk falling, ↑ risk increasing

[2] It is not possible to provide a target risk and date given the uncertainty over future availability of funding.

File Name: NHS Fife Annual Risk Management Report 2023- 2024	V 0.1	Date: 02/05/24
Author: Pauline Cumming, Risk Manager, NHS Fife	Page 11 of 13	

Appendix 2

Corporate Risk Reporting Schedule 2023-24							
Risk	**Public Health & Wellbeing Committee**	**15/05/23**	**03/07/23**	**04/09/23**	**06/11/23**	**15/01/24**	**04/03/24**
1	Population Health & Wellbeing Strategy	✓	✓	✓	✓	✓	✓
2	Health Inequalities	✓	✓	✓	✓	✓	✓
4	Policy obligations in relation to environmental management & climate change	✓	✓	✓	✓	✓	✓
10	Primary Care Services	✓	✓	✓	✓	✓	✓
	Clinical Governance Committee	**05/05/23**	**07/07/23**	**08/09/23**	**03/11/24**	**12/01/24**	**01/03/24**
3	COVID- 19 Pandemic	✓	✓	✓	✓	✓	N/A
5	Optimal Clinical Outcomes	✓	✓	✓	✓	✓	✓
9	Quality & Safety	✓	✓	✓	✓	✓	✓
16	Off-Site Area Sterilisation and Disinfection Unit Service	✓	✓	✓	✓	✓	✓
17	Cyber Resilience	✓	✓	✓	✓	✓	✓
18	Digital & Information	✓	✓	✓	✓	✓	✓
	Finance , Performance & Resources Committee	**09/05/23**	**11/07/23**	**19/09/23**	**14/11/23**	**16/01/24**	**12/03/24**
6	Whole System Capacity	✓	✓	✓	✓	✓	✓
7	Access to outpatient, diagnostic and treatment services	✓	✓	✓	✓	✓	✓
8	Cancer Waiting Times	✓	✓	✓	✓	✓	✓
13	Delivery of a balanced in-year financial position	✓	✓	✓	✓	✓	✓
14	Delivery of recurring financial balance over the medium-term	✓	✓	✓	✓	✓	✓
15	Prioritisation & Management of Capital funding	✓	✓	✓	✓	✓	✓
	Staff Governance Committee	**11/05/23**	**20/07/23**	**14/09/23**	**09/11/23**	**11/01/24**	**06/03/24**
11	Workforce Planning and Delivery	✓	✓	✓	✓	✓	✓
12	Staff Health and Wellbeing	✓	✓	✓	✓	✓	✓
19	Implementation of Health and Care (Staffing) (Scotland) Act 2019	N/A	N/A	N/A	✓NEW*	✓	✓
All	**Audit and Risk Committee**	**18/05/23** **Cancelled**	**23/06/23**	**31/08/23**	**08/12/23**	**14/03/24**	
All	**Fife NHS Board**	**30/05/23**	N/A	N/A	28/11/23 ***Approved**	N/A	N/A

Appendix 3

CORPORATE RISK DEEP DIVE REVIEW STATUS BY DATE OF ORIGINAL PRESENTATION as at 31/03/24					
No	**Risk Title**	**Committee**	**Date**	**Status** ✓ = complete	**Next Review**
8	Cancer Waiting Times (presented to both committees as originally aligned to CGC then changed to F,P&R)	CGC F, P&RC F, P&RC	04/11/22 15/11/22 14/11/23	✓ ✓ ✓	TBC
4	Policy Obligations in relation to environmental management and climate change	PHWC	07/11/22 04/09/23	✓ ✓	TBC
13	Delivery of a balanced in-year financial position	F, P&RC	15/11/22	✓	TBC
11 11.1 11.2 11.3	Workforce Planning & Delivery • Nursing & Midwifery Staffing Levels* Personal Development & Performance Review* • Bank and Agency Work* • Bank and Agency Work* • Pharmacy Workforce Overview*	SGC SGC F, P&RC SGC F, P&RC SGC SGC	TBC 12/01/23 09/03/23 09/05/23 11/05/23 11/07/23 20/07/23 14/05/24	× ✓ ✓ ✓ ✓ ✓ ✓	
18	Digital & Information	CGC	13/01/23 03/11/23	✓ ✓	TBC
14	Delivery of recurring financial balance over the medium term	F, P&RC (private session)	15/01/23	✓	TBC
2	Health Inequalities	PHWC	01/03/23 15/01/24	✓ ✓	TBC
3	COVID 19 Pandemic	CGC	03/03/23 12/01/24	✓ ✓	N/A Closed as corporate risk
7	Access to outpatient, diagnostic & treatment services	F, P&RC	14/03/23	✓	TBC
10	Primary Care Services	PHWC	15/05/23	✓	TBC
5	Optimal Clinical Outcomes	CGC	05/05/23 01/03/24	✓ ✓	TBC
1	Population Health & Wellbeing Strategy	PHWC	03/07/23	✓	TBC
9	Quality and Safety	CGC	07/07/23	✓	TBC
16	Off Site Area Sterilisation & Disinfection Unit Service	CGC	08/09/23	✓	TBC
6	Whole System Capacity	F, P&RC	TBC	×	
17	Cyber Resilience	CGC	13/01/24	✓	
15	Prioritisation & Management of Capital Funding	F, P&RC	16/01/24	✓	
12	Staff Health & Wellbeing	SGC	TBC	×	
19	Implementation of Health and Care (Staffing) Scotland Act 2019 [HCSA]	SGC	TBC	×	

(*not corporate but aligned to corporate risk)
Clinical Governance Committee (CGC)
Finance, Performance & Resources Committee (F, P&RC)
Staff Governance Committee (SGC)
Public Health & Wellbeing Committee (PHWC)

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**16 May 2024**
Title:	**Risk Management Key Performance Indicators 2023/24**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy, NHS Fife**
Report Author:	**Pauline Cumming, Risk Manager, NHS Fife**

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Annual Delivery Plan
- Emerging issue
- Local policy
- NHS Board / IJB Strategy or Direction / Plan for Fife

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Audit and Risk Committee and by extension the Board, require assurance that systems are in place to review and monitor the adequacy and effectiveness of our risk management arrangements. Key Performance Indicators (KPIs) are recognised as a tool to support this activity. This report provides an update on performance against a set of risk management KPIs cited in the Risks and Opportunities Group Update Report to the Committee on 13 December 2024.

2.2 Background

Following the commitment by the Board, in March 2022, to a risk management improvement programme, several initiatives have been progressed and completed to provide the mechanics for an effective risk management framework within NHS Fife. Elements of this work have been taken forward by the Risks and Opportunities Group (ROG). This has included consideration of a set of Key Performance Indicators to support implementation of the refreshed Framework. This is the first report on those KPIs. It is recognised that the

KPIs will continue to be refined in response to feedback from this Committee and the wider organisation, and that future iterations of this report will reflect such developments.

2.3 Assessment

Appendix 1 provides:

- summary detail on the number of risks currently held on the Datix Risk Register and the number of risks opened and closed for the period 01/04/23 to 31/03/24 ; and
- an assessment of compliance against the KPIs

The data show the dynamic nature of the risk register, with fluctuations from month to month; it is recognised that the reasons for this are multi- factorial.

The data show a relatively stable picture with room for improvement across all areas of required compliance.

As part of its workplan, the ROG will continue to consider how to further develop the operational management of risk, including working with services to drill down into the risk data to better understand the organisation's risk profile, and the quantum of risks. This will include reviews of risk type, location, ownership and related assessments, and the identification of trends or areas that may require further interrogation and / or escalation and oversight. Importantly, this activity will consider the extent to which the risk profile reflects the current operating landscape and operational challenges.

The ROG will also continue to explore and test out ways to enhance the content and presentation of data to maximum effect. It is anticipated that the implementation of the Risk Summary Dashboard will be integral to future developments.

2.3.1 Quality, Patient and Value-Based Health & Care

Effective risk management is a key component to ensure patient safety by contributing to improving the reliability and safety of our health care systems and processes.

2.3.2 Workforce

Effective management of risk is key to ensuring staff work in a safe environment and will support delivery of our strategic priorities, to support staff health and wellbeing.

2.3.3 Financial

This paper does not raise, directly, financial impacts, but these do present significant elements of risk for NHS Fife to consider and manage in pursuit of our strategic priorities.

2.3.4 Risk Assessment / Management

The arrangements for managing risk affect patients, staff and others in contact with the Board's services. Healthcare provision is complex and involves a degree of inherent and new risks. Risks must therefore, be properly managed.

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

This paper provides information in relation to risk management processes and does not raise any specific equality and diversity issues.

2.3.6 Climate Emergency & Sustainability Impact

This paper does not raise, directly, issues relating to climate emergency and sustainability. These items do form elements of risk for NHS Fife to manage.

2.3.7 Communication, involvement, engagement and consultation

This paper is informed mainly by communications with the ROG, most recently on 06/04/24, when a report summarising performance up to the end of February 2024 was considered. The information provided with this report represents an update on the latter.

2.3.8 Route to the Meeting

- Margo McGurk, Director of Finance & Strategy on 2 May 2024
- Alistair Graham, Director of Digital and Information on 2 May 2024
- Shirley- Anne Savage, Associate Director for Risk and Professional Standards on 2 May 2024

2.4 Recommendation

- Members are asked to take **assurance** from the update provided.
- **Note** that the ROG will continue to: -
    - Develop an implementation approach for the Risk Summary Dashboard
    - Continue to refine the associated KPIs

3 List of appendices

- Appendix 1, Risk Management Key Performance Indicator Report 1 April 2023 - 31 March 2024

Report Contact
Pauline Cumming
Risk Manager, NHS Fife
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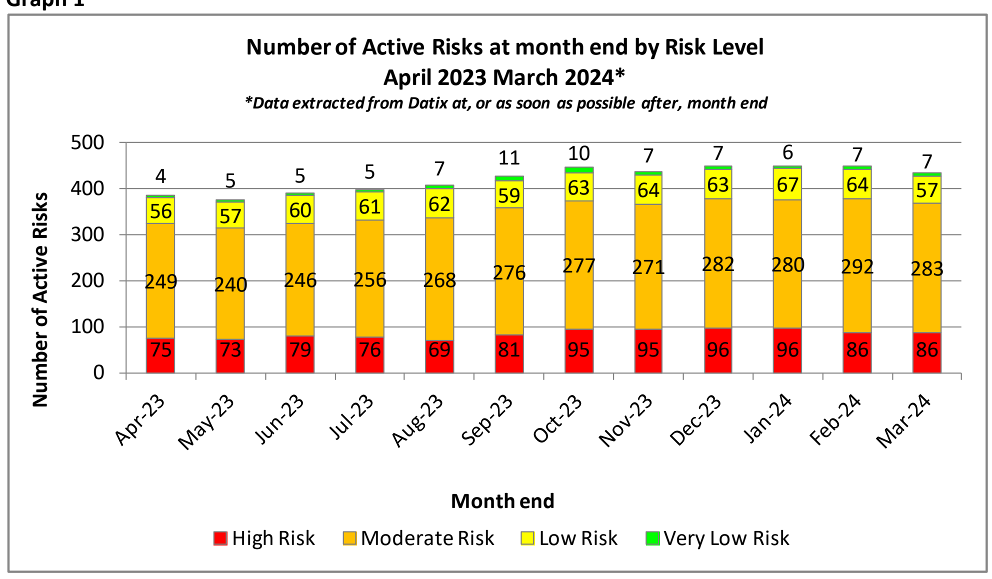
Appendix 1

Risk Management Key Performance Indicator Report - 01/04/23 to 31/03/24

Graphs 1-3 below, show the number of risks held within Datix at month end 31/03/24. Specifically:

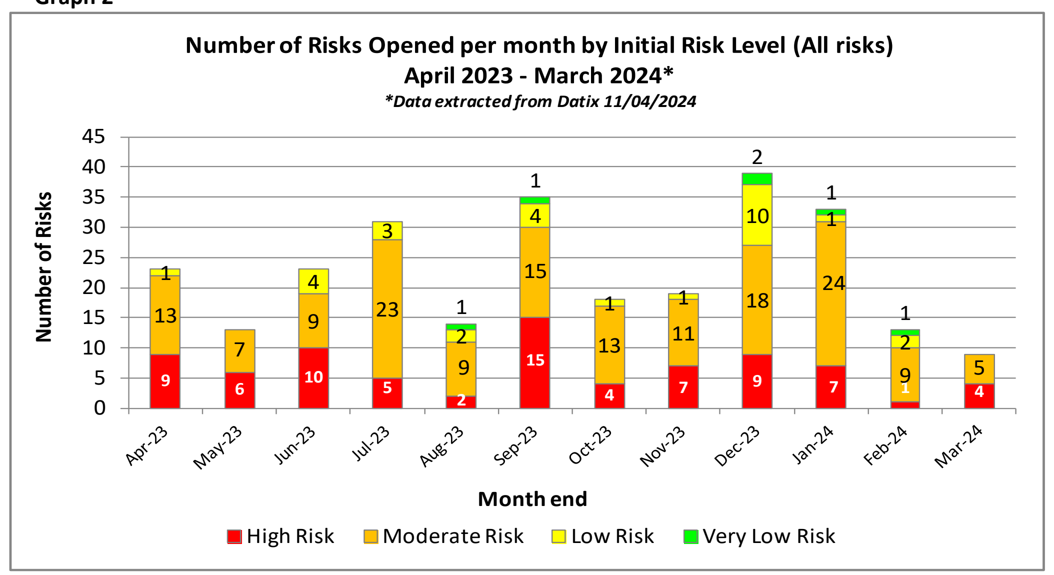
- the number of active risks at 31/03/24 (433)
- the number of risks opened since 1 April 2023 to 31/03/24 (278)
- the number of risks closed since 1 April 2023 to 31/03/24 (250)

Graph 1



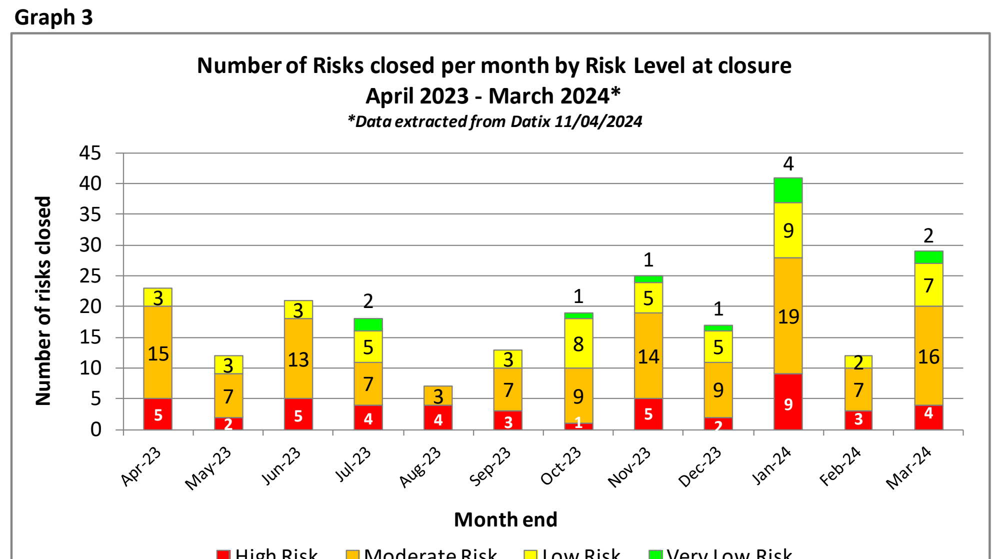
Commentary: Going forward, the developing Risk Summary Dashboard which allows visualisation of risks, along with supporting guidance and activities for individuals and teams, will make the review and management of risk easier, more consistent and effective at both operational and strategic levels. Importantly, it will facilitate drill down into the data to identify the quantum of risks, including risk type, location, and ownership and to provide greater insight into the risk profile and 'what lies behind the numbers'. For example, there are currently 118 project and programme risks.

Graph 2



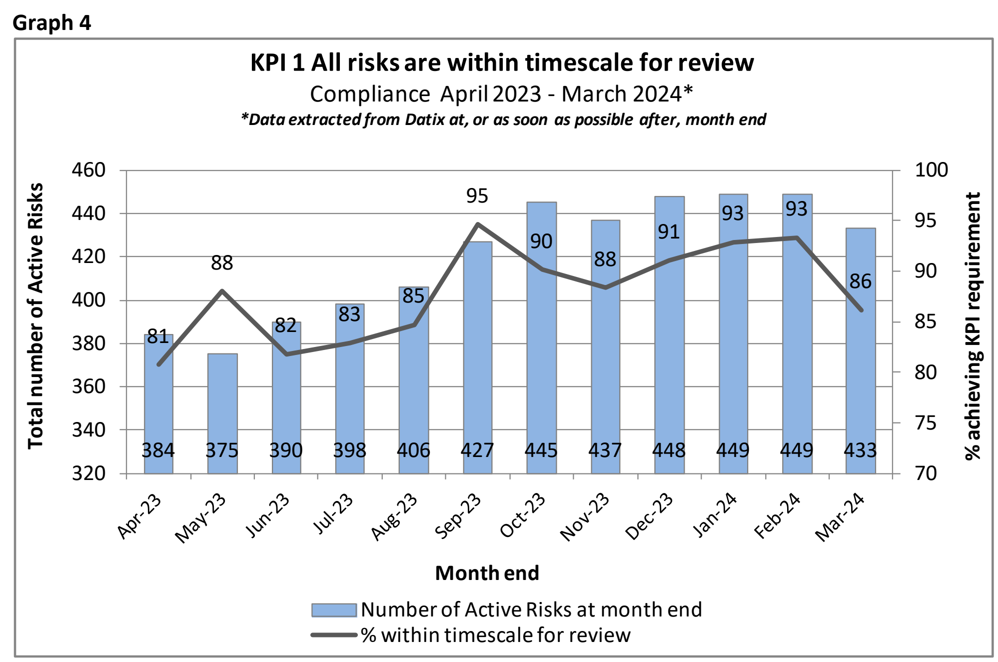
Commentary: This data shows the dynamic nature of the risk register. For example in December 2023 and January 2024, a notable number of risks were opened; these included the addition of multiple risks by one speciality (33); risks associated with two projects (18); delivery of a strategic framework (5), and the Covid - 19 Inquiry (3). The other risks opened were generated from across the wider organisation. The importance of monitoring the type of risks being opened is recognised. For example, if analysis shows a larger proportion of risks of one or two types, a concerted effort on the root cause may be required and bring efficiency to mitigation work. Similarly, analysis may highlight areas of particular organisational challenge that require focused attention and possible escalation.

Graph 3



Graphs 4 - 9 below show performance against agreed KPIs.

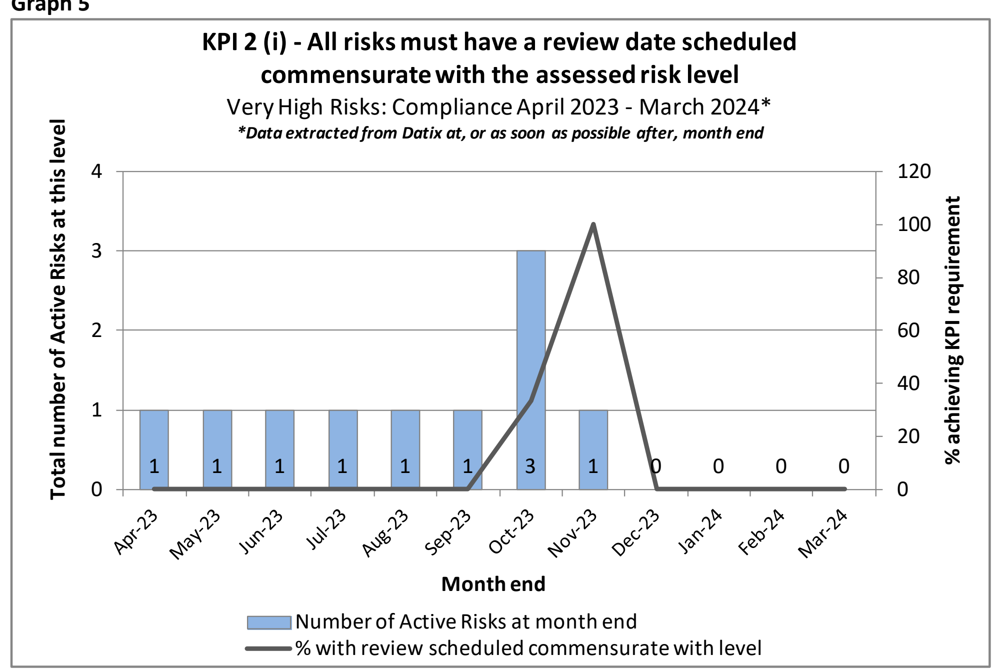
Graph 4



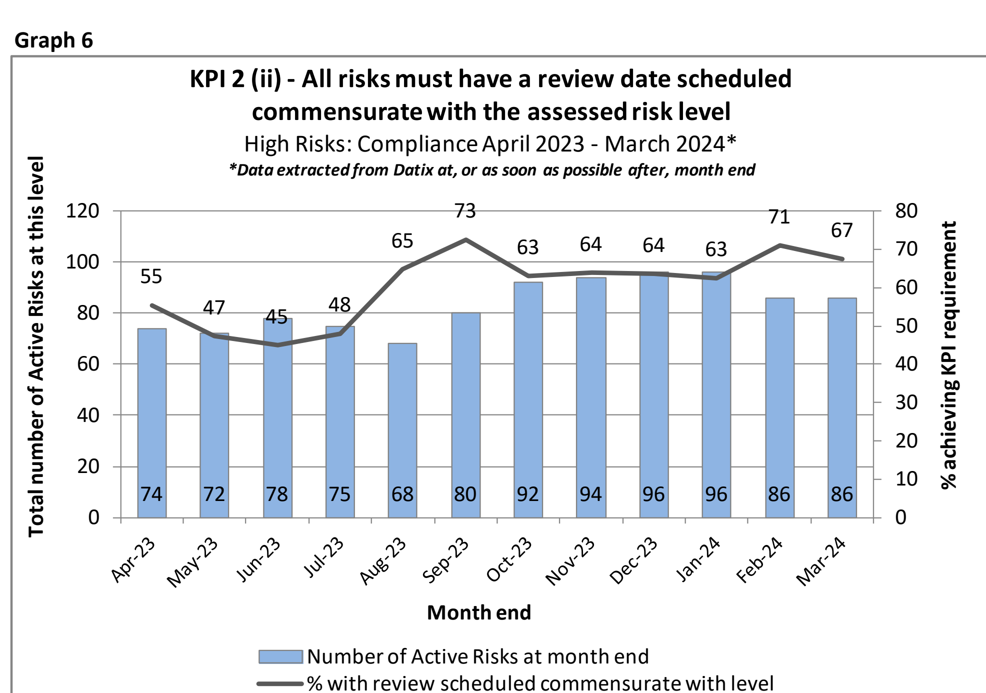
Commentary: With the exception of March 2024, performance has been stable over the past 6 months. This may be attributed to increased levels of awareness around the importance of regular and timely risk review and update, and explicit discussions about risks.

The following KPIs (2i) to (2 v) relate to risks having review dates commensurate with the assessed risk level. The review frequencies are provided for reference in Datix next to the key dates fields. They are as follows:
Very High: 25 at least monthly
High: 15 - 20 at least quarterly
Moderate: 8 -12 at least 6 monthly
Low: 4 - 6 at least annually
Very Low: 1 - 3 at least annually

Graph 5

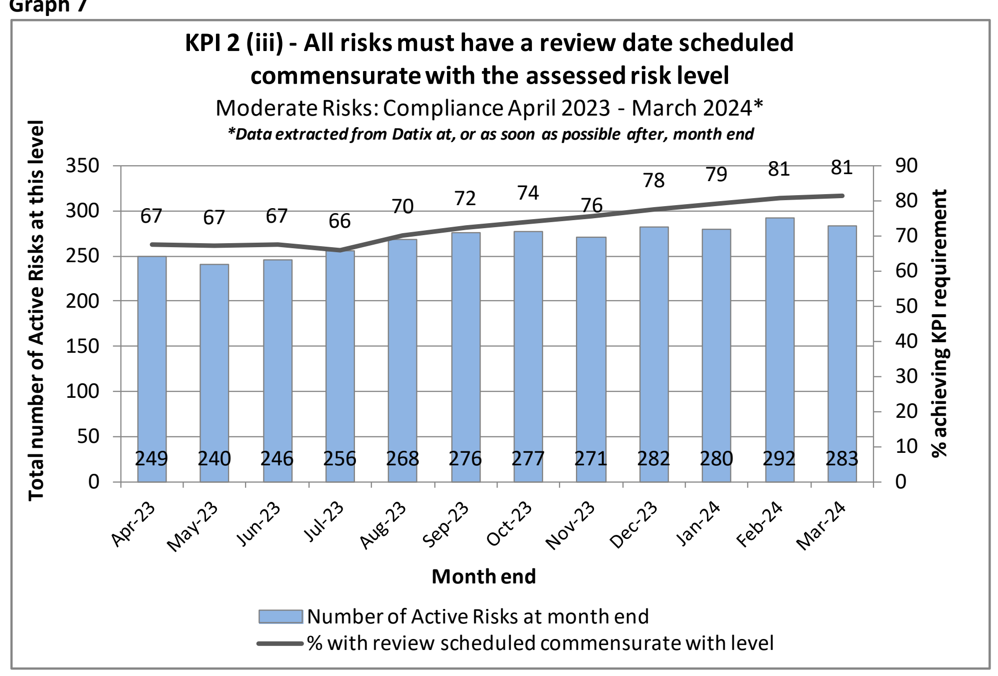


Graph 6

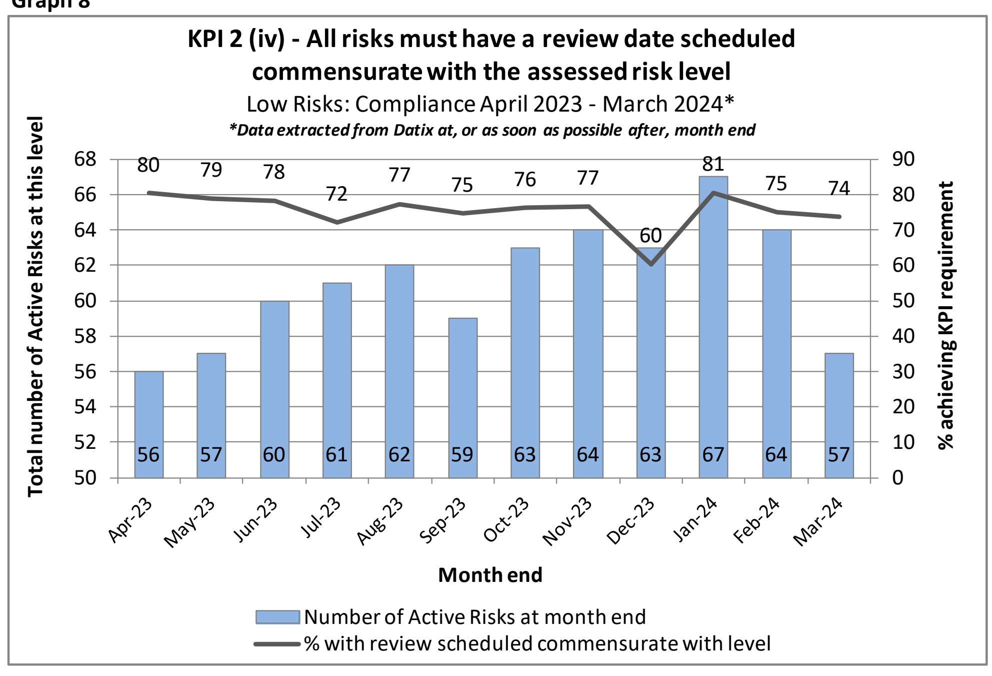


Commentary: While there has been some improvement in performance over the last year, there is considerable room for further development in this area. The importance of adhering to the timescale guidance provided in Datix when setting next review dates will continue to be reinforced to staff during training and risk conversations

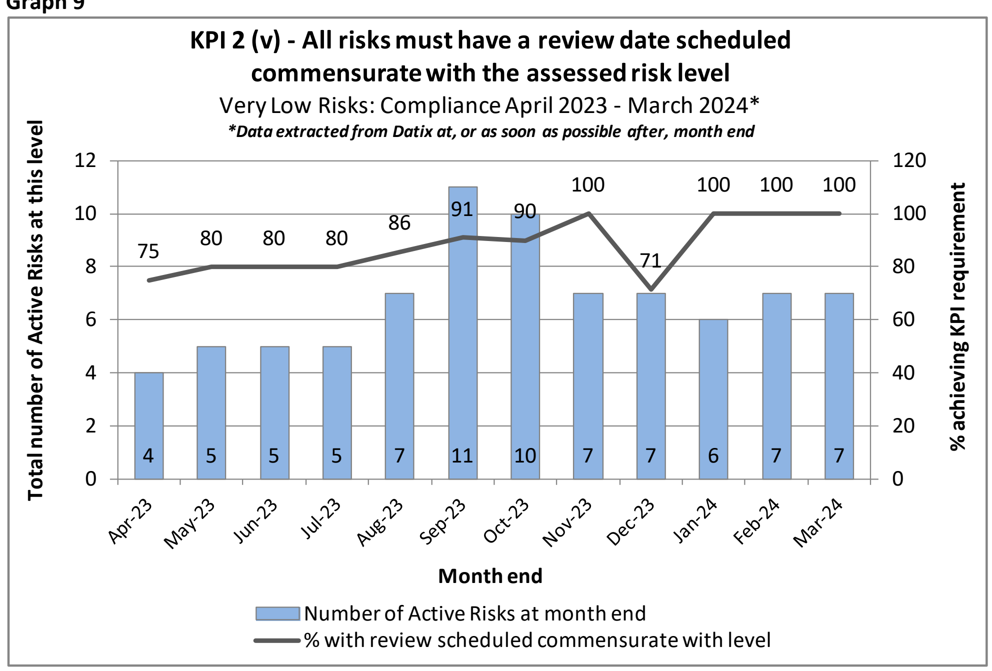
Graph 7



Graph 8



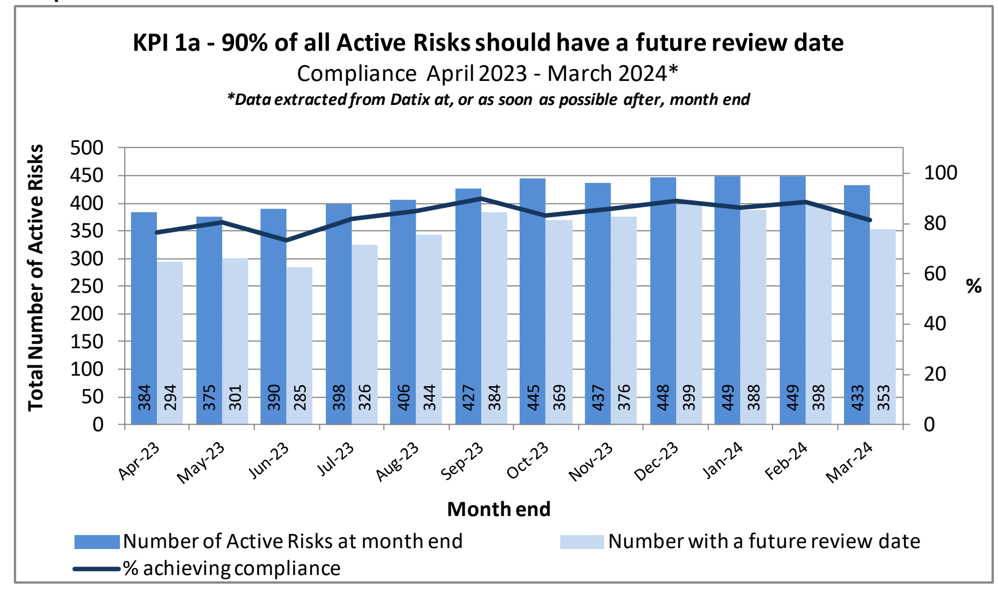
Graph 9



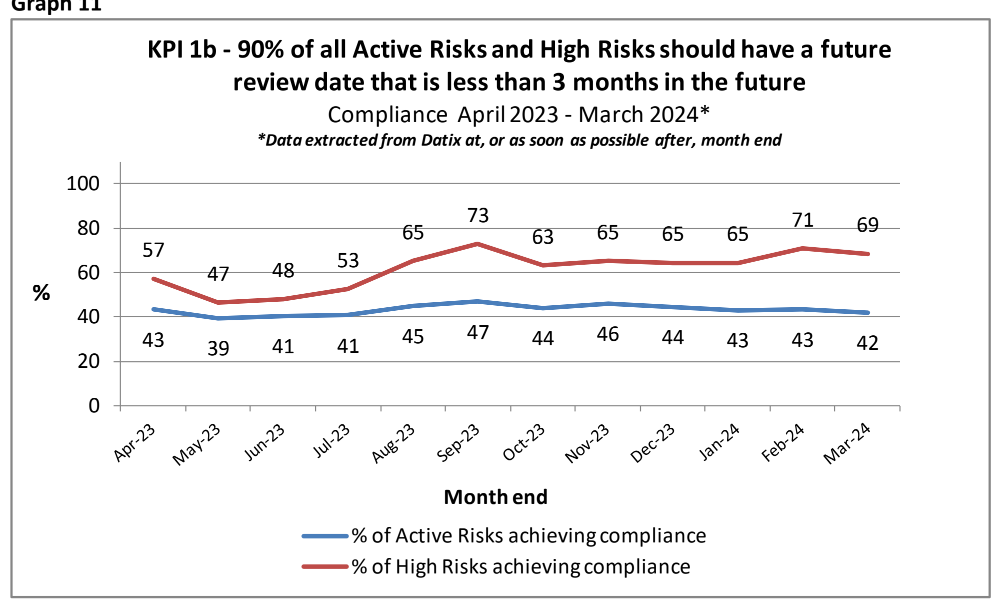
NEW

The following KPIs were proposed to the Risks and Opportunities Group as part of the developing 'Risk Management - Operational Guidance - Working with the Datix Risk Summary Dashboard'. They are presented for illustrative purposes, and to show an alternative expression and presentation of the information.

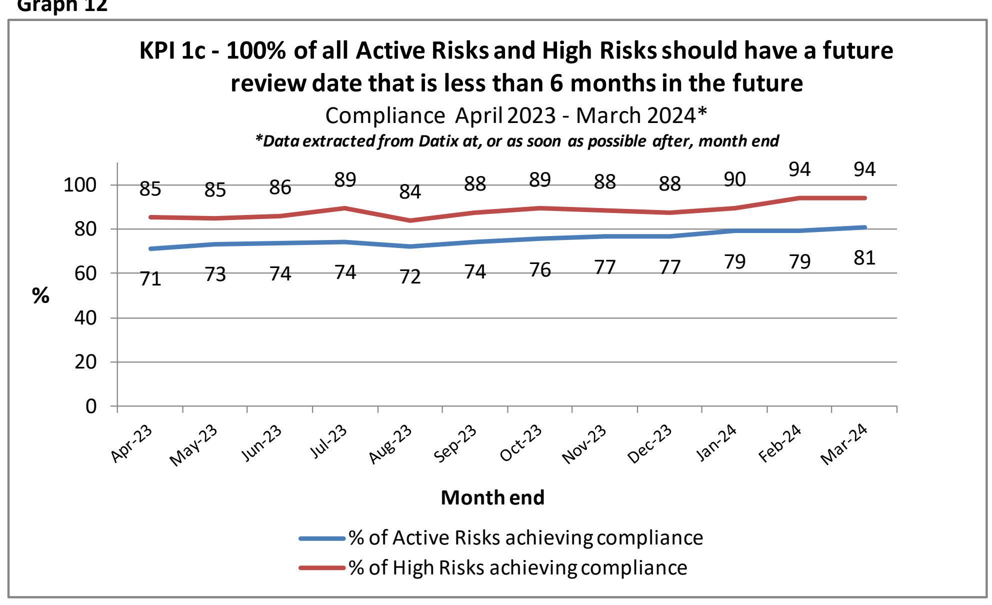
Graph 10



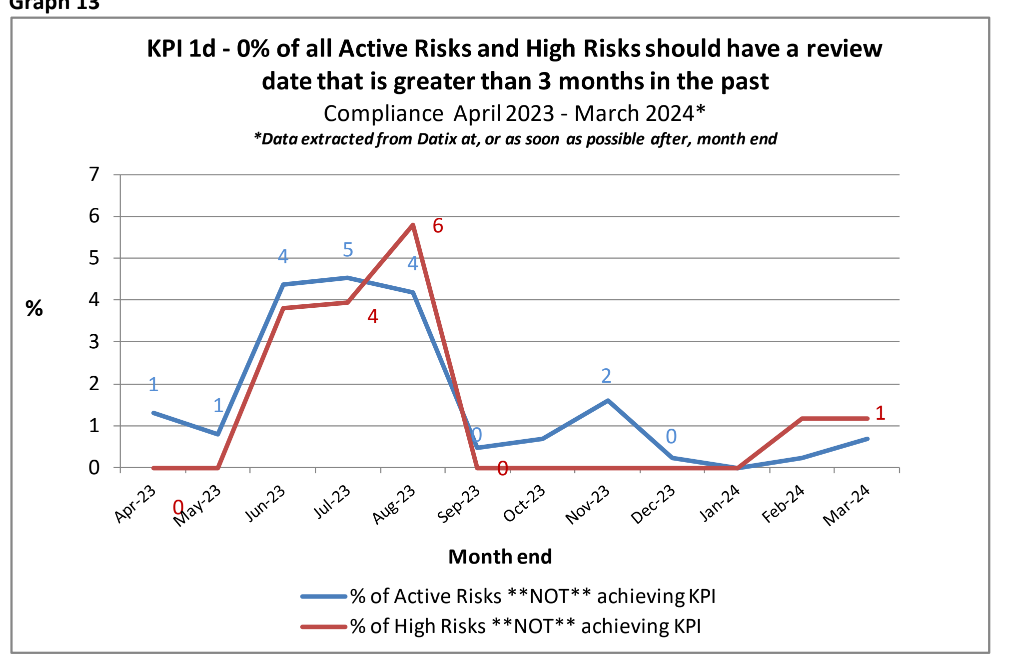
Graph 11



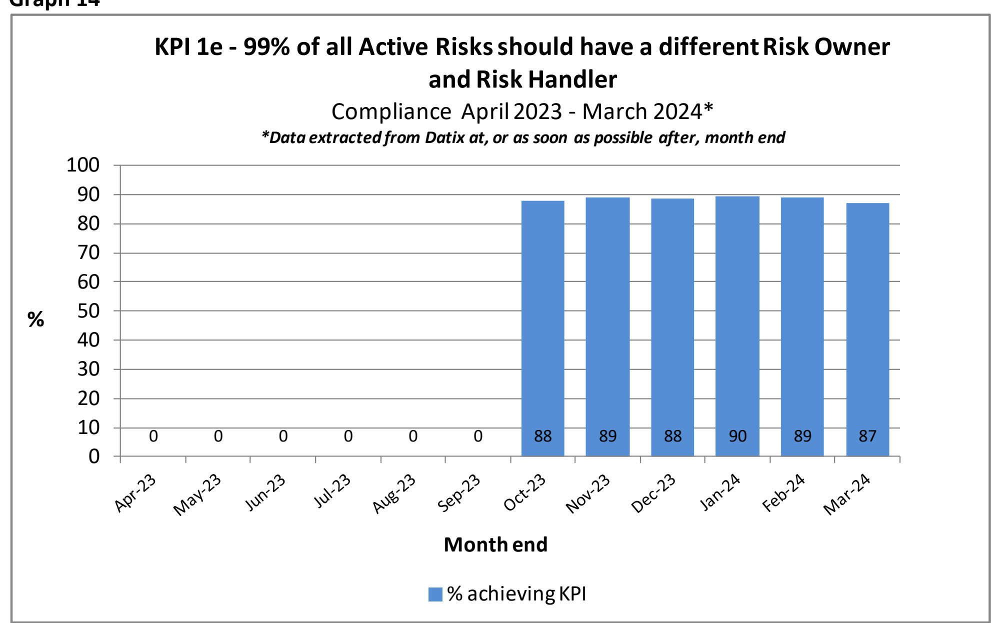
Graph 12



Graph 13

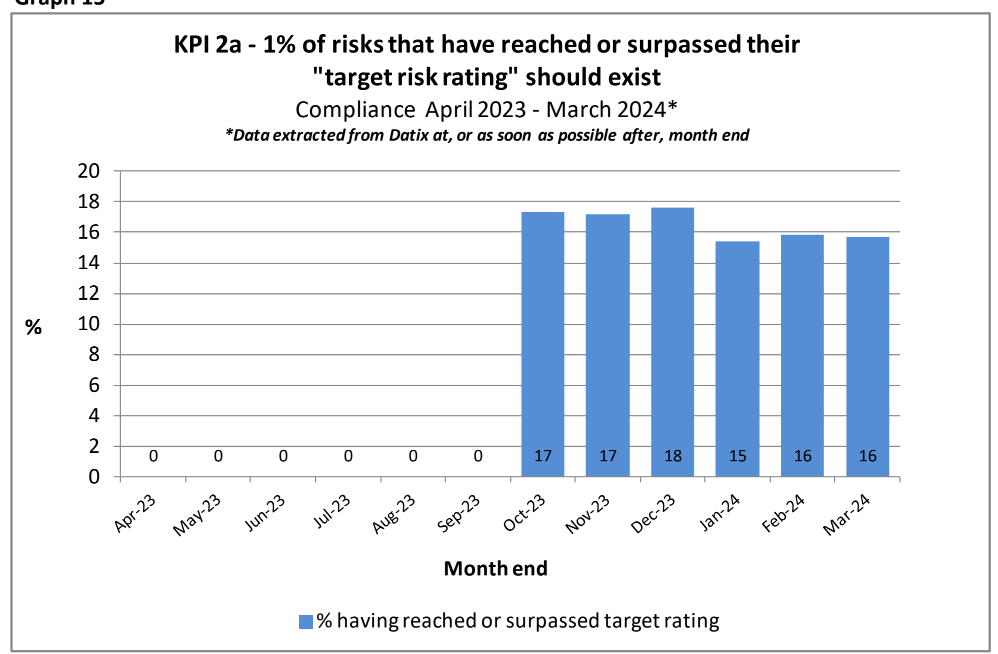


Graph 14



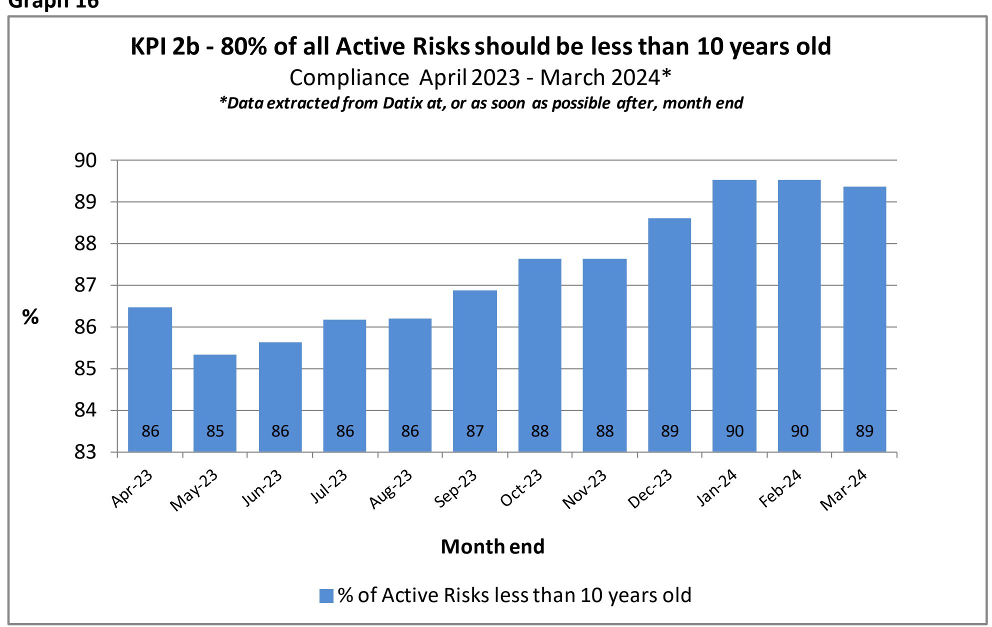
Commentary: The functions of the risk owner and handler are different. The data indicate there is scope to improve the allocation of these discrete roles. This will continue to be highlighted during training.

Graph 15



Commentary: The data show, that at time of data extraction, a significant number of risks (69) had achieved or surpassed the target risk rating. Supportive discussions have started with the individuals and teams concerned, to consider any risks where the “current risk rating” is equal to or less than the “target risk rating” and to determine why the risk remains active, if it can be closed immediately, or following a period of monitoring.

Graph 16



Commentary: While the data largely show compliance, it is important that our risk profile is contemporaneous, reflecting the current operational challenges. Discussions are ongoing with the owners of risks that are more than 10 years old. For those risks that have been opened the longest, the risk owner is invited to consider the “Likelihood of Occurrence” rating against the time the risk has been open. The longer a risk has been opened, without becoming an issue, it could be argued that it is less likely to materialise. It is recognised external factors can influence changes in the likelihood and this should considered.

NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**16 May 2024**
Title:	**Risks and Opportunities Group Statement of Assurance 2023/24**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Report Author:	**Pauline Cumming, Risk Manager**

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Local Policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This paper provides the outcome of a self-assessment exercise undertaken by the Risks and Opportunities Group which is a component part of the Group's production of its first annual statement of assurance.

2.2 Background

While the Group does not formally sit under this Committee in terms of the Board Committee structure, its Terms of Reference require it to periodically report to the Committee on recommendations or considerations from its role and remit, and on progress on its work plan. At this point in the Group's evolution, it was felt there would be value in providing assurance on how these requirements are being fulfilled. Also, the self assessment gave members an opportunity to reflect and consider ways to improve the Group's effectiveness. Combined, these processes seek to provide assurance on the risk management framework and that any potential improvements and developments will be identified and appropriately actioned.

2.3 Assessment

Statement of Assurance

The Statement summarises the business covered by the Risks and Opportunities Group during 2023/2024 and is provided at Appendix 1.

Self-Assessment questionnaire (completed by members and attendees)

The self-assessment comprised several effectiveness-related questions, where a scaled 'Strongly Agree/Strongly Disagree' response to each question was sought. Textual comments were also invited, for respondents to provide direct feedback.

Seven members or regular attendees completed the questionnaire. In general there was a positive assessment from respondents. On membership and dynamics, the majority of respondents indicated that the Group was provided with sufficient membership, authority and resource to perform its role effectively and independently, and that it exercises effective scrutiny and challenge. The agenda was felt to be well managed and covered the topics within its terms of reference. There was a strong indication that members can express their opinions openly and constructively.

While there was agreement that the membership is appropriate and members are largely clear on their role, the rates of attendance indicate the need to further explore this aspect. Some members had not attended a meeting this year, or had attended very few, which meant lack of a 'clinical voice'. Given that some of our highest risks sit with the clinical services, the Group may be missing this vital perspective. This could also apply to the 'Opportunities' part of the Group's remit.

Areas of mixed opinions suggesting the need for further discussion include:

- whether the group provides an appropriate level of scrutiny and is provided with evidence to ensure the corporate risks are being managed to an acceptable level;
- members' confidence that the delegation of responsibilities from the Executive Directors Group is operating effectively as part of the overall governance framework.

The latter may be indicative of the Group's level of maturity as it refines its remit in order to adopt an agile response to organisational requirements. This links to expectations, and possibly to its impact within the governance structure. One suggested action to further improve effectiveness, was to consider formalising the Group as part of the Board Committee structure, to sit formally under the Audit & Risk Committee, and to extend the membership to include a Non-Executive 'champion'.

There was an appreciation of the opportunity the Group gives to bring together the 'Associate and Deputy' cohort of the senior leadership team, allowing learning to take place, and a sense that, with refinement, which will follow as the Group matures, it is a useful and productive body in which to participate.

Members will consider and consult with stakeholders on the areas identified for improvement. The suggestion to review the Group's position in terms of the Board Committee structure, requires further deliberation and will be taken forward in discussion with the Executive Directors and the Board.

2.3.1 Quality, Patient and Value-Based Health & Care
N/A

2.3.2 Workforce
N/A

2.3.3 Financial
N/A

2.3.4 Risk Assessment / Management
The self-assessment offers assurance that the Group has reflected on its performance during 2023/2024, and is committed to taking the necessary improvement actions.

2.3.5 Equality and Diversity, including health inequalities and Anchor Institution ambitions
This paper does not relate to the planning and development of health services, nor any decisions that would significantly affect groups of people. Consequently, an EQIA is not required.

2.3.6 Climate Emergency & Sustainability Impact
This paper does not raise, issues relating to climate emergency and sustainability.

2.3.7 Communication, involvement, engagement, and consultation
This paper reflects the input of the Risks and Opportunities Group.

2.3.8 Route to the Meeting
Shirley- Anne Savage, Associate Director for Risk & Professional Standards on 18/04/24
Margo McGurk, Director of Finance & Strategy on 25/04/24

2.4 Recommendation

- **Assurance** – what actions members would wish to see presented to EDG

3 List of appendices

Appendix 1, Annual Statement of Assurance for the Risks and Opportunities Group

Report Contact
Pauline Cumming
Risk Manager
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ANNUAL STATEMENT OF ASSURANCE FOR NHS FIFE RISKS AND OPPORTUNITIES GROUP

1. Purpose

1.1 To provide the NHS Fife Audit and Risk Committee with the assurance that the NHS Fife Risks and Opportunities Group has fulfilled its purpose and remit during 2023/2024.

1.2 The Risks and Opportunities Group has been delegated the responsibility by the Executive Directors Group (EDG) to progress the activities described below, which largely reflect the Group's Terms of Reference, and to prepare regular formal reports on progress, and seek approval for proposals from the Group. The purpose of the Risks and Opportunities Group (ROG) is to support and embed an effective risk management framework and culture through:

- Promoting leadership to ensure the organisation gives risk management the appropriate priority;
- Contributing to the development and implementation of the risk management framework to ensure processes are in place and operating effectively to identify, manage, and monitor risks across the organisation;
- Identifying risks and opportunities in relation to delivery of the NHS Fife Population Health and Wellbeing Strategy and escalating to the EDG as appropriate;
- Assessing risks, opportunities, issues and events that arise and responding accordingly, making appropriate recommendations on potential impact upon the Board's Risk Appetite position;
- Horizon scanning for future opportunities, threats and risks linked to the delivery of NHS Fife's strategic priorities;
- Considering the external environment for review of risks and opportunities in the context of national directives;
- Ensuring continuous improvement of the organisation's control environment;
- Creating a collective and enabling approach to risk controls and actions, supporting the sharing of best practice amongst teams and senior leaders.

1.3 This assurance statement summarises the business covered during 2023/2024.

2. Membership

2.1 During the financial year to 31 March 2024, membership of the ROG comprised:

Member	Designation
Lynn Barker	Director of Nursing, Fife Health & Social Care Partnership (HSCP)
Gemma Couser	Associate Director of Quality & Clinical Governance, NHS Fife (from Jan 2024)
Pauline Cumming	Risk Manager, NHS Fife
Simon Fevre	Staff side Co Chair, HSCP Local Partnership Forum (LPF) (Retired in October 2023)
Fiona Forrest	Deputy Director of Pharmacy, NHS Fife
Susan Fraser	Associate Director of Planning & Performance, NHS Fife

Alistair Graham (Chair)	Associate Director, Digital & Information, NHS Fife
Kirsty MacGregor	Associate Director of Communications, NHS Fife
Gillian MacIntosh	Head of Corporate Governance & Board Secretary, NHS Fife
Dr Iain MacLeod	Deputy Medical Director, Acute, NHS Fife
Dr Rishma Maini	Consultant, Public Health, NHS Fife
Maxine Michie	Deputy Director of Finance, NHS Fife
Belinda Morgan	General Manager, Emergency Care Directorate, Acute Services Division, NHS Fife
Frances Quirk	Assistant Research, Knowledge & Information Director, NHS Fife
Jimmy Ramsay	Estates Manager, Compliance, NHS Fife
Kevin Reith	Deputy Director of Workforce, NHS Fife
Nicola Robertson	Director of Nursing, Corporate, NHS Fife
Shirley-Anne Savage	Associate Director of Quality & Clinical Governance, NHS Fife (until Dec 2024). Associate Director for Risk and Professional Standards, NHS Fife (from Jan 2024)
Audrey Valente	Chief Financial Officer, Fife Council
Amanda Wong	Director of Allied Health Professions, NHS Fife
Doreen Young	Head of Practice & Professional Development, NHS Fife
Attendee	**Designation**
Barry Hudson	Regional Audit Manager
Avril Sweeney	Risk Compliance Manager, Fife HSCP
Rhona Waugh	Head of Workforce Planning & Staff Wellbeing, NHS Fife

2.2 The ROG may invite other colleagues to attend meetings to contribute to particular topics as required. Attendees and deputies are recorded in the individual notes of each meeting and in the attendance schedule set out at Appendix 1.

3. Meetings

3.1 The Group met on 6 occasions during the financial year to 31 March 2024, on the undernoted dates:

- 6 April 2023
- 8 June 2023
- 5 August 2023
- 3 October 2023
- 5 December 2023
- 6 February 2024

4. Business

4.1 For the period under review, to support delivery of its annual work plan, the agenda considered the Corporate Risk Register and Operational Risk at alternate meetings.

Standing Agenda Items

4.2. Risk Register and Assurance

In the Corporate Risk area, the Group received updates on the corporate risks aligned to each of the Board's governance committees. Members took the opportunity to reflect on feedback as the risks have developed through their presentation by Executive risk

owners, and following consideration by the committees, particularly in relation to the usefulness and format of deep dive reviews.

Assurance Levels

The governance committees requested a specific review on the use of the "level of assurance" listed within the Committee Assurance Principles routinely provided with the Corporate Risk Register reports. Following agreement at EDG and endorsement by the Audit and Risk Committee in June 2023, the 4 - level assurance model, used by Internal Audit, was incorporated within the Assurance Principles.

The Deep Dive review template was also updated to incorporate the assurance levels, requiring the risk owner to provide a level of assurance to the Committee as part of the deep dive's creation or review of a previous deep dive.

These developments were implemented from July 2023 and have added consistency to our reporting. The use of the assurance levels continues to evolve, as we further seek to enhance the evidence to substantiate the level of assurance being offered.

4.3 **In Year Risk Rating Improvement**

The Group also reviewed another aspect of the Corporate Risk Register, which involved the use of a time-limited improvement target for the risk rating.

Given the complexity of corporate risks, the levels of inherent risk associated with some of the risks and the confusion of changing current risk rating targets for the in-year target, it was agreed to remove the current in-year prediction and match the overarching risk target rating with a more meaningful and realistic metric i.e. an expected date of achievement.

While mindful of the challenges to mitigating corporate risk and reducing their ratings, in a short period of time, the ROG continues to consider the risk scores, noting that there have been minimal changes to most of the risk scores over the last year. The Internal Audit team have recommended that the Group further develops its focus and feedback on this aspect of the risks in the year ahead.

4.4 **Corporate Risk Review Cycle**

In seeking to provide a balance of effective Corporate Risk review, the ROG considered how to establish a standard frequency that recognised the need for Committee assurance on both the regularity of risk review and timely risk updates. As the governance committees meet six times a year, there was an opportunity to rotate the corporate risk review frequency over these six meetings to provide assurance, while supporting the requirement for efficiency. It was agreed that while Corporate Risk owners can review and update risks at any time, they would review and update where necessary their total set of risks at least every four months.

4.5 **Deep Dive Reviews**

Corporate Risk Deep Dive reviews are an important component of our risk assurance reporting arrangements. At each meeting, the ROG received an update on the schedule of Deep Dives, and related developments.

One characteristic of a deep dive review is that it should be carried out at specific points during the life-cycle of the risk. Based on our experience and learning over the last year, and following discussion at the Audit and Risk Committee Development

Session on 12 October 2023, the ROG made recommendations to EDG on 2 November 2023 on triggers for reviews. In summary these are:

Proposal of a New Corporate Risk:
A potential risk is identified to the delivery of strategic priorities

Deteriorating Corporate Risk:
Current risk level increased from initial / risk level exceeds risk appetite

Static Risk:
There is stasis in the risk beyond the target date for achieving the target risk rating

Proposed De-escalation or Closure of Corporate Risk:
A risk has achieved or surpassed its planned risk target

Following EDG's approval of the recommendations, the Audit and Risk Committee endorsed this development at its meeting on 13 December 2023. The proposed approach was shared with the other governance committees in January 2024 with the intention to implement during Quarter 2, 2024.

Deep Dive Developments
To enhance the assurance that can be taken from deep dives, going forward the ROG will consider Internal Audit recommendations to include:

- an assessment as to the impact of management actions on the target score;
- a focus on controls, with explicit assurance and conclusion on their effectiveness;
- an assessment of the proportionality of proposed actions; and
- external and internal factors associated with risks and their potential influence

4.6 **Review of the Risk Assessment Matrix**

The matrix used in NHS Fife is based on the NHS Scotland matrix which was originally developed in 2008.

The ROG has identified the need to further promote the matrix locally as a tool to support risk assessment and decision making and will continue to encourage its use. The group also discussed the need to update the matrix to ensure descriptors are current and comprehensive in scope and terminology. For example, possibly expand to include Environmental Sustainability & Climate Change, and Health Inequalities.

Similar considerations have taken place in other NHS Boards. At a national meeting with Healthcare Improvement Scotland (HIS) on 1 February 2024 in which NHS Fife participated, it was agreed to review the national matrix and expand and modernise the content. A short life working group will be set up to take forward this work.

The ROG has agreed to let the national work emerge and conclude, after which it will reflect on the NHS Fife matrix.

4.7 **Risk Description**

The ROG has recognised the importance of ensuring that risks are clearly and succinctly described, and reflect the current organisational challenges. Descriptions should express the risk, the cause, and the consequences. Training for staff, on "how to write a risk", will be provided in the year ahead.

5. Performance

5.1 Operational Risk Management - Development of a Risk Summary Dashboard

It is recognised that the Datix system provides a well used management tool for the individual management of risk, as well as recording of incidents, complaints, claims, safety alerts, and latterly, business continuity data.

In seeking to fulfil its remit to support operational risk management and enhance the value of the data within Datix, over the last year, the ROG has considered and contributed to the development of a Risk Summary Dashboard. This has been achieved by placing a reporting tool (MicroStrategy) over the data source. The Dashboard seeks to support risk owners and handlers to move through activities detailed within a developing Operational Guidance document. These include:

- Mitigation of higher rated risks;
- Reviewing risk history and recognising that the duration of a risk's existence can offer insight into the effectiveness of management and categorisation of risks;
- Considering risks that have been in existence, without becoming an issue, for 5 years or more should have a likelihood score of "unlikely" or "remote";
- Considering the "current risk rating" and proximity to the "target risk rating" to determine if further mitigation, management and review is required, or risks that have reached or surpassed their target could be monitored or closed.

The Audit and Risk Committee and EDG received demonstrations of the Dashboard in October and November 2023 respectively.

The ROG has recommended that the Dashboard be made available and its use promoted to support our operational risk management approach, and align with the Risk Management Framework. A plan to support Dashboard implementation will be taken forward through the remit of the ROG during 2024.

5.2 Key Performance Indicators (KPIs)

The Group has considered a set of KPIs associated with operational risk which demonstrate active risk management. These include:

- 90% of all Active Risks should have a future review date
- 90% of all Active and High Risks should have a future review date that is less than 3 months in the future
- 100% of all Active and High Risks should have a future review date that is less than 6 months in the future
- 0% of all Active and High Risks should have a review date that is greater than 3 months in the past
- 1% of risks that have reached or surpassed their "target risk rating" should exist
- 80% of all Active Risks should be less than 10 years old

An initial KPI report will be provided to the Audit and Risk Committee in May 2024.

6. Horizon Scanning

The ROG continues to consider opportunities, particularly in relation to delivery of the NHS Fife Population Health and Wellbeing Strategy. Realistic Medicine principles have been identified as an area of focus for the year ahead.

7. Governance

At each meeting the ROG reviews progress against the Workplan, considers issues for escalation and receives reports on any other relevant business.

The ROG has reported on its work to the Audit and Risk Committee in June, August and December 2023, and in March 2024.

8. Developments and Emerging Business

8.1 **Risk Management Framework**

The updated Risk Management Framework was approved by the NHS Fife Board in September 2023. The intention was to also update the related Risk Register / Risk Assessment Policy GP/R7. In re-drafting the policy, there was considerable duplication with the Framework and following consultation with Internal Audit, and other key stakeholders, it was determined that a separate policy is not required as key elements of the policy not already covered will be added to the Framework.

This approach was supported by the ROG on 5 December 2023 and endorsed by the Audit and Risk Committee on 13 December 2023. The revised Framework and a Delivery Plan to support implementation are currently being finalised and will be submitted to the Audit and Risk Committee and the Board in May 2024.

8.2 **Risk Appetite**

The Board's Risk Appetite was set in July 2022, and considered as part of the update to the Risk Management Framework in September 2023. It is recognised that risk appetite is not static and must be reviewed and adjusted to reflect changes in the internal and external environment that may affect our risk profile or strategy. To this end, a Board Development Session on Risk Appetite is scheduled for 8 April 2024, and it is expected that elements of the Risks & Opportunities Group's work will be informed through the Board's discussions at that session.

9. Self-Assessment

9.1 The Group has undertaken a self-assessment of its own effectiveness, using a questionnaire considered and approved by the Group's Co - Chairs.

Seven members or regular attendees of the Group completed the questionnaire and provided the following key feedback:

In relation to membership and dynamics, the majority of respondents indicated that the Group was provided with sufficient membership, authority and resource to perform its role effectively and independently, and that there is effective scrutiny and challenge from the Group, including on matters that are critical or sensitive. Responses indicate the Group's agenda is well managed and ensures that all topics within its terms of reference are appropriately covered. There was a strong indication that members are able to express their opinions openly and constructively.

While there was agreement that the Group's membership is appropriate and members are largely clear on their role and how to contribute to the Group's overall effectiveness, the rates of attendance provided in Appendix 1 highlight a need to further explore this aspect. These show that some members have not attended a meeting this year, or have attended very few, which means the Group lacks the 'clinical voice'. Given that some of our highest risks sit with the clinical services, the Group may be missing this vital perspective. This could also apply to the 'Opportunities' part of the Group's remit,

as it could be said that clinical services are where the greatest performance and financial efficiency gains are required.

Areas on which there were mixed opinions indicating the need for further consideration and discussion include:

- whether the group provides an appropriate level of scrutiny and is provided with assurance to ensure the corporate risks are being managed to an acceptable level;
- members' confidence that the delegation of responsibilities from the Executive Directors Group is operating effectively as part of the overall governance.

The latter may relate to the fact that the Group is still relatively new in terms of its development and refining its remit and outputs. This links to the earlier comment on clarity of role and expectations, which might also be applied to the overall impact of the Group within the governance structure.

Following on from the above, members were invited to consider actions that could be taken to further improve the Group's effectiveness in respect of delivering its remit. One suggestion was that it might be helpful to consider formalising the Group as part of the Board Committee structure, to sit formally under the Audit & Risk Committee, and to extend the membership to include a Non-Executive 'champion'. In other feedback, one respondent appreciated the opportunity the Group gives to bring together the 'Associate and Deputy' cohort of the senior leadership team. They had learned a lot from the Group's work and thought, with refinement, which will naturally come as it continues its work, it is a useful and productive body in which to participate.

Members will consider and consult with key stakeholders on the areas identified for improvement. Suggestions around reviewing the Group's position in terms of the Board Committee structure, require further deliberation and will be taken forward in discussion with the Group, Executive Directors and the Board.

10. Conclusion

10.1 As Co-Chairs of the Group during financial year 2023-2024, we are satisfied that the approach, the frequency of meetings, the scope of the business undertaken and the range of attendees at meetings of the Group has allowed us to fulfil our remit. As a result of the work undertaken during the year, we can confirm that adequate and effective governance arrangements were in place in the areas under our remit during the year.

10.2 We can confirm that that there were no significant control weaknesses or issues at the year-end which the group considers should be disclosed in the Governance Statement, as they may have impacted financially or otherwise in the year or thereafter.

10.3 We commend the commitment and enthusiasm of fellow members of the Group and all attendees. We thank all staff who have prepared reports and participated in meetings.

Signed: Date: dd /mm /2024
Signed: Date: dd /mm /2024

On behalf of the NHS Fife Risks and Opportunities Group

Appendix 1
NHS Fife Risks & Opportunities Group Attendance Schedule

1 April 2023 to 31 March 2024

Member	**Designation**	**4 April 2023**	**6 June 2023**	**8 Aug 2023**	**3 Oct 2023**	**5 Dec 2023**	**6 Feb 2024**
Lynn Barker	Director of Nursing, Health & Social Care Partnership (HSCP)	x	x	x	✓	x	x
Gemma Couser	Associate Director of Quality & Clinical Governance (from Jan 2024)						✓
Pauline Cumming	Risk Manager	✓	x	✓	x	✓	✓
Simon Fevre	Staff side Co Chair HSCP Local Partnership Forum (LPF)	✓	x	x	x		
Fiona Forrest	Deputy Director of Pharmacy	x	x	✓	x	x	x
Susan Fraser	Associate Director of Planning and Performance	✓	✓	✓	x	✓	✓
Alistair Graham(Chair)	Associate Director, Digital & Information (D&I)	✓	✓	x	✓	✓	✓
Kirsty MacGregor	Associate Director of Communications	✓	✓	✓	✓	x	x
Gillian MacIntosh	Head of Corporate Governance & Board Secretary	x	✓	✓	✓	✓	x
Dr Iain MacLeod	Deputy Medical Director	✓	✓	x	x	x	x
Dr Rishma Maini	Consultant, Public Health	x	✓	✓	✓	x	x
Maxine Michie	Deputy Director of Finance	x	✓	x	✓	✓	✓
Belinda Morgan	General Manager, Emergency Care Directorate, Acute Services Division	✓	x	✓	✓	x	x
Frances Quirk	Assistant Research, Knowledge & Information (RIK) Director	x	✓	✓	x	✓	✓
Jimmy Ramsay	Estates Manager, Compliance	x	x	✓	x	x	✓
Kevin Reith	Deputy Director of Workforce	x	✓	✓			
Nicola Robertson	Director of Nursing, Corporate	x	x	x	✓	x	✓
Shirley-Anne Savage	Associate Director of Quality & Clinical Governance Associate Director for Risk and Professional Standards (from Jan 2024)	✓	✓	✓	✓	✓	✓
Audrey Valente	Chief Financial Officer, Fife Council	✓	x	x	✓	x	x
Amanda Wong	Director of Allied Health Professions	x	x	x	x	x	x
Doreen Young	Head of Practice & Professional Development	✓	x	✓	✓	x	x
In attendance	**Designation**						
Barry Hudson	Regional Audit Manager	✓	x	✓	✓	x	✓
Avril Sweeney	Risk Compliance Manager, HSCP					✓	x
Rhona Waugh	Head of Workforce Planning & Staff Wellbeing	✓			✓	✓	x

✓ attended
x did not attend

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**16 May 2024**
Title:	**Update to Scheme of Delegation**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Kevin Booth, Head of Financial Services & Procurement**

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Local policy

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

- Effective

2 Report summary

2.1 Situation

A review has been undertaken into the Boards current limits to authorise orders and commit expenditure in order to ensure that the highest value orders are approved by the most senior, accountable individuals within their Directorates, with other directorate authorisers retaining appropriate albeit lower authorisation limits.

2.2 Background

The Boards Standing Financial Instructions (SFI's), contained within the NHS Fife Code of Corporate Governance, exist to ensure adequate controls are in place for the committing and payments of funds on behalf of NHS Fife. The limitation of the levels of authority are set out within the SFI's and are further documented within the Financial Operating Procedures (FOPS) to ensure that effective controls can be applied to the financial transactions processed by the Procurement and Accounts Payable Teams.

An extract of the current FOPS (December 2023) is provided below:

Delegated Authority to Authorise Orders and Commit Expenditure

Designation	Limit	Additional Authorisation
Board	£2,000,000 - £5,000,000	If above the limit, then approval needs to be sought from the Scottish Government
Chief Executive	Up to £100,000 Greater than £100,000 up to £1,000,000 Greater than £1,000,000 up to £2,000,000	- Also countersigned by Director of Acute Services, Director of Health & Social Care or Director of Finance As above and authorised by the Director of Finance
Director of Acute Services	Up to £100,000 Greater than £100,000 up to £1,000,000 Greater than £1,000,000 up to £2,000,000	- Also countersigned by Chief Executive, Director of Health & Social Care or Director of Finance As above and authorised by the Director of Finance
Director of Health and Social Care	Up to £100,000 Greater than £100,000 up to £1,000,000 Greater than £1,000,000 up to £2,000,000	- Also countersigned by Chief Executive, Director of Acute Services or Director of Finance As above and authorised by the Director of Finance
Corporate Directors	Up to £100,000 Greater than £100,000 up to £1,000,000	- Also authorised by Chief Executive, Director of Acute Services, Director of Health and Social Care or Director of Finance
Other Designated Ordering Officers	Up to £100,000	Subject to assigned individual limits

The delegated limits set out, are in turn used to inform the approval limits used both within Procurement and Accounts Payable. Both services currently maintain separate registers of delegated members of NHS Fife and their authorisation limits to which they can approve orders and commit expenditure.

2.3 Assessment

The review carried out on the highest authorisation limits across Procurement and Accounts Payable, identified that there are inconsistencies between the authorisation limits between levels of senior staff across the organisation. In particular a number of senior staff currently have the same authorisation limits as the EDG members who they are accountable to in their Directorate. The existing extract from the FOPS currently permits both Corporate Directors and un-named other ordering officers to individually approve orders up to £100,000. This has led to a number of senior staff being provided with the ability to authorise expenditure potentially higher than would be anticipated in other areas of the Board.

In order to progress a resolution to the issues identified a revised extract to the current FOPS is planned below:

Delegated Authority to Authorise Orders and Commit Expenditure

Designation	Limit	Additional Authorisation / Notes
Board	£2,000,000 - £5,000,000	If above the limit, then approval needs to be sought from the Scottish Government
Chief Executive	Up to £100,000 Greater than £100,000 up to £1,000,000 Greater than £1,000,000 up to £2,000,000	- Countersigned by relevant other designated Corporate Officer Countersigned by relevant other designated Corporate Officer & Director of Finance
Director of Finance	Up to £100,000 Greater than £100,000 up to £1,000,000 Greater than £1,000,000 up to £2,000,000	- Countersigned by relevant other designated Corporate Officer Countersigned by relevant other designated Corporate Officer & Chief Executive
Director of Property & Asset Management	Up to £100,000 Greater than £100,000 up to £1,000,000 Greater than £1,000,000 up to £2,000,000	- Countersigned by Director of Finance Countersigned by Director of Finance & Chief Executive
Other Designated Corporate Officers	Up to £100,000	Director of Acute Services Director of Health & Social Care Medical Director Director of Public Health Director of Nursing Director of Workforce Director of Pharmacy Director of Digital & Information Deputy Director of Finance Chief Financial Officer H&SCP Charity Director

Other Designated Ordering Officers	Up to £50,000	Subject to assigned individual limits

The Designated Limit of up to £100,000 would be restricted to those named, designated corporate officers who hold ultimate responsibility for their Directorate, ensuring that they will remain accountable for the highest items of expenditure. Other designated ordering officers who are accountable to those who hold Directorate responsibility will all be restricted to the maximum limit of £50,000 and at the discretion of the designated corporate officer, who ultimately approves the ordering limits for their directorate.

Any orders greater than £100,000 and up to £1,000,000 would need to be approved by the relevant designated corporate officer and the Director of Finance. Whilst any expenditure greater than £1,000,000 and up to £2,000,000 would additionally require the approval of the Chief Executive.

Once the revised extract is updated in both the SFI's and the FOPS the authorisation levels within Procurement will be amended for all the designated corporate officers and any other existing ordering officers with individual limits of between £50,000 and £100,000 to ensure they are aligned.

Subsequently a review can then be carried out of the authorisation limits of up to £50,000 with each designated corporate officer to ensure that they approve the authorisation limits for staff accountable to them and any other senior staff within their Directorate.

In order to prevent any inconsistencies, when comparing the Procurement and Accounts Payable limits, the Accounts Payable register of authorisation levels will be updated to mirror that of the Procurement Department to ensure consistency moving forward. Any future amendments to the Procurement authorisation limits will automatically be updated on the Accounts Payable register.

An amendment has been provided to the SFI's as part of the 2024 annual review of the Code of Corporate Governance to incorporate the revised authorisation requirements for any orders placed between £100,000 and £1,000,000.

2.3.1 Quality, Patient and Value-Based Health & Care

Appropriate and consistent levels of authority to authorise orders and commit expenditure support the Boards investment in Quality, Patient and Value-Based Health & Care.

2.3.2 Workforce

The revised authorisation limits for both Procurement and Accounts Payable will be communicated to all applicable members of staff following their implementation.

2.3.3 Financial

The planned amendment to the delegated authority to authorise orders and commit expenditure will support the Chief Executives request to consider 'grip & control' measures within financial process and ensure that the most senior members of staff within Directorates authorise any expenditure above £50,000.

2.3.4 Risk Assessment / Management

The implementation of the revised limits will ensure that Designated Corporate Officers will solely retain the highest individual authorisation limit within their Directorate or area of responsibility. These limits will be carried forward into the update of both the Procurement and Accounts Payable Limits to ensure that any other designated ordering officers do not retain any authorisation limits beyond their delegated authority limit.

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

N/A

2.3.6 Climate Emergency & Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

An analysis of both the Procurement and Accounts Payable authorisation limits were carried out between the Head of Procurement and Head of Financial Services & Procurement.

2.3.8 Route to the Meeting

The amendments were agreed with the Director of Finance & Strategy and Chief Executive and subsequently presented to EDG on 18th April 2024.

2.4 Recommendation

- **Assurance**

This paper is presented to the Audit & Risk committee to provide assurance for the planned amendment to the delegated authority to authorise orders and commit expenditure as contained detailed the SFI's.

3 List of appendices

The following appendices are included with this report:

N/A

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

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**16 May 2024**
Title:	**Annual Review of Code of Corporate Governance**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Gillian MacIntosh, Board Secretary**

1. Purpose

This is presented for:
- Assurance
- Decision

This report relates to a:
- Local policy

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

2. Report Summary

2.1 Situation

The Fife NHS Code of Corporate Governance is an all-encompassing suite of documents setting out the Board's Standing Orders, Committee Terms of Reference, Scheme of Delegation, Standing Financial Instructions and Code of Conduct for Board Members. It is therefore important that it remains current and correct.

2.2 Background

An annual review of the Code of Corporate Governance is normally undertaken each spring, with this completed as scheduled previously in 2023. This version of the Code subsequently received Board approval in May 2023.

2.3 Assessment

The new version of the Code has been made available to members online for review (https://www.nhsfife.org/media/qaljyffc/code-of-corporate-governance-tracked-changes-

0524-2.pdf), to help manage the amount of pages with the paper pack. The version accessible at the above link reflects the following updates clearly tracked within:

- minor tracked changes to each Standing Committee's remit, as discussed and agreed by each Committee following their Terms of Reference review at their March cycle of meetings; (pp.17-42)
- consequential changes to the Board's Scheme of Delegation (pp.75-86);
- an amendment to the Board's Standing Financial Instructions (p.60), to reflect the proposed change to the Board's Authorisation Limits, the subject of a separate paper to the Committee; and
- minor corrections to update out-of-date references to the Board Assurance Framework (BAF) to Corporate Risk Register.

There have been no changes made to the Board's Standing Orders, Code of Conduct for Board Members and Standards of Business Conduct for Staff. Both the Standing Orders and Code of Conduct for Board members follow a national template, where content is prescribed.

2.3.1 Quality/ Patient Care

Delivering robust governance across the organisation is supportive of enhanced patient care and quality standards.

2.3.2 Workforce

N/A.

2.3.3 Financial

Ensuring appropriate scrutiny of NHS Fife's governance documents, and ensuring these remain up to date, is a core part of the Committee's remit.

2.3.4 Risk Assessment/Management

The identification and management of risk is an important factor in Board Committees providing appropriate assurance to the NHS Board. The Board Committee Terms of Reference contained with the Code outline the delegated responsibilities in this area from the Board to its key standing committees.

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

This paper does not relate to the planning and development of specific health services, nor any decisions that would significantly affect groups of people. Consequently, an EQIA is not required.

2.3.6 Climate Emergency & Sustainability Impact
No direct impact via this annual updating exercise.

2.3.7 Communication, involvement, engagement and consultation
N/A.

2.3.8 Route to the Meeting
This paper has not been considered by any previous group, though its content reflects comments received from colleagues within the Finance Directorate. Each of the Committees' Terms of Reference have been reviewed at their meetings held in March 2024.

2.4 Recommendation

The paper is provided for:

- **Assurance**
- **Recommending approval to the Board of the updated Code** – subject to members' comments regarding any further amendments necessary.

3 List of appendices

- Appendix 1 – Revised Code of Corporate Governance

Report Contact
Dr Gillian MacIntosh
Head of Corporate Governance & Board Secretary
gillian.macintosh@nhs.scot

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**16 May 2024**
Title:	**Draft Audit & Risk Committee Annual Statement of Assurance 2023/24**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Gillian MacIntosh, Board Secretary**

1 Purpose

This is presented for:
- Approval

This report relates to a:
- Legal requirement
- Local policy

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

2 Report summary

2.1 Situation

All formal Committees of the NHS Board are required to provide an Annual Statement of Assurance for the NHS Board. The requirement for these statements is set out in the Code of Corporate Governance. The Audit & Risk Committee is invited to review the draft of this year's report and comment on its content, with a view to approving a final version.

2.2 Background

Each Committee must consider its proposed Annual Statement at the first Committee meeting of the new financial year. The current draft takes account of initial comments received from the Committee Chair, Director of Finance & Strategy, Head of Financial Services & Procurement and Risk Manager.

The drafts of the Board's other committees' assurance statements have been reviewed in the production of this report and these will be included on the next meeting's agenda, once approved at this present cycle of Committee meetings.

2.3 Assessment

In addition to recording practical details such as membership and rates of attendance, the format of the report includes a more reflective and detailed section (Section 4) on agenda business covered in the course of 2023-24, with a view to improving the level of assurance given to the NHS Board.

2.3.1 Quality/ Patient Care

Delivering robust governance across the organisation is supportive of enhanced patient care and quality standards.

2.3.2 Workforce

N/A.

2.3.3 Financial

The production and review of year-end assurance statements are a key part of the financial year-end process.

2.3.4 Risk Assessment/Management

Details on the Committee's discussions on its oversight of the Board's risk management processes are detailed within the report.

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

This paper does not relate to the planning and development of specific health services, nor any decisions that would significantly affect groups of people. Consequently, an EQIA is not required.

2.3.6 Climate Emergency & Sustainability Impact

No direct impact via this report.

2.3.7 Communication, involvement, engagement and consultation

N/A.

2.3.8 Route to the Meeting

This paper has been considered in draft by the Committee Chair and lead officers involved in the Audit & Risk Committee and takes account of any initial comments thus received.

2.4 Recommendation

The paper is provided for:

- **Assurance & approval** – subject to members' comments regarding any amendments necessary

Report Contact
Dr Gillian MacIntosh
Head of Corporate Governance & Board Secretary
gillian.macintosh@nhs.scot

ANNUAL STATEMENT OF ASSURANCE
FOR THE AUDIT & RISK COMMITTEE 2023/24

1. Purpose of Committee

1.1 The purpose of the Audit & Risk Committee is to provide the Board with assurance that the activities of Fife NHS Board are within the law and regulations governing the NHS in Scotland and that an effective system of internal control is maintained.

1.2 The duties of the Audit & Risk Committee are in accordance with the principles and best practice outlined in the Scottish Government Audit & Assurance Committee Handbook, dated April 2018.

2. Membership of Committee

2.1 During the financial year to 31 March 2024, membership of the Audit & Risk Committee comprised:

Alastair Grant	Chair / Non-Executive Member
Cllr Graeme Downie	Non-Executive Stakeholder Member, Fife Council (from December 2023)
Cllr David Graham	Non-Executive Stakeholder Member, Fife Council (to August 2023)
Anne Haston	Non-Executive Member
Aileen Lawrie	Non-Executive Stakeholder Member, Area Clinical Forum
Kirstie MacDonald	Non-Executive Member (Whistleblowing Champion)

2.2 The Committee may choose to invite individuals to attend the Committee meetings for the consideration of particular agenda items, but the Chief Executive, Director of Finance & Strategy (who is also the Executive lead for risk), Head of Financial Services & Procurement, Risk Manager, Board Secretary, Chief Internal Auditor and statutory External Auditor are normally in routine attendance at Committee meetings. Other attendees, deputies and guests are recorded in the individual minutes of each Committee meeting.

3. Meetings

3.1 The Committee met on five occasions during the year to 31 March 2024, on the undernoted dates:

- 23 June 2023 (approval of Annual Accounts)
- 31 August 2023
- 12 October 2023 (Development Session)
- 13 December 2023
- 14 March 2023

Note, the meeting due to take place on 18 May 2023 was cancelled due to the unavailability of the Chair and the bulk of its business was rolled over to the June meeting.

3.2 The attendance schedule is attached at Appendix 1.

4. Business

4.1 The range of business covered at meetings held throughout the year, as further detailed below, demonstrates that the full range of matters identified in the Audit & Risk Committee's remit is being addressed. In line with its Constitution and Terms of Reference, reviewed annually in March 2024, the Committee has considered standing agenda items concerned with the undernoted aspects:

- Internal Control frameworks and arrangements;
- Internal & External Audit planning and reporting;
- Corporate Governance, including the Board's implementation of and compliance with the NHS Scotland *Blueprint for Good Governance*;
- Regular updates to the NHS Fife Code of Corporate Governance, including within the Standing Financial Instructions and Scheme of Delegation;
- Scrutiny of the Board's Annual Statutory Financial Statements, including the meaningfulness of the accompanying Governance Statement;
- Risk Management arrangements and reporting, including progress with revising the risk management framework and review of the effectiveness of the Corporate Risk Register; and
- other relevant matters arising during the year.

4.2 The first meeting of the Audit & Risk Committee's reporting period in 2023/24 was cancelled at short notice due to the unavailability of the Chair. However, papers had been issued and comments thereon were sought from members by circulation. This included the annual Code of Corporate Governance, which went onward to the Board, as the formal approving body, at its May 2023 meeting. The Draft Governance Statement for 2022/23 was reviewed via email, and comments given prior to its final formal consideration as part of the business of the June 2023 annual accounts meeting. An initial draft of the Risk Management Annual Report for 2022/23 was issued to members, with a number of comments made to be reflected in the final iteration, and an update was also provided on the risk management framework and risk register / risk assessment policy. Also issued was an initial draft of the Audit & Risk Committee Annual Assurance Statement for 2022/23. The final timeline for the Board's annual accounts preparation was provided, for members' awareness around key deadlines to be met.

4.3 The meeting in June 2023 went ahead as planned and members scrutinised in full the governance-related year-end documentation, auditor reports and statutory financial statements for 2022/23. This included the Board's annual accounts, internal and external audit annual reports, plus the Patients' Private Funds and Service Auditor Reports on Third Party Services provided on behalf of NHS Fife by NHS National Services Scotland (NSS) and NHS Ayrshire & Arran. Each of the auditor reports gave an unqualified opinion. The Annual Internal Audit Report for 2022/23 concluded that there were adequate and effective internal controls in place and that the 2022/23 Internal Audit Plan has been delivered in line with Public Sector Internal Audit Standards. In reference to External Audit, the annual audit report from Azets on 2022/23 summarised their audit of the annual financial statements, as well as their comment on financial sustainability, governance and best value. The Committee took significant assurance from these reports as part of the portfolio of evidence provided in support of its evaluation of the internal environment and the approval of the Governance Statement. The Committee was pleased to endorse to the Board the formal signing of the 2022/23 annual accounts and the Board approved the 2022/23 financial statements at their meeting on 27 June 2023.

4.4 Also at their June 2023 meeting, the Internal Audit Annual Plan for the current 2023/24 reporting year was considered, noting its alignment to the Population Health & Wellbeing

Strategy and ongoing risk management developments. At the same meeting, the Committee were advised that there were no significant amendments to the NSS Practitioner Services Partnership Agreement (for the period April 2023 to March 2028), and the Committee were thus able to take assurance from the arrangements in place to register and pay primary care contractors on the Board's behalf.

4.5 The Committee warmly endorsed the appointment of Jocelyn Lyall as the Board's new Chief Internal Auditor from 1 August 2023, thanking Tony Gaskin for his long service in the role and wishing him all the best in his retirement from the NHS. In relation generally to internal audit, members have reviewed and discussed in detail at meetings reports from the internal auditors covering a range of service areas and have considered management's progress in completing audit actions raised, through regular follow-up reporting. The interim evaluation of the internal control framework supplied at the mid-year point (December 2023) gave useful reference to any potential issues to be addressed before year-end. The largely positive findings gave a reasonable level of assurance to members. The revised Internal Audit Framework was approved by the Committee in March 2023, following earlier approval by the FTF Partnership Board. This includes the FTF Audit Charter, which is required to be approved on an annual basis, in line with public sector internal audit standards.

4.6 In relation to internal audit follow-up work, review dates had been considered for actions that have remained open longer than one year, and extensions were routinely reviewed to consider how likely it is that actions will be implemented by the revised implementation date. To provide greater assurance to the Committee, Internal Audit reports were agreed to be initially considered by the Executive Directors' Group, Chief Executive, Director of Finance and individual audit colleagues to help with oversight over outstanding action points. The Audit Follow up Protocol has been updated, as reported to the Committee in August 2023, to reflect a change to the authorisation required for extensions, to link these more explicitly to the risk assessment of the findings and recommendations of the original report.

4.7 In March 2024, the Committee in detail considered the findings of the Business Continuity Arrangements Internal Audit Report, which reported that only limited assurance could be provided from current arrangements in that area. The Executive Lead, the Director of Public Health, attended the meeting to provide further information on the resulting action plan that has been created to improve the position. The report was commissioned in recognition of the recommendations from a previous internal audit report, and through informal discussions at a national level. Further detail was provided on the risk associated to introducing a new Business Continuity Management System, noting that a new risk descriptor is being developed, to be added to the Corporate Risk Register. Members welcomed the further information given, taking assurance that progress in implementing the auditors' recommendations will be tracked via the existing follow-up process.

4.8 The Committee has approved the planning memorandum for the 2023/24 statutory accounts cycle, as also for the Patients' Private Funds from the respective External Auditor. Members have noted the approval by the Board of Trustees of the planning memorandum for the audit of Endowment Funds held by Fife Health Charity. Regular updates on the 2023/24 accounts approval timeline have been reported to the Committee, with input from both the internal and external auditor, noting the intention to seek Board approval for the annual accounts in late June 2024, meeting the relevant Scottish Government deadlines.

4.9 A summary self-assessment against the various requirements of the NHS Scotland *Blueprint for Good Governance* was carried out by Board members in late 2023, and reflection on the survey results was given at a Board Development Session in February 2024, facilitated by colleagues from NHS Education for Scotland. Subsequently, an action plan was approved by the full NHS Fife Board in March 2024, which shall be monitored to completion by the Committee. A related internal audit review on the Board's compliance

against the standards within the Blueprint has been undertaken in the reporting year and this will be reported as part of the year-end work.

4.10 The Committee has also considered national reviews undertaken by Audit Scotland, including the findings of their report 'NHS in Scotland 2023', with consideration of its implications locally. The Committee considers the content of Audit Scotland Technical Bulletins on a regular basis, noting the areas therein of relevance to public sector bodies and health boards specifically.

4.11 In year, a review of the Financial Operating Procedures for 2023 has been undertaken, with a number of key sections having had significant amendments. Confirmation was provided to the Committee in December 2023 that key individuals across NHS Fife were consulted during the review to ensure that appropriate expertise was utilised. The Committee was pleased to approve the changes for immediate effect, to support the annual Code of Corporate Governance review and the Standing Financial Instructions therein.

4.12 For assurance purposes, the Audit & Risk Committee has considered the annual assurance statements of each of the governance committees of the Board, namely: the Clinical Governance Committee; the Finance, Performance & Resources Committee; the Public Health & Wellbeing Committee; the Remuneration Committee; and the Staff Governance Committee. These detail the activity of each committee during the year, the business they have considered in discharging their respective remits and an outline of what assurance the Board can take on key matters delegated to them. No significant issues were identified from these reports for disclosure in the financial statements, as per the related content of the 2023/24 Governance Statement.

4.13 Appropriate assurance has been provided that each Committee has fulfilled their key remit areas on behalf of the Board during the reporting year. The Clinical Governance Committee report has provided due reflection on the assurance that can be taken around matters of clinical quality and safety, information security & governance, digital & information, resilience and Health & Safety. The Finance, Performance & Resources Committee has closely monitored the position in relation to the Board's year-end position, financial targets and delivery progress thereon, and has also considered key performance targets around waiting times and delivery of clinical services. The Public Health & Wellbeing Committee has responsibility for oversight of the Board's immunisation delivery programme and delegated community-based services such as children's mental health services, plus scrutiny of progression of the Board's organisational Population Health & Wellbeing Strategy and related work around health inequalities. The Staff Governance Committee has received regular updates on recruitment to support key programmes and staff development activities, in addition to ongoing detail on staff well-being initiatives and work underway to reduce sickness absence. The Remuneration Committee has completed its usual business of Executive cohort performance appraisal and objective setting. Further detail on all these areas can be found within the individual Committee reports mentioned above. In addition to the Committee reports, the individual Executive Directors' Assurance letters have provided helpful detail on the internal control mechanisms and mitigation of risks within individual portfolios and Directorates.

4.14 In reference to the Fife Integration Joint Board, due to its own year-end accounts approval timeline, it is not possible for the NHS Fife Board to receive a final version of an assurance statement from the IJB prior to the Board's approval of its own statutory financial accounts in June 2024. The Committee has, however, taken assurance from a formal letter received from the Chair of the IJB's Audit & Assurance Committee providing assurance on the adequacy of the governance and internal control environment of that body. The Committee will consider the final IJB Internal Audit report at its forthcoming meeting in September 2024.

4.15 During the year, members of the Committee engaged in a number of training opportunities, covering best practice arrangements for Audit & Risk Committees. In October 2023, members attended a Committee Development Session to review the effectiveness of the new Corporate Risk Management processes and to discuss areas that require further refinement. A training session with the Internal and External Auditors was held in May 2024 outlining the year-end processes each undertake as part of the review of the financial statements, responsibilities of the Audit & Risk Committee in reference to scrutiny of these, and details on the systems of internal control, in preparation for the review and scrutiny of the annual accounts, prior to the Committee's formal consideration of the 2023/24 financial statements. The presentation slides were usefully adapted to be used as a helpful checklist by members, when the accounts are tabled for formal approval in June 2024.

4.16 Progress with fraud cases and counter fraud initiatives were discussed by the Committee in private session on a regular basis throughout the year. The Committee received quarterly fraud updates, on relevant cases and investigations; initiatives undertaken to identify and address fraud; and the work carried out by Practitioner & Counter Fraud Services in relation to detecting, deterring, disabling and dealing with fraud in the NHS. These reports also detail the counter fraud training delivered to staff, including the roll-out of a newly updated Fraud Awareness module. This has provided the Committee with the assurance that the risk of fraud is being proactively managed across NHS Fife. The Committee acknowledged that whilst there were no significant findings following the Board's participation in the National Fraud Initiative Assignment 2023 , there were a number of minor outcomes, and a summary of these was provided to support the Committee's understanding of the process and provide assurance that this source of intelligence was appropriately actioned. In August 2023, the Committee took reasonable assurance from the Counter Fraud Standards Assessment report for 2022/23, noting the anticipated position that NHS Fife did not assess itself as fully meeting all the Standards by the end of 2022/23 and that the aim is for all the Standards to be met fully by the end of the three-year partnership agreement, which is line with other NHS Boards. The Committee were assured from the Fraud Annual Action Plan, which was developed between all NHS Scotland Health Boards and Counter Fraud Services, and in addition has been tailored locally to support the delivery of the Counter Fraud Standards.

4.17 Regular reporting on losses and special payments is factored into the Committee's workplan on a quarterly basis, to help support the annual accounts reconciliation process generally and, in support of Counter Fraud Standards, to increase the Committee's oversight. The Committee is also provided with regular updates on the application of any Procurement Waivers of Competitive Tender to provide assurance that the process is being correctly applied and therefore the risk to the board of non-compliance is effectively managed.

4.18 Minutes of Committee meetings have been approved by the Committee and presented to Fife NHS Board. The Board also receives a verbal update at each meeting from the Chair, highlighting any key issues discussed by the Committee at its preceding meeting. The Committee maintains a rolling action log to record and manage actions agreed from each meeting, and reviews progress against deadline dates at subsequent meetings. The Committee's workplan is presented to each meeting, detailing any delays to agenda items and providing information on delivery dates, to increase the visibility over the completion of each Committee's annual schedule of business.

5. Best Value

5.1 Since 2013/14 the Board has been required to provide overt assurance on Best Value. The introduction of both the SPRA process in 2020/21 and the Financial Improvement & Sustainability Programme established in 2022/23 build on the aims of the previous organisational Best Value Framework (2018). Their combined impact facilitates a more effective triangulation of workforce, operational and financial planning, which supports the promotion and delivery of best value across all of our resource allocation. Appendix 3 provides evidence of where and when the Committee considered the relevant matters during 2023/24.

6. Risk Management

6.1 All NHS Boards are subject to the requirements of the Scottish Public Finance Manual (SPFM) and must operate a risk management strategy in accordance with the relevant guidance issued by Scottish Ministers. The general principles for a successful risk management strategy are set out in the SPFM.

6.2 All of the key areas within the organisation maintain a risk register. All risk registers are held on Datix, the Risk Management digital information system. Training and support for all Datix modules, including risk registers, is provided by the risk management team according to the requirements of individuals, specialities and teams etc.

6.3 In line with the Board's agreed risk management arrangements, the Audit & Risk Committee has considered risk through a range of reports and scrutiny, including review of the Corporate Risk Register. During 2023/24, the high-level risks identified as having the potential to impact on the delivery of NHS Fife's strategic priorities, and related operational high-level risks, were reported bi-monthly through the Corporate Risk Register to the governance committees, and subsequently to the Audit & Risk Committee and the Board.

6.4 The Corporate Risk Register report was presented to the full NHS Board at the November 2023 meeting for scrutiny, and Board members were provided with the necessary levels of assurance on the effectiveness of mitigating actions. The Committee were informed of a new approach of reviewing corporate risks, with some risks moving to a triannual reporting schedule. Furthermore, the Committee held a Development Session in October 2023 to review the effectiveness of the new Corporate Risk Register process and explored members' understanding of their risk management responsibilities.

6.5 Operationally, the Risk & Opportunities Group have continued with the risk management improvement programme work during 2023/24, particularly around the work on the presentation of the Corporate Risk Register. Linkages to the Board's overall risk appetite have been discussed with members, noting that for those individual risks currently facing a risk profile in excess of the Board's agreed appetite, a degree of tolerance was required, given the complexity, system volatility and scale of external challenges at this time. The Risk & Opportunities Group have also been acknowledging feedback from the Governance Committees and taking forward considerations and recommendations on the corporate risk register to further support this, particularly around opportunities and risks directly related to the Population Health & Wellbeing Strategy. The Covid-19 risk was removed from the Corporate Risk Register following extensive discussions and due diligence, reflecting its transition to business-as-usual activity, with a related new risk, on future preparedness for any potential future pandemics, being developed as a replacement. A new corporate risk on the preparation for implementing the legislation around the Health & Care Staffing (Scotland) Act was approved in late 2023, and new risks around capital funding restrictions and Pandemic Preparedness / Biological Threats are being developed. Deep dives were carried out across all the Board's committees, allowing greater scrutiny of the root causes of risks, and providing an opportunity for discussion on the effectiveness of management actions in place to reduce risk levels. Enhancements have also been made to the risk

guidance for Governance papers and SBAR templates, to strengthen the content of the risk assessment and risk management sections.

6.6 The Committee endorsed the updated risk management framework in August 2023, which reaffirms the Board's commitment to embed an effective risk management framework and culture to support the achievement of the strategic priorities, and the ambitions of the Population Health and Wellbeing Strategy. In December 2023, the Committee approved an expansion to the risk management framework document to capture essential content from the previous standalone risk policy. The framework now contains all new or additional content, which will enable easier engagement and guidance for staff.

6.7 The Board began reassessing its risk appetite at a dedicated Development Session held in April 2024. Further work is required to complete this, which is anticipated to be complete early in the 2024/25 reporting year.

7. Self-Assessment

7.1 The Committee has undertaken a self-assessment of its own effectiveness, utilising a revised questionnaire considered and approved by the Committee Chair. Attendees were also invited to participate in this exercise, which was carried out via an easily accessible online portal. A report summarising the findings of the survey was considered and approved by the Committee at its March 2024 meeting, and action points are being taken forward at both Committee and Board level.

8. Conclusion

8.1 As Chair of the Audit & Risk Committee during financial year 2023/24, I am satisfied that the integrated approach, the frequency of meetings, the breadth of the business undertaken and the range of attendees at meetings of the Committee has allowed us to fulfil our remit as detailed in the Code of Corporate Governance. As a result of the work undertaken during the year, I can confirm that adequate and effective governance arrangements were in place throughout NHS Fife during the year. Audit & Risk Committee members conclude that they have given due consideration to the effectiveness of the systems of internal control in NHS Fife, have carried out their role and discharged their responsibilities on behalf of the Board in respect of the Committee's remit as described in the Standing Orders.

8.2 I can confirm that that there were no significant control weaknesses or issues at the year-end which the Committee considers should be disclosed in the Governance Statement, as they may have impacted financially or otherwise in the year or thereafter.

8.3 I would pay tribute to the dedication and commitment of fellow members of the Committee and to all attendees. I would thank all those members of staff who have prepared reports and attended meetings of the Committee.

Signed: Date: ** June 2024

Alastair Grant, Chair
On behalf of the Audit & Risk Committee

Appendix 1 – Attendance Schedule
Appendix 2 – Best Value

APPENDIX 1

AUDIT & RISK COMMITTEE - ATTENDANCE RECORD
1 April 2023 – 31 March 2024

	23.06.23	31.08.23	13.12.23	14.03.24
Members				
A Grant, Non-Executive Member **(Chair)**	⚐	⚐	⚐	⚐
Cllr G Downie, Stakeholder Member, Fife Council			⚐	⚐
Cllr D Graham, Stakeholder Member, Fife Council	⚐			
A Haston, Non-Executive Member	⚐	⚐	⚐	⚐
A Lawrie, Area Clinical Forum Representative	x	⚐	x	⚐
K McDonald, Non-Executive Member	⚐	⚐	⚐	x
In attendance				
K Booth, Head of Financial Services	⚐	⚐	⚐	⚐
A Brown, Principal Auditor		⚐	⚐	⚐
C Brown, Head of Public Sector Audit (UK), Azets	⚐	⚐	⚐	⚐
P Cumming, Risk Manager	x	⚐	⚐	⚐
A Ferguson, Senior Audit Manager, Azets			⚐	
T Gaskin, Chief Internal Auditor	⚐	⚐		
Alistair Graham, Associate Director of Digital & Information	⚐		⚐	⚐ Item 8.2
B Hudson, Regional Audit Manager	⚐	x	⚐	⚐
A Hughes, Senior, Azets			⚐	⚐
K Jones, Director of Audit & Assurance, Azets	⚐	x		
J Lyall, Chief Internal Auditor		x	⚐	⚐
G MacIntosh, Head of Corporate Governance & Board Secretary	⚐	⚐	⚐	⚐
Sally McCormack, Associate Medical Director for Emergency Care and Planned Care				
M McGurk, Director of Finance & Strategy **(Exec Lead)**	⚐	⚐	⚐	x
Alan Mitchell, Thomson Cooper				⚐ Item 5.1
C Potter, Chief Executive	⚐	⚐	x	⚐ Part
Shirley-Anne Savage, Associate Director of Quality & Clinical Governance	⚐			x

	23.06.23	31.08.23	13.12.23	14.03.24
J Tomlinson, Director of Public Health				Item 7.5

BEST VALUE FRAMEWORK

Vision and Leadership

A Best Value organisation will have in place a clear vision and strategic direction for what it will do to contribute to the delivery of improved outcomes for Scotland's people, making Scotland a better place to live and a more prosperous and successful country. The strategy will display a clear sense of purpose and place and be effectively communicated to all staff and stakeholders. The strategy will show a clear direction of travel and will be led by Senior Staff in an open and inclusive leadership approach, underpinned by clear plans and strategies (aligned to resources) which reflect a commitment to continuous improvement.

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
The Board has identified the risks to the achievement of its strategic and operational plans are identified together with mitigating controls.	Each strategic risk has an Assurance Framework which maps the mitigating actions/risks to help achieve the strategic and operational plans. Assurance Framework contains the overarching strategic risks related to the strategic plan.	**COMMITTEES** **AUDIT & RISK COMMITTEE** **BOARD**	Bi-monthly 5 times per year 2 times per year	Corporate Risk Register (to CG/FP&R/PH&W/SG Committees) Corporate Risk Register (to A&R Committee) Board

GOVERNANCE AND ACCOUNTABILITY

The "Governance and Accountability" theme focuses on how a Best Value organisation achieves effective governance arrangements, which help support Executive and Non-Executive leadership decision-making, provide suitable assurances to stakeholders on how all available resources are being used in delivering outcomes and give accessible explanation of the activities of the organisation and the outcomes delivered.

A Best Value organisation will be able to demonstrate structures, policies and leadership behaviours which support the application of good standards of governance and accountability in how the organisation is improving efficiency, focusing on priorities and achieving value for money in delivering its outcomes. These good standards will be reflected in clear roles, responsibilities and relationships within the organisation. Good governance arrangements will provide the supporting framework for the overall delivery of Best Value and will ensure open-ness and transparency. Public reporting should show the impact of the organisation's activities, with clear links between the activities and what outcomes are being delivered to customers and stakeholders. Good governance provides an assurance that the organisation has a suitable focus on continuous improvement and quality. Outwith the organisation, good governance will show itself through an organisational commitment to public performance reporting about the quality of activities being delivered and commitments for future delivery.

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
Board and Committee decision-making processes are open and transparent.	Board meetings are held in open session and minutes are publicly available. Committee papers and minutes are publicly available	**BOARD** **COMMITTEES**	On going	Meetings publicly accessible NHS website
Board and Committee decision-making processes are based on evidence that can show clear links between activities and outcomes	Reports for decision to be considered by Board and Committees should clearly describe the evidence underpinning the proposed decision.	**BOARD** **COMMITTEES**	Ongoing	SBAR reports EQIA forms

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
NHS Fife has a robust framework of corporate governance to provide assurance to relevant stakeholders that there are effective internal control systems in operation which comply with the SPFM and other relevant guidance.	Explicitly detailed in the Governance Statement.	**AUDIT & RISK COMMITTEE** **BOARD**	Annual Annual Ongoing	Code of Corporate Governance review Annual Assurance statements Compliance with NHS Scotland Blueprint for Good Governance

USE OF RESOURCES

The “Use of Resources” theme focuses on how a Best Value organisation ensures that it makes effective, risk-aware and evidence-based decisions on the use of all of its resources.

A Best Value organisation will show that it is conscious of being publicly funded in everything it does. The organisation will be able to show how its effective management of all resources (including staff, assets, information and communications technology (ICT), procurement and knowledge) is contributing to delivery of specific outcomes.

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
NHS Fife maintains an effective system for financial stewardship and reporting in line with the SPFM.	Statutory Annual Accounts process	**AUDIT & RISK COMMITTEE**	Annual	Statutory Annual Accounts Assurance Statements SFIs
NHS Fife understands and exploits the value of the data and information it holds.	Annual Delivery Plan Integrated Performance & Quality Report	**BOARD** **COMMITTEES**	Annual Bi-monthly	Annual Delivery Plan Integrated Performance & Quality Report

PERFORMANCE MANAGEMENT

The “Performance Management” theme focuses on how a Best Value organisation embeds a culture and supporting processes which ensures that it has a clear and accurate understanding of how all parts of the organisation are performing and that, based on this knowledge, it takes action that leads to demonstrable continuous improvement in performance and outcomes.

A Best Value organisation will ensure that robust arrangements are in place to monitor the achievement of outcomes (possibly delivered across multiple partnerships) as well as reporting on specific activities and projects. It will use intelligence to make open and transparent decisions within a culture which is action and improvement oriented and manages risk. The organisation will provide a clear line of sight from individual actions through to the National Outcomes and the National Performance Framework. The measures used to manage and report on performance will also enable the organisation to provide assurances on quality and link this to continuous improvement and the delivery of efficient and effective outcomes.

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
Performance is systematically measured across all key areas of activity and associated reporting provides an understanding of whether the organisation is on track to achieve its short and long-term strategic, operational and quality objectives	Integrated Performance & Quality Report encompassing all aspects of operational performance, Annual Delivery Plan targets / measures, and financial, clinical and staff governance metrics. The Board delegates to Committees the scrutiny of performance Board receives full Integrated Performance & Quality Report and notification of any issues for escalation from Committees.	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance & Quality Report Code of Corporate Governance Minutes of Committees

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
The Board and its Committees approve the format and content of the performance reports they receive.	The Board / Committees review the Integrated Performance & Quality Report and agree the measures.	**COMMITTEES** **BOARD**	Annual	Integrated Performance & Quality Report
Reports are honest and balanced and subject to proportionate and appropriate scrutiny and challenge from the Board and its Committees.	Committee Minutes show scrutiny and challenge when performance is poor as well as good; with escalation of issues to the Board as required	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance & Quality Report Minutes of Committees
The Board has received assurance on the accuracy of data used for performance monitoring.	Performance reporting information uses validated data.	**COMMITTEES** **BOARD**	Every meeting Annual	Integrated Performance & Quality Report Annual Accounts including External Audit report
NHS Fife's performance management system is effective in addressing areas of underperformance, identifying the scope for improvement, agreeing remedial action, sharing good practice and monitoring implementation.	Encompassed within the Integrated Performance & Quality Report	**COMMITTEES** **BOARD**	Every meeting	Integrated Performance & Quality Report Minutes of Committees

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
NHS Fife overtly links Performance Management with Risk Management to support prioritisation and decision-making at Executive level, support continuous improvement and provide assurance on internal control and risk.	Corporate Risk Register	**AUDIT & RISK COMMITTEE** **BOARD**	Ongoing	Corporate Risk Register Minutes of Committees

CROSS-CUTTING THEME – SUSTAINABILITY

The "Sustainability" theme is one of the two cross-cutting themes and focuses on how a Best Value organisation has embedded a sustainable development focus in its work.

The goal of Sustainable Development is to enable all people throughout the world to satisfy their basic needs and enjoy a better quality of life without compromising the quality of life of future generations. Sustainability is integral to an overall Best Value approach and an obligation to act in a way which it considers is most sustainable is one of the three public bodies' duties set out in section 44 of the Climate Change (Scotland) Act 2009. The duty to act sustainably placed upon Public Bodies by the Climate Change Act will require Public Bodies to routinely balance their decisions and consider the wide range of impacts of their actions, beyond reduction of greenhouse gas emissions and over both the short and the long term. The concept of sustainability is one which is still evolving. However, five broad principles of sustainability have been identified as:

- promoting good governance;
- living within environmental limits;
- achieving a sustainable economy;
- ensuring a stronger healthier society; and
- using sound science responsibly.

Individual Public Bodies may wish to consider comparisons within the wider public sector, rather than within their usual public sector "family". This will assist them in getting an accurate gauge of their true scale and level of influence, as well as a more accurate assessment of the potential impact of any decisions they choose to make. A Best Value organisation will demonstrate an effective use of resources in the short-term and an informed prioritisation of the use of resources in the longer-term in order to bring about sustainable development. Public bodies should also prepare for future changes as a result of emissions that have already taken place. Public Bodies will need to ensure that they are resilient enough to continue to deliver the public services on which we all rely.

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE
NHS Fife can demonstrate that it is making a contribution to sustainable development by actively considering the social, economic and environmental impacts of activities and decisions both in the shorter and longer term.	Sustainability and Environmental report incorporated in the Annual Accounts process.	**AUDIT & RISK COMMITTEE** **BOARD**	Annual	Annual Accounts Climate Change Template

CROSS-CUTTING THEME – EQUALITY

The “Equality” theme is one of the two cross-cutting themes and focuses on how a Best Value organisation has embedded an equalities focus which will secure continuous improvement in delivering equality.

Equality is integral to all our work as demonstrated by its positioning as a cross-cutting theme. Public Bodies have a range of legal duties and responsibilities with regard to equality. A Best Value organisation will demonstrate that consideration of equality issues is embedded in its vision and strategic direction and throughout all of its work.

The equality impact of policies and practices delivered through partnerships should always be considered. A focus on setting equality outcomes at the individual Public Body level will also encourage equality to be considered at the partnership level.

REQUIREMENT	MEASURE / EXPECTED OUTCOME	RESPONSIBILITY	TIMESCALE	OUTCOME / EVIDENCE:
NHS Fife meets the requirements of equality legislation.	Evidence of equality considerations in Board’s decision-making structure	**BOARD** **COMMITTEES**	Ongoing	EQIA form on all reports
The Board and senior managers understand the diversity of their customers and stakeholders.	Equality Impact Assessments are reported to the Board and Committees as required and identify the diverse range of stakeholders.	**BOARD** **COMMITTEES**	Ongoing	EQIA form on all reports
NHS Fife’s policies, functions and service planning overtly consider the different current and future needs and access requirements of groups within the community.	In accordance with the Equality and Impact Assessment Policy, Impact Assessments consider the current and future needs and access requirements of the groups within the community.	**BOARD** **COMMITTEES**	Ongoing	Population Health & Wellbeing Strategy EQIA forms on reports
Wherever relevant, NHS Fife collects information and data on the impact of policies, services and functions on different equality groups to help inform future decisions.	In accordance with the Equality and Impact Assessment Policy, Impact Assessments will collect this information to inform future decisions.	**BOARD** **COMMITTEES**	Ongoing	EQIA forms on reports

NHS Fife

Meeting:	**Audit & Risk Committee**
Meeting date:	**16 May 2024**
Title:	**Draft Governance Statement**
Responsible Executive:	**Margo McGurk, Director of Finance & Strategy**
Report Author:	**Gillian MacIntosh, Head of Corporate Governance & Board Secretary**

1 Purpose

This is presented for:

- Discussion

This report relates to a:

- Government policy/directive
- Legal requirement

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

- Effective

2 Report summary

2.1 Situation

As Accountable Officers, Chief Executives are responsible for maintaining sound systems of internal control. Chief Executives must prepare a Governance Statement that complies with guidance in the Scottish Public Finance Manual (SPFM), which is accurate, complete and fairly reports the known facts.

2.2 Background

For 2023/24, there have been no substantial changes made to the Governance Statement format or guidance, as set out within the NHS Scotland Annual Accounts Manual. However, there are a number of areas which merit consideration in the Governance Statement for 2023/24. These include:

- detail on the 'Re-form, Transform, Perform' Framework introduced during the latter half of the year;
- review of the first year of the Board's Population Health & Wellbeing Strategy; and
- details of a disclosure within the Annual Accounts, related to an Information Governance & Security breach, for which the Board has received a formal reprimand from the Information Commissioner's Office.

2.3 Assessment

A fundamental part of the Accountable Officer's responsibility is to manage and control all the available resources used in his or her organisation. The Governance Statement is a key feature of the annual report / accounts and provides commentary on how these duties have been carried out in the course of the year, including aspects of corporate governance and risk management.

As part of the overall governance and assurance processes of the Board, both the Chief Internal Auditor and the Board's External Auditor (currently Azets) are required to provide an annual report within the dimensions of their respective remits. In providing the Internal Audit Annual report, the Chief Internal Auditor specifically reviews the Governance Statement for:

- consistency with information the internal audit team are aware of from their own work;
- accurate and appropriate description of processes adopted in reviewing the effectiveness of the system of internal control and how these are reflected within;
- that the format and content of the Governance Statement are compliant with relevant guidance; and
- disclosure of all relevant issues.

2.3.1 Quality / Patient Care

Good governance is a central pillar in enhancing quality standards and improving patient care.

2.3.2 Workforce

The Draft Governance Statement reflects the control environment supporting staff governance.

2.3.3 Financial

The Draft Governance Statement reflects the control environment supporting financial governance and is a central part of the annual accounts document.

2.3.4 Risk Assessment/Management

Details on developments in-year on the Board's risk management processes are detailed within the report.

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

This paper does not relate to the planning and development of specific health services, nor any decisions that would significantly affect groups of people. Consequently, an EQIA is not required.

2.3.6 Climate Emergency & Sustainability Impact

Relevant section included in the broader accounts narrative front-end.

2.3.7 Communication, involvement, engagement and consultation

Appropriate communication, involvement, engagement and consultation within the organisation and with key external stakeholders (such as the auditors and Scottish Government colleagues) was conducted in the preparation of the paper. The Clinical Governance Committee has been supportive of the disclosure being made within the Accounts, as per the recommendation of the Information Governance & Security Steering Group, which reports into Clinical Governance.

2.3.8 Route to the Meeting

The Audit & Risk Committee is the first group to whom the draft Governance Statement has been made available.

2.4 Recommendation

The paper is provided for **discussion**. The Committee is invited to review the draft Governance Statement as attached and provide any comments on its content as required. A further version will come back to the Committee for formal approval with the annual financial statements.

3 List of appendices

The following appendices are included with this report:

- Appendix 1 – Draft Governance Statement (submitted in draft to External and Internal Audit)

Report Contact
Dr Gillian MacIntosh
Head of Corporate Governance & Board Secretary
gillian.macintosh@nhs.scot

Corporate Governance Report

Directors' Report

Date of Issue

Financial statements were approved by the Board and authorised for issue by the Accountable Officer on 25 June 2024.

Appointment of Auditors

The Public Finance and Accountability (Scotland) Act 2000 places personal responsibility on the Auditor General for Scotland to decide who is to undertake the audit of each health body in Scotland. The Auditor General has appointed Chris Brown, Regional Managing Partner, Azets, to undertake the audit of Fife Health Board. The general duties of the auditors of health bodies, including their statutory duties, are set out in the Code of Audit Practice issued by Audit Scotland, and approved by the Auditor General.

Board Membership

Under the terms of the Scottish Health Plan, the NHS Fife Board is a board of governance whose membership will be conditioned by the functions of the Board. Members of the NHS Board are selected on the basis of their position or the particular expertise, which enables them to contribute to the decision-making process at a strategic level.

The NHS Fife Board has collective responsibility for the performance of the local NHS system as a whole, and reflects a partnership approach, which is essential to improving health and health care. NHS Board members are also Trustees of the Fife Health Board endowment funds held by the Fife Health Charity. The members of the NHS Fife Board who served during the year from 1 April 2023 to 31 March 2024 were as follows:

Non-Executive Members

Patricia Kilpatrick	Chairperson (from 01.02.2024)
Alistair Morris	Acting Chairperson (from 01.04.2023 to 31.01.2024) / Vice Chairperson (from 01.02.2024)
Sinead Braiden	Non-Executive Member
Alastair Grant	Non-Executive Member
Colin Grieve	Non-Executive Member
Anne Haston	Non-Executive Member
Dr John Kemp	Non-Executive Member
Kirstie MacDonald	Whistleblowing Champion & Non-Executive Member
Mansoor Mahmood	Non-Executive Member (to 31.12.2023)
Arlene Wood	Non-Executive Member
Wilma Brown	Stakeholder Member, Employee Director (Co-Chair, Area Partnership Forum) (to 30.09.2023)
Lynne Parsons	Stakeholder Member, Employee Director (Co-Chair, Area Partnership Forum) (from 01.10.23)
Aileen Lawrie	Stakeholder Member (Chairperson, Area Clinical Forum)
Councillor David Graham	Stakeholder Member (Fife Councillor) (to 28.08.2023)
Councillor Graham Downie	Stakeholder Member (Fife Councillor) (from 01.10.2023)

Executive Members

Carol Potter	Chief Executive
Janette Keenan	Director of Nursing
Margo McGurk	Director of Finance & Strategy / Deputy Chief Executive
Dr Chris McKenna	Medical Director
Dr Joy Tomlinson	Director of Public Health

Statement of Board Members' Responsibilities

Under the National Health Service (Scotland) Act 1978, the Health Board is required to prepare accounts in accordance with the directions of Scottish Ministers, which require that those accounts give a true and fair view of the state of affairs of the Health Board as at 31 March 2024 and of its operating costs for the year then ended. In preparing these accounts the Directors are required to:

- Apply on a consistent basis the accounting policies and standards approved for the NHS Scotland by Scottish Ministers.

- Make judgements and estimates that are reasonable and prudent.

- State where applicable accounting standards as set out in the Financial Reporting Manual have not been followed where the effect of the departure is material.

- Prepare the accounts on the going concern basis unless it is inappropriate to presume that the Board will continue to operate.

The Health Board members are responsible for ensuring that proper accounting records are maintained, which disclose with reasonable accuracy at any time the financial position of the Board and enable them to ensure that the accounts comply with the National Health Service (Scotland) Act 1978 and the requirements of the Scottish Ministers. They are also responsible for safeguarding the assets of the Board and hence taking reasonable steps for the prevention of fraud and other irregularities.

The NHS Board members confirm they have discharged the above responsibilities during the financial year and in preparing the accounts.

Board Members and Senior Managers' Interests

Details of any interests of Board members, senior managers and other senior staff in contracts, or potential contractors, with the NHS Board, as required by IAS 24, are disclosed in Note 24.

A register of interests, which includes details of company directorships or other significant interests held by Board members that may conflict with their management responsibilities, is available by contacting the Corporate Governance Support Officer, Corporate Governance & Board Administration, Queen Margaret Hospital, Whitefield Road, Dunfermline KY12 0SU or via fife.boardadministration@nhs.scot. A copy is also published online at the following link: https://www.nhsfife.org/about-us/nhs-fife-board/register-of-board-interests/.

Directors' third-party indemnity provisions

Individual members of the NHS Board or the NHS Board as a group are covered by the NHS Board's Clinical Negligence and other Risks Indemnity Scheme (CNORIS) in respect of potential claims against them.

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Remuneration for non-audit work

No non-audit work has been carried out by Azets or the Fife Health Charity auditors, Thomson Cooper, during 2023/24.

Value of Land

During the year the Board has had 100% of land revalued by the Valuation Office Agency, who have confirmed that the Board's Statement of Financial Position values do not significantly differ from market values.

Public Services (Scotland) Act 2010

Sections 31 and 32 of the Public Services Reform (Scotland) Act 2010 imposed duties on the Scottish Government and listed public bodies to publish information on expenditure and certain other matters as soon as is reasonably practicable after the end of each financial year.

NHS Fife publishes the required information on the NHS Fife website at the following link:
https://www.nhsfife.org/about-us/guide-to-information-available-through-the-model-publication-scheme/finance-guide-to-information/.

Information Governance and Security Incidents reported to the Information Commissioner's Office

There were two outstanding personal data-related incidents / data protection breaches from Financial Year 2022/23 concluded in this reporting year. The Information Commissioner's Office (ICO) subsequently issued a Reprimand to the Board for an incident that occurred in February 2023, in which an unauthorised person gained access to a ward at St Andrews Community Hospital. Due to a lack of identification checks and formal processes, the non-staff member was handed a document containing the personal information of 14 people and assisted with administering care to one patient. The data was taken off site by the person and has not been recovered. Whilst the hospital had CCTV installed, the wall socket with the CCTV had been accidentally turned off by a member of staff prior to the incident. The police have not been able to identify the person or recover the lost data, hindered by the lack of CCTV footage. The ICO's investigation concluded that NHS Fife did not have appropriate security measures for personal information, as well as low staff training rates. Following this incident, NHS Fife has introduced new measures, such as a system for documents containing patient data to be signed in and out, as well as updated identification processes. An update on all actions undertaken by the Board in response to the Reprimand is due to be submitted to the ICO in June 2024.

A breach originally reported to the ICO in March 2023 related to a change in TrakCare referral vetting text, resulting in some rejected referrals never being communicated back to the Referrer, with the potential risk of a lack of follow-up actions and/or care. The ICO confirmed in June 2023 that they were taking no further action due to no harm to patients occurring and noted that technical system changes had been implemented to prevent this issue reoccurring.

For Financial Year 2023/24, there were a total of 12 breaches reported to the ICO and/or the Scottish Government (a reduction from the 14 reported in 2022/23). Of the 12 incidents, no further action was required for 8 of the breaches reported. One breach (pertaining to three GP Practices) was subsequently identified as not meeting the legislative requirement to report, as it fell under the Privacy & Electronic Communications Regulations 2003, as

opposed to the Data Protection Act; this was unclear at the time of original reporting but this incident was subsequently categorised as ‘Breach obligation did not apply’’. The other 3 incidents were reported in August and September 2023, and, at the time of writing, we await a response from the ICO on these breaches.

Disclosure of Information to Auditors

The Directors who have held office at the date of approval of this Directors’ Report confirm that, so far as they are each aware, there is no relevant audit information of which the Board’s auditors are unaware; and each Director has taken all the steps that they ought reasonably to have taken as a Director to make themselves aware of any relevant audit information and to establish that the Board’s auditors are aware of that information.

Statement of the Chief Executive’s Responsibilities as the Accountable Officer of the Health Board

Under Section 15 of the Public Finance and Accountability (Scotland) Act, 2000, The Principal Accountable Officer (PAO) of the Scottish Government has appointed me as Accountable Officer of Fife Health Board.

This designation carries with it the responsibility for:

- the propriety and regularity of financial transactions under my control;
- the economical, efficient, and effective use of resources placed at the Board’s disposal; and
- safeguarding the assets of the Board.

In preparing the Accounts I am required to comply with the requirements of the Government’s Financial Reporting Manual and in particular to:

- observe the accounts direction issued by the Scottish Ministers including the relevant accounting and disclosure requirements and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the Government’s Financial Reporting Manual have been followed and disclose and explain any material departures; and
- prepare the accounts on a going concern basis.

I confirm that the Annual Report and Accounts as a whole are fair, balanced, and reasonable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced, and understandable.

I am responsible for ensuring proper records are maintained and that the Accounts are prepared under the principles and in the format directed by Scottish Ministers.

To the best of my knowledge and belief, I have properly discharged my responsibilities as accountable officer as intimated in the Departmental Accountable Officer’s letter to me of 31 January 2020.

Governance Statement

Scope of Responsibility

As Accountable Officer, I am responsible for maintaining an adequate and effective system of internal control that supports compliance with the organisation's policies and promotes achievement of the organisation's aims and objectives, including those set by Scottish Ministers. I am also responsible for safeguarding the public funds and assets assigned to the organisation. These financial statements consolidate the Health Board's Endowment fund, the Fife Health Charity. This statement includes any relevant disclosure in respect of these Endowment funds.

Purpose of Internal Control

The system of internal control is based on an ongoing process designed to identify, prioritise, and manage the principal risks facing the organisation. The system aims to evaluate the nature and extent of risks, and manage risks efficiently, effectively, and economically.

The system of internal control is designed to manage rather than eliminate the risk of failure to achieve the organisation's aims and objectives. As such, it can only provide reasonable and not absolute assurance.

The process within the organisation accords with guidance from Scottish Ministers in the Scottish Public Finance Manual (SPFM) and supplementary NHS guidance and has been in place for the year up to the date of approval of the annual report and accounts.

The SPFM is issued by Scottish Ministers to provide guidance to the Scottish Government and other relevant bodies on the proper handling and reporting of public funds. The SPFM sets out the relevant statutory, parliamentary, and administrative requirements, emphasises the need for efficiency, effectiveness, and economy, and promotes good practice and high standards of propriety.

Governance Framework

The Board has collective responsibility for health improvement, the promotion of integrated health and community planning through partnership working, involving the public in the design of healthcare services and staff governance.

Members of Health Boards, as detailed on page 15, are selected on the basis of their position, or the particular expertise, which enables them to contribute to the decision-making process at a strategic level.

The Board meets every two months to progress its business and holds a Development Session in intervening months to discuss topical and strategic issues for NHS Fife. The Code of Corporate Governance, which is revised on an annual basis, identifies Committees and Sub-Committees that report to the Board to help it fulfil its duties. These include the following governance Committees:

- Clinical Governance;
- Audit & Risk;
- Staff Governance;
- Remuneration;
- Finance, Performance & Resources; and
- Public Health & Wellbeing

<u>Clinical Governance Committee</u>

Principal Function:

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To provide the Board with the assurance that appropriate clinical governance mechanisms and structures are in place and effective throughout the whole of Fife Health Board's responsibilities.

Membership:
- Six Non-Executive or Stakeholder Members of the Board
- Chief Executive
- Medical Director
- Director of Nursing
- Director of Public Health
- A Staff Side Representative of NHS Fife Area Partnership Forum
- One Representative from the NHS Fife Area Clinical Forum

Chair:
Arlene Wood, Non-Executive Board Member

Frequency of Meetings:
As necessary to fulfil its remit and not less than six times per year.

Audit & Risk Committee

Principal Function:
To provide the Board with the assurance that the activities of Fife Health Board are within the law and regulations governing the NHS in Scotland and that an effective system of internal control is maintained. The duties of the Audit & Risk Committee are in accordance with the Scottish Government Audit & Assurance Committee Handbook, dated March 2018, and associated Treasury guidance on assurance mapping.

Membership:
- Five Non-Executive or Stakeholder Members of the Board

Chair:
Alastair Grant, Non-Executive Board Member

Frequency of Meetings:
As necessary to fulfil its remit and not less than four times per year.

Staff Governance Committee

Principal Function:
To support the development of a culture within the health system where the delivery of the highest standard possible of staff management is understood to be the responsibility of everyone working within the system, and is built upon partnership and collaboration, and within the direction provided by the Staff Governance Standard.

Membership:
- Four Non-Executive Members of the Board
- Employee Director
- Chief Executive
- Director of Nursing
- Staff Side Chairpersons of the Local Partnership Forums

Chair:
Sinead Braiden, Non-Executive Board Member

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Frequency of Meetings:
As necessary to fulfil its remit but not less than four times a year.

Remuneration Committee

Principal Function:
To consider and agree performance objectives and performance appraisals for staff in the Executive cohort, to oversee performance arrangements for designated senior managers, and to direct the appointment process for the Chief Executive and Executive Members of the Board.

Membership:
- Fife NHS Board Chairperson
- Two Non-Executive Members of the Board
- Employee Director

Chair:
Alistair Morris, Acting Chairperson (to 31.01.2024)
Patricia Kilpatrick, Chairperson (from 01.02.2024)

Frequency of Meetings:
As necessary to fulfil its remit but not less than three times a year.

Finance, Performance & Resources Committee

Principal Function:
To keep under review the financial position and performance against key non-financial targets of the Board and to ensure that suitable arrangements are in place to secure economy, efficiency, and effectiveness in the use of all resources, and that the arrangements are working effectively.

Membership:
- Six Non-Executive or Stakeholder Members of the Board
- Chief Executive
- Director of Finance
- Medical Director
- Director of Nursing
- Director of Public Health

Chair:
Alistair Morris, Non-Executive Board Member

Frequency of Meetings:
As necessary to fulfil its remit but not less than four times per year.

Public Health & Wellbeing Committee

Principal Function:
To assure Fife NHS Board that NHS Fife is fully engaged in supporting wider population health and wellbeing for the local population, including overseeing the implementation of the population health and wellbeing actions defined in the Board's strategic plans and ensuring effective contribution to population health and wellbeing related activities.

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Membership:

- Fife NHS Board Chairperson
- Three Non-Executive Members of the Board
- Employee Director
- Chief Executive
- Director of Finance & Strategy
- Director of Nursing
- Director of Public Health
- Medical Director

Chair:
Alistair Morris, Acting Chairperson (to 31.01.2024)
Patricia Kilpatrick, Chairperson (from 01.02.2024)

Frequency of Meetings:
As necessary to fulfil its remit but not less than six times per year.

Other Governance Arrangements

The conduct and proceedings of the NHS Board are set out in the Board's Standing Orders. These specify the matters which are solely reserved for the NHS Board to determine, the matters which are delegated under the scheme of delegation and the matters which are remitted to a Standing Committee of the NHS Board. In April 2020, the Board adopted the new national Model Standing Orders for NHS Boards, created to support the implementation of the NHS Blueprint for Good Governance, and to improve consistency across NHS Boards using this 'Once for Scotland' approach. There have been no amendments to the Standing Orders in 2023/24.

A new Code of Conduct for Members of Fife NHS Board (https://www.nhsfife.org/about-us/nhs-fife-board/code-of-conduct-for-board-members/) was formally adopted in 2022, based on model guidance created for NHS Scotland and approved by the Standards Commission for Scotland. Board members have received national briefings on the revised Code's requirements and regular updates from the Standards Commission on related guidance, and updates have been made to the Board's internal Gifts & Hospitality and Registering and Declaration of Interests processes to capture the required information under the Code. Both the Standing Orders, Code of Conduct for Members and Scheme of Delegation are contained within the Board's Code of Corporate Governance, which also includes the Standing Financial Instructions. These documents are the focus of the NHS Board's annual review of governance arrangements. The annual review also covers updating the remits of the NHS Board's Standing Committees and a self-assessment of each Committee's effectiveness, along with a review of the Board's Financial Operating Procedures.

All committees of the Board are required to provide an Annual Statement of Assurance to the Audit & Risk Committee and Board, describing their membership, attendance, frequency of meetings, business addressed, outcomes and extent of assurances provided. Each Statement also provides detail on risk management arrangements and an assessment of how Best Value principles have been addressed and seek to demonstrate how each Committee have fully fulfilled their roles and remit during the reporting year. The format and content of these reports have been further expanded in the current year, taking on board past feedback, and a template for the respective sub-committees / groups that formally report into a Standing Committee has been followed to ensure consistency. Further guidance has also been provided to governance colleagues in the Fife Integration Joint Board in order to improve the content of assurances from their committees to the NHS Board.

All NHS Board Executive Directors undertake a review of development needs as part of the annual performance management and development process. Access to external and national programmes in line with development plans and career objectives is also available. During 2023/24, the Executive Directors continued their programme of team coaching to further develop strong collaborative leadership and to establish an approach to model and enact ways of working and behaviours that are integral to the vision of NHS Fife.

From November to December 2023, the Board has been engaged in a self-assessment of its governance against the terms of the second edition of the Blueprint for Good Governance, published in December 2022. The self-assessment involved all Board members and routine attendees undertaking a detailed survey measuring the Board's current operations against the Blueprint functions. This was subsequently followed by a dedicated in-person Board development session held in February 2024, facilitated by Board Development colleagues from NHS Education for Scotland, to agree the Board's actions, collating these in the format of an improvement plan.

The self-assessment exercise and resulting action plan is a key element of implementing the arrangements of the NHS Scotland Blueprint for Good Governance and the survey and plan format are provided to Boards by Scottish Government as part of a Once for Scotland approach common across all Health Boards. The second edition of the Blueprint builds on the original guidance issued by Scottish Government in 2019 and sets out the methodology for assessing the effectiveness of the healthcare governance system against the principles of good governance. The aim is for Boards to develop a programme of activity to drive continuous improvement in the delivery of good governance. In seeking to map the Board's arrangements for governance against the standards given in the national Blueprint, detailed consideration has been given as to whether the right systems are in place to provide appropriate levels of assurance and to identify areas where improvements can be made.

The Board's action plan (available at https://www.nhsfife.org/media/xz1jg4n5/nhs-fife-blueprint-action-plan-march-24-1.pdf) was formally approved in March 2023 and submitted to Scottish Government thereafter. A series of actions were identified, including renewal of the Board's risk appetite statement, finalising a stakeholder engagement strategy, increasing the benchmarking information available to the Board, and facilitating more opportunities for Board members to engage with staff and stakeholder groups. Monitoring the delivery of these actions will continue over the next 2024/25 reporting year, with external reporting to Scottish Government on progress thereon.

To support the Board-level governance review, each year every Board committee also undertakes a detailed self-assessment exercise, via the format of an online questionnaire surveying both members and attendees for their feedback. The regular review of Board committee effectiveness is an important tool in identifying areas where improvements can made, such as in enhancing training opportunities, and is a central part of the internal year-end assurance process.

The Chief Executive is accountable to the NHS Board through the Chair of the Board. The Remuneration Committee agrees the Chief Executive's annual objectives in line with the Board's strategic and corporate plans.

Non-Executive Directors have a supported orientation to the organisation, as well as a series of site visits and briefing sessions aligned to their committee appointments. An enhanced induction programme has been established to support new members and a dedicated Induction Pack (available at https://www.nhsfife.org/about-us/nhs-fife-board/board-members-induction-pack/) is updated on a rolling basis. This programme, developed originally by NHS Fife, has been used to create national guidance issued to all Boards across Scotland, as an

example of best practice. Opportunities for ongoing member support also exist at a national level via the NHS Scotland Board Development website (https://learn.nes.nhs.scot/17367/board-development) and related resources, and discussions around individual member development are a key part of the annual appraisal process of each member by the Chair.

To ensure that the NHS Board complies with relevant legislation, regulations, guidance and policies, a distribution process is in place to ensure that all Circulars and communications received from the Scottish Government Health and Social Care Directorate (SGHSCD) are directed to Senior Managers who are held responsible for implementation. A dedicated Covid-19 log has continued to operate throughout the current year to capture and track all relevant correspondence. A process to monitor compliance with regulations and procedures laid down by Scottish Ministers and the SGHSCD is in place.

In accordance with the principles of Best Value, the Board aims to foster a culture of continuous improvement. The Board Committees support the Board in delivering best value through the relevant focus within their Terms of Reference and the annual workplans. Directors and Managers are encouraged to review, identify, and improve the efficient and effective use of resources.

NHS Fife has implemented the National Whistleblowing Standards, introduced to all Boards from 1 April 2021. A dedicated Whistleblowing Champion took up position on the Board as a full Non-Executive Member in April 2021. The Board's Staff Governance Committee has undertaken review of the National Whistleblowing Standards and have overseen their adoption locally, including the cycle of regular reporting on the number of cases raised under the Standards and also any anonymous concerns raised. A refreshed approach, realigning the responsibilities for implementation of the Standards outwith the Workforce Directorate, is anticipated to take effect in 2024/25. The Board is committed to achieving the highest possible standards of service and the highest possible ethical standards in public life in all of its practices. To achieve these ends, it encourages staff to use internal mechanisms for reporting any fraud, malpractice or illegal acts or omissions by its staff. The Board wishes to create a working environment which encourages staff to contribute their views on all aspects of patient care and patient services. All staff have a duty to protect the reputation of the service they work within. The Board does not tolerate any harassment or victimisation of staff using this policy, and treats this as a serious disciplinary offence, managed under the NHS Scotland Conduct Policy.

There is a well-established feedback and complaints system in place whereby members of the public can make a formal complaint to the Board regarding care or treatment provided by or through the NHS, or how services in their local area are organised if this has affected care or treatment. Information on our complaints procedures is available on the NHS Fife website at https://www.nhsfife.org/get-involved/feedback-and-complaints/.

The Board is committed to working in partnership with staff, other public sector organisations and the third sector. NHS Fife strives to consult all of its key stakeholders. We do this in a variety of ways. How we inform, engage and consult with patients and the public in transforming services is an important part of how we plan for the future. To fulfil our responsibilities for public involvement, we routinely communicate with, and involve, the people and communities we serve, to engage with them on our plans and performance.

An Integrated Performance & Quality Report (IPQR) was presented to each Clinical Governance Committee, Finance, Performance & Resources Committee, Staff Governance Committee, Public Health & Wellbeing Committee and Board meeting. This provides detailed monitoring information on a range of measures covering financial and clinical delivery. The enduring impact of the pandemic on performance against key metrics has been significant

and the Board notes the challenges faced in recovering the position, particularly in relation to reducing waiting times and the number of referrals. The NHS Board also considers at each meeting the most up-to-date information available in relation to the financial position. A review of the IPQR's content and format is presently underway, to address actions from the Board's Blueprint Improvement Plan, improve benchmarking data, and to ensure it remains relevant and clear to Board members.

Any reports resulting from external regulatory inspections of, or visits to, NHS Fife healthcare sites are considered in detail at the Board's Clinical Governance Committee. The report of an unannounced Healthcare Improvement Scotland (HIS) inspection of Mental Health services at Queen Margaret and Whyteman's Brae hospitals (available online at www.healthcareimprovementscotland.scot/publications/queen-margaret-hospital-infection-prevention-and-control-in-mental-health-services-inspection-report-may-2023-pdf-376k/) focused on infection prevention and control and was considered by the Committee at its July 2023 meeting. This inspection resulted in the identification of three areas of good practice, seven requirements and two recommendations for the Board to implement. Members were able to take broad assurance from the positive feedback on the good practice identified therein and the robust action plan to address any outstanding requirements, detailing improvement actions necessary. A Safe Delivery of Care Inspection was undertaken by HIS in the Victoria Hospital between 31 July and 2 August 2023, and the report was published in October 2023 (available at www.healthcareimprovementscotland.scot/publications/victoria-hospital-safe-delivery-of-care-inspection-report-october-2023/). The inspection resulted in four areas of good practice, two recommendations and nine requirements to be addressed. At their September 2023 meeting, the Clinical Governance Committee considered the issues raised by the inspectors, particularly in relation to concerns around adequate estate environment and backlog maintenance in Ward 5, resulting in the decant of services and the priority refurbishment of the ward area. The Committee's consideration of the issue was also informed by a site visit to the ward by a number of the Board's Non-Executive members. The Board has taken assurance from the remedial work underway to address the areas of risk highlighted in the inspection, noting, however, some concern that internal controls had not operated to the required levels of efficiency to pick up the various estate-related issues outwith the inspection process. It was noted that the inspection had also highlighted issues about the oversight, communication and escalation processes in relation to the condition of the environment. An update on progress in meeting the action plan created to address the inspector's findings was considered at the Clinical Governance Committee's March 2024 meeting, with members taking assurance from the fact that the action plan had been fully accepted by HIS and the remedial refurbishment works to Ward 5 were on track for completion in March 2024. A follow-up visit to the ward was undertaken by Non-Executive members in April 2024, to view the refurbished space and to take assurance from the actions implemented.

During 2023/24 the Board, as the Corporate Trustee for the Fife Health Charity, kept under review the overall governance for charitable funds, including the approach to the management and oversight of funds.

Integration Joint Board (IJB)

A number of NHS Fife Board Members also have a role on the Integration Joint Board and its Committees and maintain responsibility for their respective professional remits at all times. The Director of Health & Social Care as the Accountable Officer for the IJB is also a direct report to the NHS Fife Chief Executive. The Chief Executive maintains responsibility for all aspects of governance relating to health services across Fife.

Minutes of the IJB's Quality & Communities Committee are considered at the Clinical Governance Committee of the NHS Board and an annual assurance statement is also

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provided from the IJB's Chief Internal Auditor and the IJB's Quality & Communities Committee to support the assurance process. The Integrated Performance & Quality Report encompasses all aspects of delegated services.

The approach adopted for health and social care within Fife is the 'fully delegated' model, with the IJB responsible for governance and assurance of all operational activities for its delegated functions. During 2023/24 the NHS Board and supporting governance committees maintained an overarching assurance role in relation to both clinical and financial governance, and therefore oversight of the adequacy and effectiveness of controls for delegated functions. The operational and governance framework of the IJB continues to be developed, to ensure clarity and consistency of approach.

A revised Fife Integration Scheme, following joint review by the partners, received formal sign-off by the Scottish Government on 8 March 2022 and is next due for review in 2027. The format of the reviewed Scheme continues to follow the Model Integration Scheme introduced across Scotland. The Fife version clearly details:

- Information on the role of the Chief Officer in respect of operational direction and accountability to the IJB, in addition to their role overseeing clinical and care governance.
- Clarity around the responsibilities and accountabilities of NHS Fife and Fife Council for clinical and care governance and the professional roles held by the Executive Nurse Director, the Executive Medical Director, and the Chief Social Work Officer.
- Confirmation that the IJB will ensure mechanisms to discharge its statutory responsibilities for the delivery of integrated health and social care services, health and wellbeing outcomes, the quality aspects of integrated functions for strategic planning and public involvement and delivery, monitoring and reporting on integration thought Localities, Directions, and its Annual Performance Report.
- Details on the financial basis upon which the parties share the cost of overspends or underspends incurred by the IJB.

Review of Adequacy and Effectiveness

As Accountable Officer, I am responsible for reviewing the adequacy and effectiveness of the system of internal control. My review is informed by:

- Discussions with Executive Directors and senior managers who are responsible for developing, implementing and maintaining internal controls across their areas.
- Annual Statements of Assurance from each Director.
- Reports from other inspection bodies.
- The work of the internal auditors, who submit regular reports to the Audit & Risk Committee, which include their independent and objective opinion on the effectiveness of risk management, control and governance processes, together with recommendations for improvement.
- The work of the external auditors, which includes their independent and objective opinion on the audit of the annual report and accounts, their review of key financial systems and consideration of the four key audit dimensions in their Annual Report.
- The completion of self-assessment questionnaires considering the Board's own performance and that of its Committees.
- The range of topics covered at Board Development Sessions, to develop the knowledge, awareness and engagement of both Executive and Non-Executive Board members on strategic matters.
- The effectiveness of the Board's agreed approach to Risk Management.

- The work of the other assurance Committees and groups supporting the Board: Staff Governance Committee, Remuneration Committee, Finance, Performance & Resources Committee, Public Health & Wellbeing Committee, and the Clinical Governance Committee (which also embraces Information Governance & Security).

The Annual Internal Audit Report 2023/24 was provided to the Audit & Risk Committee concluding that the Board has adequate and effective controls in place, and that the 2023/24 internal audit plan has been delivered in line with public sector internal audit standards.

(Comment to be added in connection with service audit reports when received).

Data Quality

The Board receives a range of reports which include financial, clinical and staffing information. In general, these reports are considered by the Executive Directors' Group and at a Governance Committee prior to being discussed at the Board. This allows for detailed consideration and scrutiny of the content, completeness and clarity of the information being provided to the Board.

Assurance on the information included in reports also comes from the overall approach to the management of information (overseen by the Information Governance & Security Steering Group) and validation processes and assurances on the quality of information provided from internal audit and other scrutiny bodies. I can confirm that that there were no significant control weaknesses or issues reported at the year-end which the Information Governance & Security Steering Group considered should be disclosed in the Governance Statement, as they may have impacted financially or otherwise in the year or thereafter.

Risk Management

The Chief Executive of the NHS Board, as Accountable Officer, whilst personally answerable to Parliament, is ultimately also accountable to the Board for the effective management of risk.

NHS Scotland bodies are subject to the requirements of the SPFM and must operate a risk management strategy in accordance with relevant guidance issued by Scottish Ministers. The general principles for an effective risk management strategy are set out in the SPFM.

NHS Fife is committed to maintaining and fully embracing an effective organisational risk culture. All of the key areas within the organisation maintain a risk register. The risk registers are held in Datix, the Risk Management Information System. The Risk Management team provide training and support in response to the needs of individuals and teams.

During 2023/24 several initiatives have been implemented to improve the effectiveness of the risk management framework within NHS Fife. These include details of key workstreams described below.

Risk Management Framework

An updated Risk Management Framework was approved by the Fife NHS Board in September 2023. The intention was to also subsequently update the related Risk Register / Risk Assessment Policy GP/R7. However, whilst redrafting the policy, it was recognised that there was considerable duplication with the Framework. Following consultation with key stakeholders, it was determined that a separate policy was not required as key elements of the policy not already covered will be added to the Framework. This approach was supported by the Risks & Opportunities Group on 5 December 2023 and endorsed by the

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Audit & Risk Committee at its meeting on 13 December 2023. The revised Framework and a Delivery Plan to support implementation are currently being finalised and will be submitted to the Audit & Risk Committee and the Board for approval in May 2024.

Risk Appetite

The Board's Risk Appetite was set in July 2022, and considered and maintained as part of the update to the Board's Risk Management Framework in September 2023. In recognition that risk appetite must be reviewed and adjusted where necessary to reflect changes in the internal and external environment, a Board Development Session on Risk Appetite was held on 8 April 2024. This has provided further opportunity to discuss and reflect on the extant appetite and consider if changes are required in terms of both the risk appetite descriptors, and the levels of risk the Board is prepared to tolerate or treat in the pursuit of its strategic priorities and delivery of the Population Health & Wellbeing Strategy. This is particularly relevant as we respond and adapt to the challenging financial outlook, and further develop and implement the Board's new 'Re-form, Transform, Perform' Framework, which sets out the approach the Board will take to enable change and work toward a financially and operationally sustainable future.

Risk reports to the governance committees, the Audit & Risk Committee and the Board make explicit reference to the status of the risks in relation to the related risk appetite.

Corporate Risk Register

The corporate risks collectively outline the organisational risks associated with the delivery of the Board's Population Health & Wellbeing Strategy. It is recognised that all risks on the corporate risk register are impacted by and are aligned to the Strategy. All corporate risks are reviewed regularly and reported bi-monthly to the governance committees and twice a year to the Board.

Committee feedback received on the Corporate Risk Register during 2023-2024, through its presentation by Executive risk owners and following discussion by the governance committees, has been carefully considered and acted upon to improve its content. This has included specific reviews of the following aspects associated with corporate risk reporting:

Assurance Levels

A review was carried out on the use of the "levels of assurance" detailed within the Committee Assurance Principles document routinely provided to committees with the Corporate Risk Register reports, including Deep Dive Reviews. Following agreement by the Executive Directors' Group and endorsement by the Audit & Risk Committee in June 2023, it was agreed to adopt the four-level assurance model, used by our Internal Auditors. The Assurance Principles document was updated to incorporate this assurance model, as was the Deep Dive Review template. The latter now requires the risk owner to provide a level of assurance to the Committee as part of the Deep Dive's creation or review of a previous deep dive.

These developments were implemented from July 2023 and have added consistency to our reporting. The use of the assurance levels continues to evolve, as we further seek to enhance the evidence to substantiate the level of assurance being offered.

Since November 2023, reports to the governance committees have also included a statement on the latest position in relation to the management of risks linked to the respective committees, and on the proposed "level" of assurance that members can take

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from the report, and that all actions, within the control of the organisation, are being taken to mitigate these risks as far as it is possible to do so.

Deep Dive Reviews

Corporate Risk Deep Dive reviews continue to form an important component of our risk assurance arrangements and provide a focus for in-depth discussion and scrutiny. As at 31 March 2024, 14 of the 18 corporate risks had undergone at least one deep dive. The instances in which this has not occurred include where committees have commissioned reviews of related non-corporate risks that are otherwise significant to their remit and, in one case, the addition of a new corporate risk.

An Audit & Risk Committee Development Session in October 2023 provided the opportunity to reflect on our experience and learning from deep dives undertaken over the last year. Recognising that a key characteristic of a risk deep dive review is that it should be carried out at specific points during the life-cycle of a risk, it was agreed to develop criteria for undertaking a deep dive review. The requirement for a deep dive will continue to be determined through routes including the Executive Directors' Group and the Risks & Opportunities Group. Decisions will be informed by consideration of specific trigger factors such as the creation of a new corporate risk, materially deteriorating risks, or the proposed de-escalation / closure of a corporate risk, as well as intelligence from within operational teams.

This approach was endorsed by the Audit & Risk Committee in December 2023 and shared with the other governance committees in January 2024.

Risk Rating Improvement Timescale

By their nature corporate risks are complex and carry an underlying level of inherent risk that can make effective risk management challenging. In some cases, the opportunity to conduct risk mitigation on the current risk level is limited or outwith the risk owner's ability to influence. Part of the complexity means the ability to mitigate corporate risk, in a short period of time, can be limited and so requires extended periods of time to plan, deliver and embed the risk mitigation actions.

Given this complexity, the levels of inherent risk associated with some of the risks and the confusion of changing current risk rating targets for the in-year target, it was agreed to remove the current in-year prediction and match the overarching risk target rating with a more meaningful and realistic timescale i.e. an expected date of achievement. This development was implemented from July 2023.

Corporate Risk Review Cycle

During the period under review, consideration was given to establishing a more balanced and efficient approach to providing reports to the governance committees that recognised the need for Committee assurance on both the regularity of risk review and meaningful risk updates. As the governance committees meet six times a year, there was an opportunity to rotate the corporate risk review frequency over these six meetings to provide assurance, while supporting the requirement for efficiency. It was agreed that while corporate risk owners can review and update their risks at any time, they would be required to review and update where necessary their total set of risks at least every four months. This approach was implemented from September 2023 and is working effectively.

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During 2023- 2024, developments of note in relation to the corporate risks include the following :

Covid-19: The risk achieved and surpassed its risk target. In light of this and as the risk had been stable over several months, it was recommended to and agreed by the Clinical Governance Committee in January 2024, that the risk should close on the Corporate Risk Register with oversight transferred to the Public Health Assurance Committee.

Quality and Safety: Given the governance arrangements in place, and the number of completed mitigations, a risk review indicated the potential to reduce the risk level from high to moderate and so bring the risk within its risk appetite of Moderate. This was recommended to and agreed by the Clinical Governance Committee in March 2024.

Optimal Clinical Outcomes: This risk was subject to a dedicated Board Development session in October 2023, and a second deep dive review. It was agreed at the Clinical Governance Committee in March 2024. that there should be further discussion through the Risks & Opportunities Group on whether it is appropriate to close the risk and develop a revised risk or risks.

Preparation for the Implementation of the Health and Care (Staffing) (Scotland) Act 2019: In November 2023, the Board approved the addition to the Corporate Risk Register of the above risk.

Potential New Corporate Risks

Pandemic Preparedness/Biological Threat: A report and an initial deep dive review are being prepared and progressed through the Public Health Assurance Committee and the Executive Directors' Group in March/April to consider if the new risk should be included on the Corporate Risk Register, and if so, to which committee it is best aligned before reporting to Committee in May 2024.

Capital Funding - Service Sustainability: A report and an initial deep dive review are being prepared and progressed through the Financial Capital Investment Group (FCIG) and the Executive Directors' Group during March/April 2024, to consider if the new risk should be included on the Corporate Risk Register, before reporting to the Finance, Performance & Resources Committee in May 2024.

The Corporate Risk Register and the associated assurance framework continues to evolve and in this way will be subject to ongoing refinement and development.

Strategic Risk Profile

The Strategic Risk Profile, as a dashboard set in the context of the Board's risk appetite, continues to be reported in the monthly Board Integrated Performance & Quality Report.

The full Profile is part of the introductory Corporate Risk Summary section. Extracts related to specific strategic priorities are contained within the Assessment section against the following areas of performance; clinical governance, operational, finance, staff governance and public health and wellbeing. A section on the corporate risks is now included in the introduction to the Annual Delivery Plan.

Risks & Opportunities Group

The Risks & Opportunities Group was established in September 2022 and supports and embeds an effective risk management framework and culture across the organisation. The

Group meet bi-monthly to support the continued development of an effective and consistent approach to the management of Operational Risk as well as the ongoing consideration of enhancements to the Corporate Risk Management approach.

The Group has reviewed and updated its Terms of Reference, with the most recent iteration approved in August 2023. At each meeting the Risks & Opportunities Group reviews progress against its Annual Workplan, considers issues for escalation and receives reports on any other relevant business. The Risks & Opportunities Group has reported on its work to the Audit & Risk Committee in June, August and December 2023, and in March 2024.

During 2023-2024, the Group's work has included:

- Supporting the development and updates of the Risk Management Framework;
- Continuing to inform and support the developments and improvements mentioned above in relation to the Corporate Risk Register, recommendations on changes or additions to the corporate risks and the broader organisational risk profile, assurance levels and Deep Dive Reviews;
- Contributing to the development of a Risk Summary Dashboard and Guidance to support and enhance our operational risk management approach and maintain alignment to the principles outlined within the Risk Management Framework. The Guidance seeks to provide a working method and activities for individuals and teams to use when reviewing the Dashboard to manage their risks in a consistent and time effective manner. A plan to support Dashboard implementation will be taken forward through the remit of the Risks & Opportunities Group during 2024;
- Reviewing the Risk Assessment Matrix and considering the need for updates to descriptors and terminology. Similar considerations have taken place in other NHS Boards. At a national meeting facilitated by Healthcare Improvement Scotland in February 2024 in which the Board took part it was agreed to review the national matrix and expand and modernise the content. A short life working group is to be set up to take forward this work in which NHS Fife will seek to be involved.
- Considering the development of meaningful Key Performance Indicators which should be implemented to demonstrate active risk management;
- Identifying opportunities, particularly in relation to delivery of the Population Health and Wellbeing Strategy. Realistic Medicine principles have also been agreed as an area of focus for 2024/25.

The Group has undertaken a self-assessment of its own effectiveness, which has been considered at its meeting in April 2024 and thereafter reported to the Audit & Risk Committee in May 2024. The assessment covers elements including membership and group dynamics, role clarity and expectations, effectiveness of the scrutiny and challenge function, management of the agenda and impact of the Group in terms of outputs, as well as suggested actions to further improve the Group's effectiveness in respect of delivering its remit.

The Risks & Opportunities Group has developed a workplan for 2024/25 that will drive efforts to further develop a positive and proactive approach to risk management across the organisation.

During 2023/24, the Director of Finance & Strategy, as Executive Lead for Risk Management, reported on all of the above to the Audit & Risk Committee.

Population Health & Wellbeing Strategy – Year One

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NHS Fife Board formally approved a new Population Health & Wellbeing Strategy at its meeting in March 2023. The new strategy sets out the strategic ambitions for NHS Fife for the next five years, focusing on our key strategic priorities and how we will take forward plans to deliver these. The strategy is intended to be dynamic and to allow NHS Fife to be agile to respond to future emergent pressures and changing priorities on an ongoing basis. It candidly acknowledges the legacy of the pandemic on our population, our staff and our services. We know that across our healthcare system, performance on a range of metrics (for example, waiting times) is not to the standard that we want it to be. Addressing this is a theme running throughout the strategy, in line with national policy.

Development of the strategy has been underpinned by a strategic framework that includes the overall vision Living Well, Working Well and Flourishing in Fife. This is supported by four strategic priorities: (i) improving health and wellbeing; (ii) improving the quality of health and care services; (iii) improving staff experience and wellbeing; and (iv) delivering value and sustainability. For each of the four priorities we have identified key ambitions, summarised what we were told through the engagement work, and given examples of what we plan to do to deliver against each. Each priority is supported with stories that emerged from our engagement work to make our work relatable to our public and our staff. The strategy is enabled by supporting workstreams in the distinct areas of digital and information, property and asset management, finance and workforce.

Board committees have received the first mid-year update on the strategy's implementation, covering the period April to September 2023, which has detailed the achievements delivered in the first six months of 2023/24 and the plans in place for the October 2023 to March 2024 period. An annual report outlining activities in support of delivery of the strategy has been considered by the Board in May 2024. Given the early stage of strategy implementation, it is not yet possible to show achievement of key outcomes, but the reporting seeks to provide assurance on the breadth of work underway at the present time. The annual report includes information on:

- activities undertaken between October 2023 and March 2024.
- a summary of the proposed suite of impact indicators with baselines and measurement plans.
- refreshed deliverables (the 'what we will do' section) for 2024/25, to ensure that our work remains aligned to the priorities of the organisation; and
- description of any changes in national policy that will affect NHS Fife and impact upon local priorities.

A range of opportunities and challenges are emerging as we consider longer term planning horizons, beyond the timescale of the current strategy, and these are being considering as we undertake our ongoing planning work.

'Re-form, Transform, Perform' Framework

In response to the Scottish Government's budget announcement in December 2023, which will impact on the future delivery of public services across Scotland, the Executive Directors' Group, supported by the System Leadership Team across services, have worked at pace to develop the Board's new Re-form, Transform, Perform (RTP) Framework. This has been in parallel with finalisation of the Board's Annual Delivery Plan and the Medium-Term Financial Plan for 2024/25 – 2026/27. All three documents received formal Board approval in March 2024, with subsequent submission to Scottish Government.

The Scottish Government advised on 4 April 2024 that given the projected financial position for 2024/25, after 3% efficiency savings, does not achieve a breakeven position, that the

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Board must work to reduce expenditure to move towards that position. There are a number of schemes being developed to bridge the remaining 4% target efficiency reduction which will be progressed at pace during April and May 2024. This will require NHS Fife to make cost savings at a level not previously delivered. We will need to ensure that these savings are achieved and delivered on a recurring basis to ensure long-term sustainability.

The Board's Population Health & Wellbeing Strategy remains the foundation of strategic intent and priorities for NHS Fife through to 2028, and the RTP will serve as a tactical plan to deliver these strategic aims, supported by our annual planning mechanisms. The new framework sets out our intention to implement a renewed strategic approach to creating the right conditions for us to evolve our services, empower our staff and to ensure a more sustainable future for NHS Fife, whilst meeting our statutory responsibility to contain spend within our allocated resources.
In developing the concept of RTP, several principles have been developed to describe the approach that will be taken by NHS Fife over the coming year:

Values Based Approach: Our values of care and compassion, dignity and respect, openness honesty and transparency, and quality and teamwork. These core values will guide decision-making, ensuring that all reforms and transformations explicitly consider our ethos and commitment to delivering quality care. This approach endeavours to foster a culture where staff feel valued and supported, promoting an environment conducive to innovation and excellence, and will offer opportunities to further embed our values in everything we do.

Staff Engagement: This approach will necessitate multi-professional input from clinical, managerial, corporate and all services in NHS Fife, to ensure we leverage the diverse expertise and experience of our teams to fully engage, influence and deliver change.

Systems Leadership: Collaboration across the system is vital for the success of the RTP approach. This approach will ensure we are collaborating closely with our partners, and across the totality of NHS Fife to ensure our efforts to deliver health and care are well coordinated. Systems leadership will be critical for driving the RTP agenda, leading beyond traditional boundaries and fostering collective responsibility across NHS Fife.

Pace of Delivery: To facilitate the pace, agility and urgency required to make rapid change, several approaches will be adopted. A weekly 'RTP' meeting of the Executive Directors' Group and associates will be convened to ensure rapid decision making and unlock of issues. An incident management mindset of 'what, so what, now what' will be core in understanding how delivery of initiatives remain on track and are moving at pace. Governance of RTP initiatives will be systems focussed to deliver strategic aims, as opposed to tasked focussed. To further support this work, it is proposed non-essential organisational governance activities are reviewed to release capacity to enable us all to prioritise RTP activities which deliver:

- cost reduction and/or
- improvement in performance and/or
- enhanced quality/safety.

Evidence Based: The RTP framework approach will triangulate data, analytics, and qualitative narrative to enhance health and care delivery. Intelligent use of these resources will enable informed and rapid decision making, and improve service efficiency, as well as delivery.

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Relentlessly Focused on Delivering Value Based and Care: Ensuring that our RTP plans foster a culture of stewardship where health and care colleagues take responsibility for the resources they use, practise shared decision making, and tackle unwarranted variation to provide better value care will be essential. Ensuring an organisational focus on value-based health and care will enable teams to increase job satisfaction as well as delivering better outcomes.

Close Alignment of Enabling Functions, Infrastructure Services and Operational Delivery: Alignment of our enabling functions (e.g., planning, workforce, finance, communications), our infrastructure services (e.g., estates and facilities, digital, pharmacy and medicines) and our operational delivery teams (acute services and Fife HSCP) in the organisation will be essential. This will require our systems leaders to embrace matrix management approaches for delivery of key objectives.

NHS Fife is mobilising for “Re-form, Transform, Perform” through four primary workstreams: Medicines; Service Design and Delivery; Infrastructure; and Workforce, each under executive leadership. These workstreams are designed to be agile and fluid, enhancing delivery without altering individual roles or accountabilities. Initial savings are allocated to these streams, enabling focused delivery, rapid progress, and effective monitoring, all under Executive oversight to align with strategic goals. Combined, these activities seek to deliver the required level of financial savings, to deliver a sustainable and recurring balanced financial position, whilst fostering new and innovative ways of addressing the healthcare challenges facing our local population.

Disclosures

During the 2023/24 Financial Year, there was one significant failure of internal control, related to a data breach / unauthorised release of patient-related information. The incident is described fully on page 17. The Information Commissioner’s Office has issued a Reprimand to the Board for the incident, concluding that NHS Fife did not have appropriate security measures in place to secure personal information, as well as low staff training rates. Following this incident, the Board has introduced new measures to strengthen internal controls in the related areas. An update on all actions undertaken by the Board in response to the Reprimand is due to be submitted to the Information Commissioner in June 2024 and as such, at the time of writing, full assurance cannot be given that the Board’s actions have fully addressed the original weaknesses in the control environment. Following the review and the action taken by the Information Commissioner’s Office, the Board assessed the incident matched the requirements for disclosure.

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NHS Fife

Meeting:	**Audit and Risk Committee**
Meeting date:	**16 May 2024**
Title:	**Losses and Special Payments Quarter 4**
Responsible Executive:	**Margo McGurk, Director of Finance and Strategy**
Report Author:	**Kevin Booth, Head of Financial Services & Procurement**

1 Purpose

This is presented for:
- Assurance

This report relates to a:
- National policy

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

2 Report summary

2.1 Situation

This paper presents a summary of the Board's losses and special payments covering quarter to (01/01/24 – 31/03/24).

2.2 Background

The Boards losses and special payments are controlled by the Financial Services Department and are reported to the Scottish Government as part of the annual accounts process.

As per section 16 of the Financial Operating Procedures, any potential losses or special payments are approved by the relevant Directorate/Department Head. The loss, theft or damage paperwork is then provided to the Head of Financial Services & Procurement for final approval.

The losses and special payments for the quarter are compiled into a report with a format and categories defined by the requirements of the Scottish Government. These categories include losses relating to fraud, damage to buildings/equipment, debtors' balances written

off, damage/loss of equipment and stock, vehicle accident and insurance excess payments and compensation payments covering financial losses suffered by patients amongst others. The report also quantifies both the clinical and non-clinical ex-gratia compensation payments for any legal claims that are negotiated and settled on the Board's behalf by the Central Legal Office following consultation with the Director of Finance & Strategy.

2.3 Assessment

The attached appendix summarises the Boards losses and special payments for the period 01/01/24 – 31/03/24. The reports categorise the types of losses and special payments made in the period whilst also quantifying the number of cases of each and the total monetary value.

There were 184 losses and special payments in the quarter which was a reduction in comparison to those reported in the third quarter (235). The total cost reported has also significantly decreased in the quarter to £470,374, down from £1,323,435 reported in quarter three. This decrease was predominantly as a result of the decrease in value of the clinical ex-gratia compensation payments (£380,363 down from £1,276,577). The value of non-clinical ex-gratia payments did however increase in the quarter (£65,200 up from £28,978). The total of Losses and Special Payments out with Clinical and Non-Clinical ex-gratia compensation payments was £24,811 which was an increase in comparison to quarter three (£17,880).

The Treasury team carried out their quarterly analytical review to provide additional assurance and the following items were noted:

1 – As a result of the year end debtors review, £12,898 was written off in relation to payroll debtors. This was an increase in the £5,661 written off in the mid-year review and this increase was the main contributor to the increased losses and special payments in the quarter out with the increase in clinical ex-gratia compensation payments.

2 - Non-clinical ex gratia payments (section 27) increased in the quarter (£65,200 up from £28,978) whilst the number of claims paid (4) remained the same as in the previous quarter.

3– Compensation payments for Patients and Staff Financial Loss (Section 28) reduced significantly in the quarter (£167 down from £4,428)

The above findings will be carried into the quarter one review to assist with the identification of any developing trends which may materially affect the Boards expected position moving forward.

At the end of the fourth quarter, the total losses and special payments in the year are £3,171,091 from 748 reports. This is significantly below the £4,387,238 from 767 reports that were recorded in the Annual Accounts for the year 2022/23.

The attached charts (see appendix 2) are presented to provide additional assurance over the trajectory of the high level categories. The clinical ex-gratia payments have averaged

£3.64m over the six year period and the spend in 2023/24 is below this average. The non clinical ex-gratia payments have averaged £196k over the six year period. Whilst the 2023/24 spend is above this level, the chart illustrates a significant increase in costs from 2021/22. The losses out with the clinical and non-clinical ex-gratia payments have averaged £86k across the six years and the 2023/24 spend remains below this level. It should be noted that there were significant one-off items in both 2018/19 and 2022/23 which if excluded show a more consistent average cost across the period of £64k which is in line with the 2023/24 spend.

2.3.1 Quality, Patient and Value-Based Health & Care

The losses and special payments require to be tightly controlled as they can have a material impact on the Boards financial position and ability to maintain budgets to ensure/enhance Patient Care.

2.3.2 Workforce

The procedural guidance for Managers to ensure the appropriate treatment for any losses or special payments is stated in the Financial Operating Procedures.

2.3.3 Financial

The losses and special payments are included within the Boards Annual Accounts process, subject to external audit and submitted to the Scottish Government for oversight.

2.3.4 Risk Assessment/Management

The level of the Board's losses and special payments are monitored to minimise any potential reoccurrence and future exposure to the Board.

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

The Board's treatment of its losses and special payments is consistently applied and follows the Financial Operating Procedures where relevant to ensure equity of treatment.

2.3.6 Climate Emergency and Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

The Boards quarterly losses and special payments are compiled by the Treasury Team and are presented to the Head of Financial Services and Procurement ahead of the annual submission to the Scottish Government. The losses and special payments included in the report have been approved by the appropriate Directorate/Department Head or in the case of legal settlements have come through following agreement/notification by the Central Legal Office.

2.3.8 Route to the Meeting

This paper is brought to the members attention to give visibility of the Board's losses and special payments in the quarter to 31 March 2024.

2.4 Recommendation

- **Assurance**

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Summary of Losses and Special Payments 01/01/24 – 31/03/24
- Appendix No 2, Previous 6 Years Comparison

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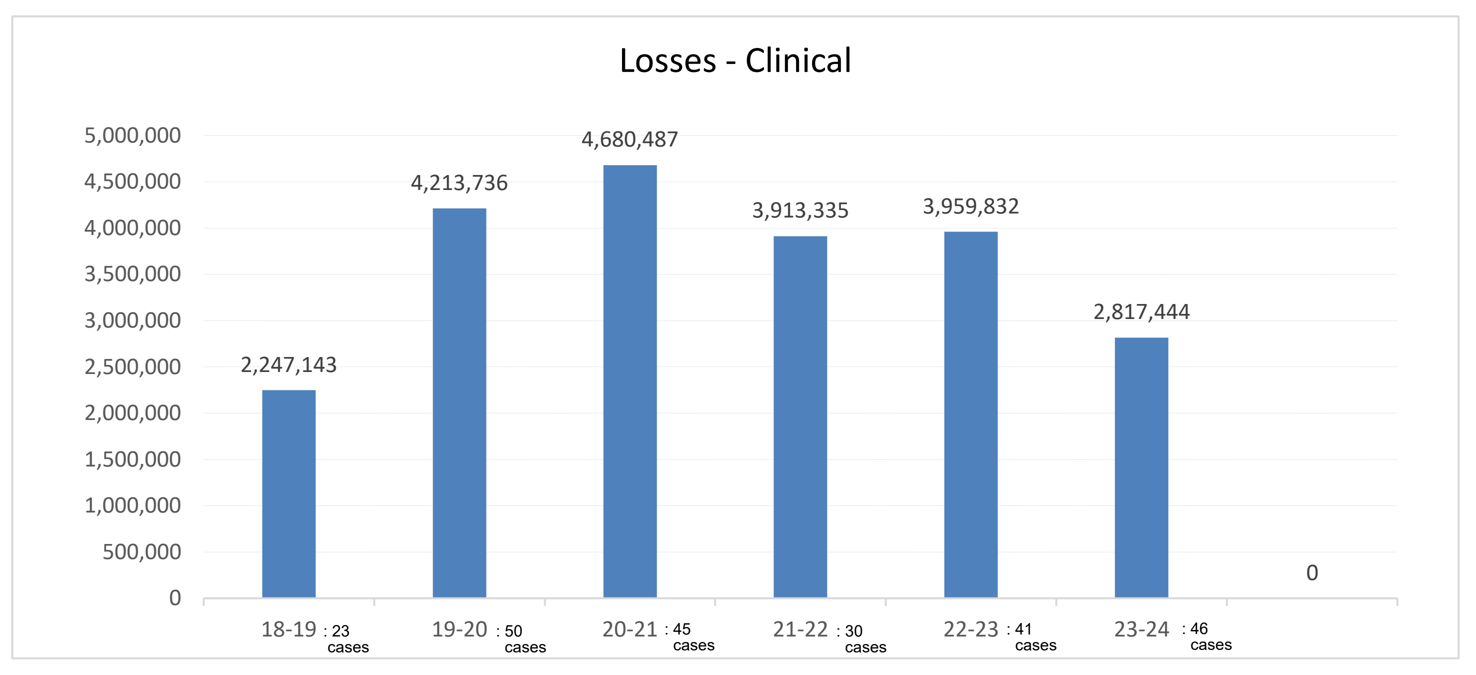
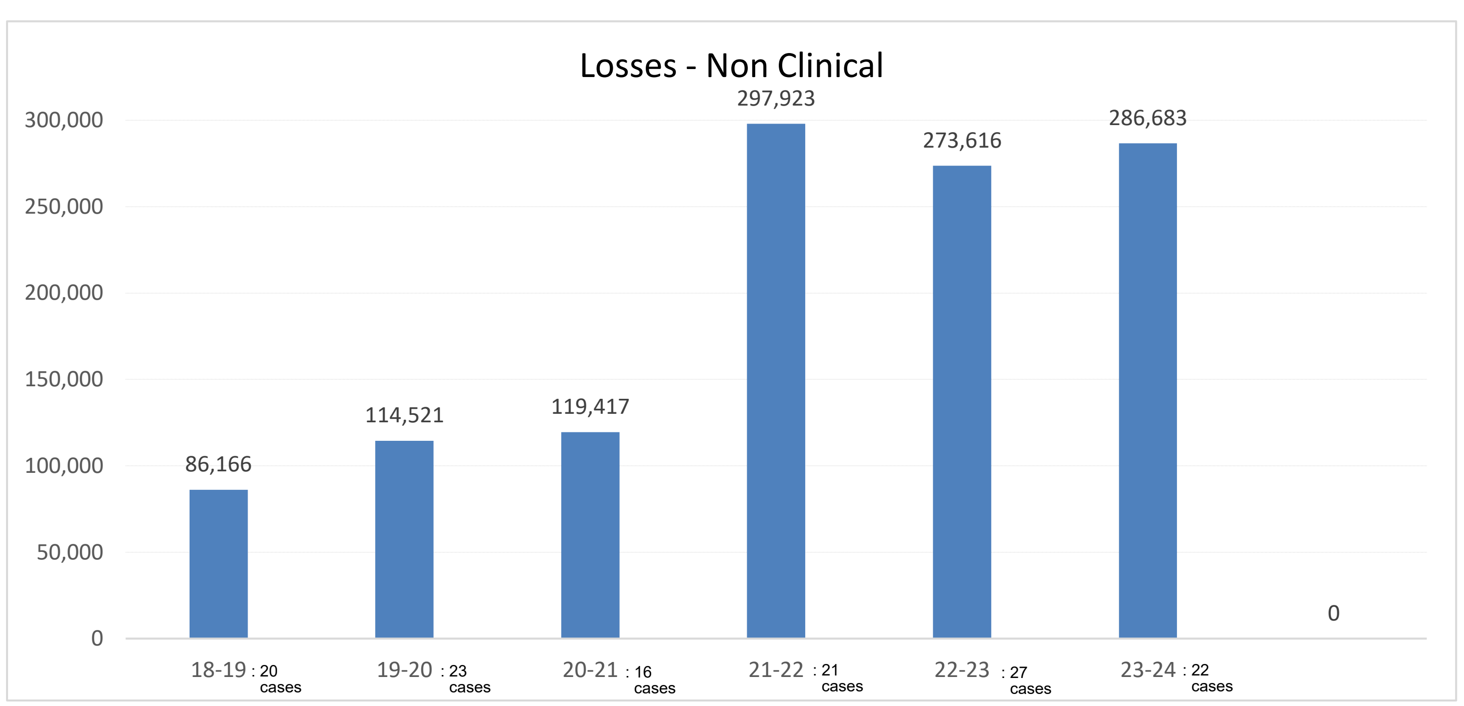
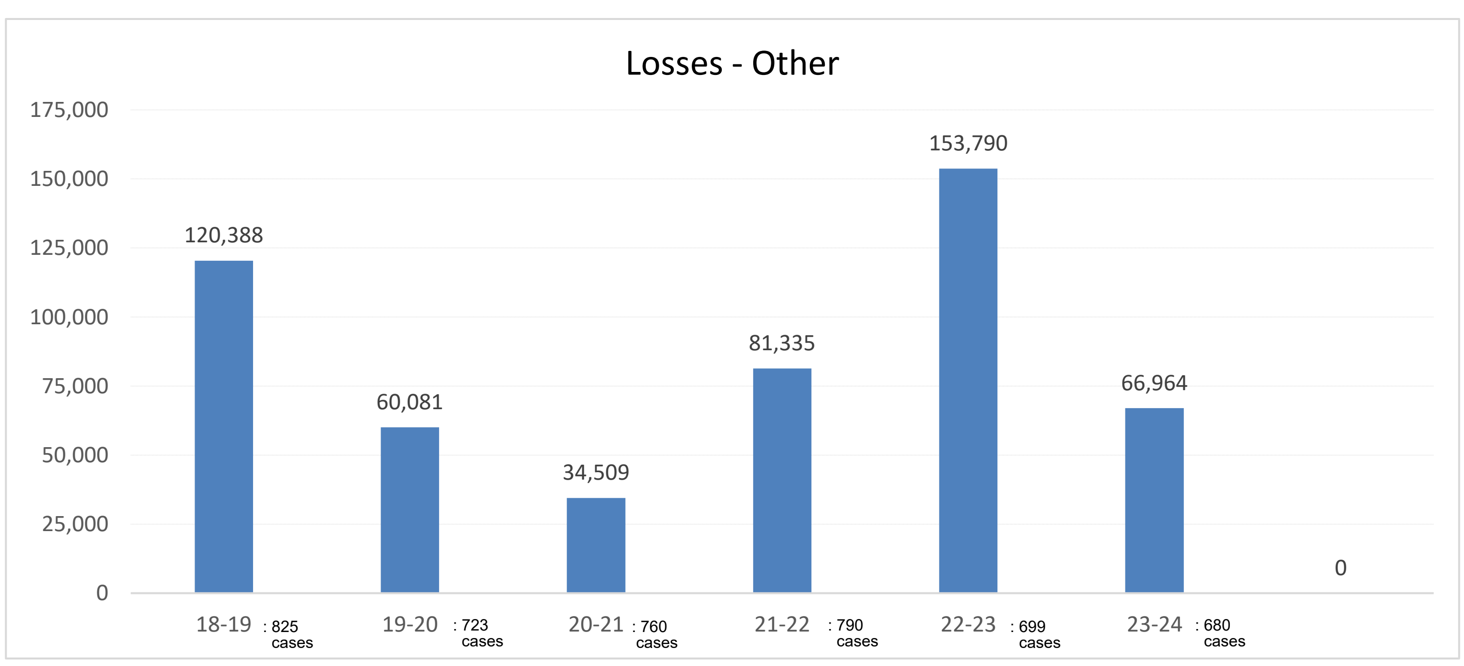
FIFE HEALTH BOARD
SUMMARY OF LOSSES AND SPECIAL PAYMENTS

ITEM NO.	CATEGORY	Apr-Jun'23		Jul-Sep'23		Oct-Dec'23		Jan-Mar'24		TOTAL Apr'23-Mar'24		TOTAL Apr'22-Mar'23	
		NO. OF CASES	TOTAL £	NO. OF CASES	TOTAL £	NO. OF CASES	TOTAL £	NO. OF CASES	TOTAL £	NO. OF CASES	TOTAL £	NO. OF CASES	TOTAL £
	Miscellaneous / Theft / Arson / Wilful Damage												
1	Cash											3	295.00
2	Stores/procurement												
3	Equipment					1	236.40			1	236.40	2	2,416.20
4	Contracts												
5	Payroll *Salary Overpayment Debtors Invoices*					8	2,587.96	17	12,898.11	25	15,486.07	43	34,441.28
6	Buildings & Fixtures *Vandalism*	15	1,839.09	19	2,516.21	18	298.76	13	778.15	65	5,432.21	57	6,778.80
7	Other											1	354.52
	Fraud, Embezzlement & other irregularities (incl. attempted fraud)												
8	Cash												
9	Stores/procurement												
10	Equipment												
11	Contracts												
12	Payroll												
13	Other												
14	**Nugatory & Fruitless Payments**											1	70,728.00
	Claims Abandoned:												
15	(a) Private Accommodation												
	(c) Other *Hardship Accounts / Insurance Excess / Debtors WO's*	59	1,202.38	175	2,938.69	172	5,814.00	129	5,950.97	535	15,906.04	551	19,630.24
	Stores Losses:												
16	Incidents of the Service :												
	- Fire												
	- Flood												
	- Accident												
17	Deterioration in Store												
18	Stocktaking Discrepancies												
19	Other Causes												
	Losses of Furniture & Equipment and Bedding & Linen in circulation:												
20	Incidents of the Service :												
	- Fire												
	- Flood												
	- Accident *Loss / Damaged Equipment*	9	7,855.34	4	2,203.40	9	4,314.45	6	4,636.87	28	19,010.06	15	6,711.58
21	Disclosed at physical check												
22	Other Causes												
	Compensation Payments - legal obligation												
23	Clinical												
24	Non-clinical												
	Ex-gratia payments:												
25	Extra-contractual Payments												
26	Compensation Payments - ex-gratia - Clinical	7	924,944.78	13	235,558.15	16	1,276,577.10	10	380,363.86	46	2,817,443.89	41	3,959,832.33
27	Compensation Payments - ex-gratia - Non Clinical	4	87,885.00	10	104,620.35	4	28,978.00	4	65,200.00	22	286,683.35	27	273,615.83
28	Compensation Payments - ex-gratia - Financial Loss	6	1,638.00	5	3,396.00	6	4,428.80	3	167.00	20	9,629.80	23	11,713.22
29	Other Payments												
	Damage to Buildings and Fixtures:												
30	Incidents of the Service :												
	- Fire												
	- Flood												
	- Accident *Vehicle Expenditure*			3	684.08	1	200.00	2	379.38	6	1,263.46	3	721.23
	- Other Causes												
31	**Extra-Statutory & Extra-regulationary Payments**												
32	**Gifts in cash or kind**												
33	**Other Losses**												
		100	1,025,364.59	229	351,916.88	235	1,323,435.47	184	470,374.34	748	3,171,091.28	767	4,387,238.23

748 3,171,091.28


Losses - Clinical
5,000,000
4,500,000
4,000,000
3,500,000
3,000,000
2,500,000
2,000,000
1,500,000
1,000,000
500,000
0
2,247,143
4,213,736
4,680,487
3,913,335
3,959,832
2,817,444
0
18-19 : 23 cases
19-20 : 50 cases
20-21 : 45 cases
21-22 : 30 cases
22-23 : 41 cases
23-24 : 46 cases


Losses - Non Clinical
300,000
250,000
200,000
150,000
100,000
50,000
0
86,166
114,521
119,417
297,923
273,616
286,683
0
18-19 : 20 cases
19-20 : 23 cases
20-21 : 16 cases
21-22 : 21 cases
22-23 : 27 cases
23-24 : 22 cases


Losses - Other
175,000
150,000
125,000
100,000
75,000
50,000
25,000
0
120,388
60,081
34,509
81,335
153,790
66,964
0
18-19 : 825 cases
19-20 : 723 cases
20-21 : 760 cases
21-22 : 790 cases
22-23 : 699 cases
23-24 : 680 cases

NHS Fife

Meeting: **Audit & Risk Committee**

Meeting date: **16 May 2024**

Title: **Procurement Tender Waivers Compliance Quarter 4**

Responsible Executive: **Margo McGurk, Director of Finance & Strategy**

Report Author: **Kevin Booth, Head of Financial Services & Procurement**

1 Purpose

This report is presented for:

- Assurance

This report relates to:

- Government policy / directive
- Legal requirement

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

- Safe

2 Report summary

2.1 Situation

In order to allow the Audit & Risk Committee to take assurance that the Boards Procurement Function is operating within the legal requirements of the Scottish Government. This paper presents oversight of the Contract Awards over £50,000 in the period January 2024 – March 2024 that were subject to a waiver of competitive tender.

2.2 Background

As per the Guidance in the Public Contracts Scotland Act 2015. Any non-competitive award of a contract with an anticipated value of £50,000 or more (inclusive of vat) must have a waiver of competitive tender completed prior to award and be signed off by both the Head of Procurement and then counter signed by both the Director of Finance & Strategy and the Chief Executive.

The waiver of competitive tender confirms the restricted conditions which when in existence, the Board is permitted to award the contract without following the existing procurement journey route 2 as prescribed in the Act.

The restricted, permitted conditions (as per the Code of Corporate Governance, appendix 3 Standing Financial Instructions, section 9.11) which must be in existence are as follows:

1. Where the repair of a particular item of equipment can only be carried out by the manufacturer.
2. Where the supply is for goods or services of a special nature or character in respect of which it is not possible or desirable to obtain competitive quotations or tenders.
3. A contractor's special knowledge is required.
4. Where the number of potential suppliers is limited, and it is not possible to invite the required number of quotations or tenders, or where the required number do not respond to an invitation to tender or quotation to comply with these SFIs.
5. Where, on the grounds of urgency, or in an emergency, it is necessary that an essential service is maintained or where a delay in carrying out repairs would result in further expense to NHS Fife.

Any other justification including the unavailability of time should not be considered without the prior agreement with the Scottish Government.

2.3 Assessment

During the period January 2024 – March 2024 the Procurement Team awarded three contracts to the value of £50,000 or above. All three contracts were processed and awarded through the full procurement journey, and none were subject to a waiver of competitive tender.

There was a total of two tender waivers applied for the financial year 2023/24, totalling £1,056,730, one for additional capacity with The Aberdeen Clinic for NHS Lothian patients and one for GI manometry equipment with Medtronic. This was a significant reduction in the twelve waivers that were applied in 2022/23 totalling £5.4m.

2.3.1 Quality, Patient and Value-Based Health & Care

A waiver of competitive tender will only ever be considered by Procurement where all applicable information is provided to a high quality, allowing for an effective decision to be made.

2.3.2 Workforce

The current guidance for the application of a waiver of competitive tender is contained within the Financial Operating Procedures section 11(a) for staff to refer to when consideration is required. The qualifying criteria contained mirrors that within the Boards Standing Financial Instructions.

2.3.3 Financial

As per the Public Contracts Scotland Act 2015 any procurement of £50,000 or above is subject to Procurement Journey Route 2 (or Route 3 if £138,760 or above), where a Tender would be posted through the Public Contracts Tender Portal. The implementation of the Tender Waiver negates the requirement for this process.

2.3.4 Risk Assessment / Management

The implementation of a Waiver of Competitive Tender needs to be robustly controlled to ensure the Board does not expose itself to challenge which could result in legally imposed financial penalties and reputational damage.

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

The governed application of the waiver of competitive tender ensures applicable treatment of suppliers across the marketplace.

2.3.6 Climate Emergency & Sustainability Impact

N/A

2.3.7 Communication, involvement, engagement and consultation

The consideration of the application of a waiver of competitive tender is considered by the Senior Procurement Team following discussions with the order requisitioner and service lead before being approved if applicable by the Head of Procurement and then issued to the Director of Finance & Strategy and the Chief Executive for final sign off.

2.3.8 Route to the Meeting

The Procurement Governance Board monitors the Procurement KPI's which includes the number of Competitive Tender Waivers implemented.

2.4 Recommendation

- **Assurance** – Members are asked to take assurance that the Procurement process for the waiver of competitive tenders was correctly applied in the period.

3 List of appendices

N/A

Report Contact
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Head of Financial Services & Procurement
Kevin.booth@nhs.scott

DRAFT AUDIT & RISK COMMITTEE

ANNUAL WORKPLAN 2024 / 2025

Governance – General						
	Lead	**16/05/24**	**20/06/24**	**12/09/24**	**12/12/24**	**13/03/25**
Minutes of Previous Meetings	**Chair**	✓	✓	✓	✓	✓
Action Plan	**Chair**	✓	✓	✓	✓	✓
Escalation of Issues to NHS Board	**Chair**	✓	✓	✓	✓	✓
Governance Matters						
	Lead	**16/05/24**	**20/06/24**	**12/09/24**	**12/12/24**	**13/03/25**
Audit Scotland Technical Bulletin	**Head of Financial Services**		✓ 2024/1	✓ 2024/2	✓ 2024/3	✓ 2024/4
Annual Assurance Statement 2023/24	**Board Secretary**	✓ Draft	✓ Final			
Annual Assurance Statements from Standing Committees 2023/24	**Board Secretary**		✓			
Annual Review of Code of Corporate Governance	**Board Secretary**	✓				
Committee Self-Assessment	**Board Secretary**					✓
Corporate Calendar / Committee Dates 2025/26	**Board Secretary**			✓		
Delivery of Annual Workplan 2024/25	**Director of Finance & Strategy**	✓	✓	✓	✓	✓
Financial Operating Procedures Review	**Head of Financial Services**	(Two yearly review. Next review due December 2025)				
Governance Statement	**Director of Finance & Strategy**	✓ Draft	✓ Final			
IJB Annual Assurance Statement 2023/24	**Board Secretary**		✓ TBC	✓ TBC		
Internal Audit Review of Property Transactions Report 2023/24	**Internal Audit**			✓ TBC		

Governance Matters (cont.)						
	Lead	**16/05/24**	**20/06/24**	**12/09/24**	**12/12/24**	**13/03/25**
Losses & Special Payments	**Head of Financial Services**	✓		✓	✓	✓
Procurement Tender Waivers Compliance 2024/25	**Head of Financial Services**	✓ Q4		✓	✓	✓
Review of Annual Workplan 2025/26	**Board Secretary**				✓ Draft	✓ Approval
Review of Terms of Reference	**Board Secretary**					✓ Approval
Risk						
	Lead	**16/05/24**	**20/06/24**	**12/09/24**	**12/12/24**	**13/03/25**
Annual Risk Management Report 2023/24	**Risk Manager**	✓ Draft	✓ Final			
Corporate Risk Register	**Director of Finance & Strategy/Risk Manager**	✓	✓	✓	✓	✓
Risk Management Key Performance Indicators 2023/24	**Risk Manager**	✓ **2023/24**		✓		
Risk Management Strategic Framework	**Risk Manager**	On hold until risk appetite work is complete				
Risks & Opportunities Group Progress Report	**Risk Manager**	✓ **Annual Statement of Assurance**		✓	✓	✓
Governance – Internal Audit						
	Lead	**16/05/24**	**20/06/24**	**12/09/24**	**12/12/24**	**13/03/25**
External Quality Assessment (5 yearly)	**Internal Audit**					✓
FTF Shared Service Agreement / Service Specification	**Internal Audit**				✓	
Internal Audit Progress Report	**Internal Audit**	✓		✓	✓	✓
Internal Audit Annual Plan 2024/25	**Internal Audit**		✓ Final			
Internal Audit Annual Report 2023/24	**Internal Audit**		✓			
Internal Audit – Follow Up Report on Audit Recommendations 2023/24	**Internal Audit**	✓		✓	✓	✓

Governance – Internal Audit (cont.)						
	Lead	**16/05/24**	**20/06/24**	**12/09/24**	**12/12/24**	**13/03/25**
Internal Audit Framework	**Chief Internal Auditor**					✓
Internal Controls Evaluation Report 2023/24	**Internal Audit**				✓	
Governance – External Audit						
	Lead	**16/05/24**	**20/06/24**	**12/09/24**	**12/12/24**	**13/03/25**
Annual Audit Plan 2023/24	**External Audit**				✓	
External Audit – Follow Up Report on Audit Recommendations	**Director of Finance & Strategy**					✓
Patients' Private Funds - Audit Planning Memorandum	**Head of Financial Services**					✓
Service Auditor Reports on Third Party Services	**Head of Financial Services**		✓			
Annual Accounts						
	Lead	**16/05/24**	**20/06/24**	**12/09/24**	**12/12/24**	**13/03/25**
Annual Accounts Preparation Timeline	**Head of Financial Services**	✓ Follow Up				✓ Initial
External Auditors Annual Accounts Progress Update	**External Auditor**	✓				✓
Annual Accounts & Financial Statements 2023/24	**Director of Finance & Strategy / External Audit**		✓			
Annual Audit Report 2023/24	**External Audit**		✓			
Letter of Representation 2023/24	**Director of Finance & Strategy / External Audit**		✓			
Patients' Funds Accounts 2023/24	**Head of Financial Services**		✓			
Annual Statement of Assurance to the NHS Board 2023/24	**Board Secretary**		✓			
Counter Fraud						
	Lead	**16/05/24**	**20/06/24**	**12/09/24**	**12/12/24**	**13/03/25**
Counter Fraud Service – Quarterly Report (Alerts & Referrals)	**Head of Financial Services**	Private Session		Private Session	Private Session	Private Session
Counter Fraud Standards Assessment	**Head of Financial Services**	Private Session				Private Session

Counter Fraud (cont.)						
	Lead	**16/05/24**	**20/06/24**	**12/09/24**	**12/12/24**	**13/03/25**
Counter Fraud Action Plan 2024/25	**Head of Financial Services**			Private Session		
Counter Fraud Annual Report 2023/24	**Head of Financial Services**	**Deferred to next mtg**	Private Session			
Adhoc						
	Lead	**16/05/24**	**20/06/24**	**12/09/24**	**12/12/24**	**13/03/25**
Private Meeting with Internal / External Auditors	**Committee**			Private Session		Private Session
Appointment of Patients' Private Funds Auditor	**Director of Finance & Strategy**	**As required**				
Legal & regulatory updates (e.g. Audit Scotland reports etc.)	**Head of Financial Services**					
Progress on National Fraud Initiative (NFI)	**Head of Financial Services**				✓	
Additional Agenda Items (Not on the Workplan e.g. Actions from Committee)						
	Lead	**16/05/24**	**20/06/24**	**12/09/24**	**12/12/24**	**13/03/25**
Update to Scheme of Delegation	**Head of Financial Services**	✓				
Training Sessions Delivered						
	Lead	**16/05/24**	**20/06/24**	**12/09/24**	**12/12/24**	**13/03/25**
Members' Training Session – the Annual Accounts: The Role & Function of the Audit & Risk Committee	**External Auditors**	✓				