FTF Internal Audit Service

Annual Internal Audit Report 2023/24

Report No. T06/25

Issued To: **L Birse-Stewart, Chair**

N Connor, Chief Executive
B Jenkins, Deputy Chief Executive
S MacLeod, Deputy Chief Executive

S Lyall, Director of Finance
L Lyall, Assistant Director of Finance – Infrastructure

Directors / Executive Leadership Team

M Dunning, Board Secretary
H Walker, Head of Strategic Risk & Resilience Planning

Audit Follow-Up Co-ordinator

Audit and Risk Committee
External Audit

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Draft Report Issued	10 June 2024
Target Audit & Risk Committee Date without Management Responses	20 June 2024
Management Responses Received	16 August 2024
Target Audit & Risk Committee for Final Report	**12 September 2024**
Final Report Issued with Management Responses	**02 September 2024**

INTRODUCTION AND CONCLUSION

1. This annual report to the Audit & Risk Committee provides details on the outcomes of the 2023/24 internal audit and my opinion on the Board's internal control framework for the financial year 2023/24.

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

- The Board has adequate and effective internal controls in place.
- The 2023/24 Internal Audit Plan has been delivered in line with Public Sector Internal Audit Standards.

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

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

ACTION

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

AUDIT SCOPE & OBJECTIVES

5. The Strategic and Annual Internal Audit Plans for 2023/24 incorporated the requirements of the NHSScotland Governance Statement and were based on a joint risk assessment by Internal Audit and the Director of Finance. The resultant audits range from risk based reviews of individual systems and controls through to the strategic governance and control environment.

6. The authority, role, and objectives for Internal Audit are set out in Section 20 of the Board's Standing Financial Instructions and are consistent with Public Sector Internal Audit Standards (PSIAS).

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

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

INTERNAL CONTROL

Previous recommendations

8. The 2023/24 Internal Control Evaluation (ICE), issued February 2024, was informed by detailed review of formal evidence sources including Board, Standing Committee, Executive Leadership Team (ELT), and other papers. The ICE concluded that NHS Tayside's assurance structures were adequate and effective and agreed improvement recommendations for implementation by management.

9. Recommendations identified in previous ICE and Annual Reports are set out in Section 5, together with a summary of progress. Internal Audit monitor progress with outstanding recommendations through the Audit Follow Up system and all management responses are validated. Progress continues to be reported to the ELT and to the Audit & Risk Committee.

10. NHS Tayside has demonstrated progress towards completion of previous recommendations, with some extended to take account of changing plans and some not yet due. Development of the Strategy continues with the intention that it will be in place for March 2025.

11. We have completed testing to identify any material changes to the control environment in the period from the issue of the 2023/24 ICE to the year-end.

12. The 2024/25 ICE will provide an update and opinion on the efficacy of implementation of previous internal audit actions and agreed actions from this annual report.

Governance Statement and Conclusion

13. Throughout the year, our audits have provided assurance and made recommendations for improvements, with four reports providing an opinion of limited assurance, reflecting the scale of challenge in certain areas. Management accepted all report recommendations and plans are in place to address the findings. Where applicable, our detailed findings have been included in the NHS Tayside 2023/24 Governance Statement.

14. All Executive Directors and Senior Managers were required to provide a statement confirming that adequate and effective internal controls and risk management arrangements were in place throughout the year across all areas of responsibility, with each completing an Internal Control Checklist and Statement based on the Scottish Public Finance Manual. These assurances have been reviewed and no breaches of Standing Orders / Standing Financial Instructions were reported.

15. The Governance Statement format and guidance are included within the NHSScotland Annual Accounts Manual. The 2023/24 Annual Accounts Manual states that the Governance Statement should explain the relationships (including the Health Boards responsibility for any operational aspects of activities) with any IJBs and how the Board maintains governance oversight over its activities and receives assurance from the IJB on the development and delivery of its strategy and its overall governance. The Governance Statement guidance also includes compliance with the principles of good governance set out in the NHS Scotland – Blueprint for Good Governance: second edition and sets out the essential features of the Risk Management section of the Governance Statement.

16. The Board has produced a Governance Statement which states that: *'As the appointed Accountable Officer, I am able to conclude with the ongoing improvement work undertaken throughout the year, as evidenced above; the governance framework and the assurances and evidence received from the Board's committees, that corporate governance continues to be strengthened and internal controls were operating adequately and effectively throughout the financial year ended 31 March 2024'*.

17. Our audit work has provided evidence of compliance with the requirements of the Accountable Officer Memorandum, and this combined with a sound corporate governance framework in place within the Board throughout 2023/24, provides assurance for the Chief Executive as Accountable Officer.

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

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

Key Themes

19. Detailed findings are shown later in the report. Key themes emerging from this review and other audit work during the year are detailed in the following paragraphs.

20. A Route Map and timetable for the Strategy development was presented to Board on 25 April 2024, with the launch planned for March 2025. The Board report set out activities undertaken between January 2024 and March 2024 and plans for the year ahead. The 2024/25 Board Development Plan includes an action for the Board to 'be fully engaged as key stakeholders in the development of the Board's refreshed strategic plan which will reset the priorities of the organisation and restate the Board's values and ways of working.' The planned Strategy must set out a clear vision and direction of travel for healthcare provision in Tayside and support health and wellbeing.

21. The Audit Scotland 'NHS in Scotland 2023' report, published in February 2024 stated that *'Significant service transformation is required to ensure the financial sustainability of Scotland's health service. Rising demand, operational challenges and increasing costs have added to the financial pressures on the NHS and, without reform, its longer-term affordability'*. Financial sustainability remains a significant and enduring risk for all Health Boards and for NHS Tayside. Whilst the 2023/24 savings target of £30 million was exceeded, with £40.9 million delivered, 64% of savings were non-recurring. The 2023/24 revenue underspend was achieved largely following receipt of unplanned funding from the Scottish Government, other non-recurring sources, and brokerage of £16.1 million.

22. Finance reporting to Board and Performance & Resources Committee (P&RC) by the Director of Finance has consistently and clearly articulated the severe financial challenges. Financial projections have fluctuated in line with an extremely volatile external environment.

23. The financial sustainability challenge is significant, with an estimated financial gap before savings of £192 million over 2024/25 – 2026/27. Level 1 and 2 savings plus Scottish Government support totalling £105 million have been identified with a residual gap of £86.6 million. Scottish Government correspondence dated 4 April 2024 provided feedback on the financial plan and acknowledged the steps being taken by NHS Tayside, however the Scottish Government did not approve the plan.

24. The 2024/25 financial plan includes brokerage of £17.2 million which reduces the three year residual gap of £86.6 million to £69.4 million. However, given the emerging public sector financial constraints NHS brokerage funding may not be guaranteed to the extent it has been in past and NHS Tayside may need to prepare contingency plans accordingly. The impact from the known reductions in capital funding and the resultant risk and impact will be a key consideration. Should the Board be unable to meet the brokerage cap, an overspend may need to be shown in the financial statements.

25. Financial sustainability must underpin all decisions taken by the Board and by Officers, and all staff have a part to play in moving the organisation to a more sustainable footing. The approach must be

collaborative and prioritised within the developing new Strategy, ensuring there is absolute clarity over the extent to which the strategy will deliver transformation and recurrent savings.

26. In common with many Health Boards, NHS Tayside is finding achievement of national targets extremely challenging in certain areas, particularly against targets for patients treated within 18 weeks and patients starting cancer treatment within 62 days of receipt of referral. Whilst not meeting national targets, activity levels across inpatients, outpatients and diagnostic tests are all close to or exceed planned levels. NHS Tayside also continues to have the highest performance across Scotland's mainland Boards against the 4 hour A&E target.

27. Capacity to deliver sustainable service change whilst improving performance, and a rigorous focus on the most significant issues will mean that less important issues will need to be de-prioritised and delegated. The planned Strategy must set achievable, realistic targets against which performance can be measured, focusing on priority areas with a clear understanding of clinical risk.

28. Performance reports should continue to identify where performance is below expectations and provide meaningful narrative on the underlying causes and barriers to achievement, proposed solutions and vitally, an objective, evidence-based assessment including where available benchmarking data of the effectiveness of previous actions. This will need to be accompanied by a culture of rigorous but supportive challenge.

29. There have been a number of changes within the Non-Executive and Executive cohorts, including interim and acting appointments within NHS Tayside and the IJBs. A new Chief Executive has been appointed and is expected to take up post by the end of July 2024. Leadership capacity will require to be carefully managed over the coming period as the organisation works to deliver healthcare services and navigates the financial challenge alongside developing its new Strategy.

30. The Blueprint for Good Governance states that *"An organisation's culture comprises its shared values, norms, beliefs, emotions, and assumptions about "how things are and should be done around here"*. These 'things' include how decisions are made, how people interact and how work is carried out." Maintaining an appropriate organisational culture continues to be important and more so in the current environment when taking account of the scale of the financial challenge for Tayside alongside increasing service pressures. Such pressures will require to be carefully managed and may require some very difficult decisions.

31. The 2024/25 Governance Development Plan was approved by the Board on 25 April 2024 prior to for submission to the Scottish Government. Implementation of the Board Development Plan is a significant task and as accountability measures change and develop it is important to ensure that governance arrangements continue to support and respond to the needs of the organisation. Non-Executives must continue to provide robust scrutiny and have a responsibility to ensure that they are effective in their review of assurances on key risks and actions. The Board should be formally updated on implementation of the Plan, including completion of action agreed at the Board Seminars and care should be taken to ensure no diminution in governance during the life of the Board Development Plan.

32. Partners will need to work together to ensure that they deliver on the integration agenda and must ensure they are clear on their responsibilities in line with the Integration Schemes, and that they fulfil their roles accordingly in the true spirit of integration. Action within the 2024/25 Board Development Plan demonstrates the need for continued work in this area.

33. Whilst recognising there are further development areas planned, we continue to conclude that overall risk management arrangements within NHS Tayside are robust, based on the continuing

operation of the overarching risk management arrangements and associated governance arrangements. Annual review of the Strategic Risk Profile to identify the proposed strategic risks for the organisation during 2024/25 commenced in February 2024 and the revised risk profile is to be presented to the ELT and Board in June 2024 for approval.

34. Work is ongoing to develop a revised Clinical and Care Governance Framework by October 2024. There is strong evidence that much has been achieved in implementing previous clinical governance internal audit recommendations with commentary in this Annual Report consolidating the remaining actions.

35. During the year we reported that whilst there is evidence that the Public Health Directorate and Committee have achieved much in recent years, there are significant and increasing expectations on public health as a key driver to support the delivery of sustainable health services, now and into the future.

36. Audit Scotland, in their 'NHS in Scotland 2023' report stated that *'Investing in preventative measures and implementing service reforms will help to ensure services are sustainable in the future'*. This view has also been reported by Public Health Scotland as outlined in the January 2023 discussion paper 'Public health approach to prevention and the role of NHSScotland' which stated that *'there is a growing body of economic evidence that supports the case for investing in public health interventions and prevention.'*

37. Reflecting on the Audit Scotland and Public Health Scotland conclusions, public health measures including prevention should be a key area of focus to ensure services are sustainable in the future. Public Health actions are therefore of the utmost criticality, alongside the need to be financial sustainability, and should be prominent in Strategy development.

38. The Audit Scotland report 'NHS Scotland 2023' also reported *'The NHS, and its workforce, is unable to meet the growing demand for health services. Activity in secondary care has increased in the last year but it remains below pre-pandemic levels and is outpaced by growing demand. This pressure is creating operational challenges throughout the whole system and is having a direct impact on patient safety and experience.*' Reporting to the Staff Governance Committee (SGC) on critical elements for organisational success has been limited, including the Workforce Plan Action Plan, the Talent Strategy and succession planning and the culture framework. We reiterate that the SGC should have ownership and oversight of key workforce issues to effectively support the achievement of the Board's operational and strategic objectives.

39. Across NHS Scotland, the level of supplementary staffing is higher than normal. The 2023/24 workstream programme set out the need to deliver £30.0 million recurring savings, £4m of which related to supplementary staffing. At end of March 2024, recuring savings of £1 million had been confirmed. Board Directed supplementary staff spend in 2023/24 was £32 million, showing a small reduction compared to 2022/23 spend of £33.6 million. Supplementary staffing arrangements will be reviewed in the 2024/25 Internal Audit Plan.

40. NHS Tayside's performance in compliance with the 2023 Network & Information Systems Regulations (NISR) was reported in May 2024 Audit & Risk Committee as 49% achieved against the target of 60%. The draft Governance Statement includes a section on this position against the national target. The most recent NISR review is to be reported in June 2024. A business case to increase the capacity of the Information Governance team was approved in April 2024 to allow four posts to be filled. Once the posts have been recruited to, this should allow the team to progress work that over the last few years has increased in both volume and legislative requirements.

Key developments

41. Key developments since issue of our 2023/24 ICE report included:

- Appointment of a permanent Chief Executive.
- Approval of Code of Corporate Governance updates.
- Approval of Strategy revised timeline.
- Board approval of Financial Plan 2024/25 – 2026/27.
- Board approval of Capital Plan 2024/25 – 2028/29.
- Approval of the Board Development Plan.
- Board consideration of the Annual Climate Emergency and Sustainability Report 2022/23.
- Whistleblowing Annual Assurance Report 2023/24 considered at the April 2024 Staff Governance Committee.
- Approval for four key Information Governance posts.

AUDIT OUTPUT

42. During 2023/24 we delivered 34 audit products with one currently at draft report stage. Work is progressing on the three remaining reviews for NHS Tayside and on six IJB reviews, including the IJB Annual Reports. These audits reviewed the systems of financial and management control operating within the Board and the IJBs.

43. Our 2023/24 audits of the various financial and business systems provided opinions on the adequacy of controls in these areas. Summarised findings or the full report for each review were presented to the Audit & Risk Committee throughout the year.

44. A number of our reports, including the ICE, have been wide ranging and complex audits and have relevance to a wide range of areas within NHS Tayside.

45. Following a period of improvement across 2023/24, the May 2024 Audit Follow-Up paper provided limited assurance that timely action has been taken by Responsible Officers as expected, to address identified control weaknesses. The Director of Finance led an ELT discussion on the importance of audit follow up and the ELT considered the work required to address the outstanding internal audit recommendations. Internal audit would emphasise the importance of realistic and achievable implementation dates.

ADDED VALUE

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

- Examining a wide range of controls in place across the organisation.
- Completing a departmental review of the Property Department – Facilities Directorate.
- Completion of Missing Clinical Psychology Case Records – Follow Up Review.

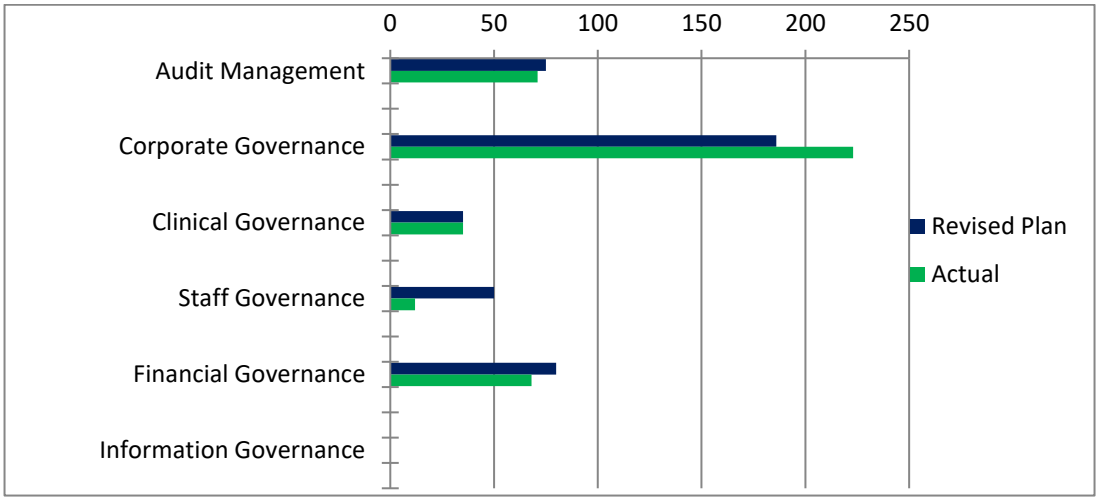
- In conjunction with Local Authority Internal Auditors, undertaking IJB internal audits and providing the Chief Internal Auditor Service for Angus IJB and Dundee City IJB.
- Updating and enhancing the IJB Governance Statement self-assessment checklist.
- Chief Internal Auditor and Regional Audit Manager liaison with the Director of Finance, Directors, and the Angus and Dundee City Chief Finance Officers' on issues of governance, risk, control, and assurance.
- The Chief Internal Auditor refresh of the Assurance Mapping Group, which coordinates consideration of assurance issues and updates, dissemination, and implementation of the Committee Assurance Principles across FTF clients.
- Highlighting relevant national governance developments.
- Continued promotion and advice on the use of the Committee Assurance Principles.
- Providing opinion on and evidence in support of the Governance Statement at year-end and conducting an extensive ICE which provided the opportunity for remedial action to be taken in-year.
- Provision of the Deputy Fraud Liaison Officer function for NHS Tayside.

47. Internal Audit have reflected on our working practices and an External Quality Assessment (EQA) is planned in 2024/25.

48. The 2023/24 Annual Internal Audit Plan included provision for delivering audit services, together with council colleagues, and providing the Chief Internal Auditor function to Dundee City Integration Joint Board and Angus Integration Joint Board. Internal Audit Plans were agreed for each IJB. Internal Audit has continued to highlight the importance of maintaining momentum to clear long-standing issues with all partners, the requirement for coherence between governance structures, performance management, risk management, risk score and, in particular, assurance to improve IJBs' ability to monitor the achievement of strategic objectives.

INTERNAL AUDIT COVERAGE

49. Figure 1: Internal Audit Coverage 2023/24



50. Figure 1 summarises the 2023/24 outturn position against the revised internal audit plan, approved by the Audit & Risk Committee in March 2024. As at end of April 2024 we had delivered 409 days against the 426 revised planned days.

51. During 2023/24 we have regularly reported to the Audit & Risk Committee delays in finalising audits, mainly due to resource issues. To account for time lost due, a revised Audit Plan for 2023/24 was approved by the Audit & Risk Committee.

52. There are currently three Health Board reviews in progress, including work on the New Deal. An audit of supplementary staffing arrangements will be carried out in 2024/25.

53. Information Governance did not have any formal reviews finalised during 2023/24 but work on the ICE and the finalisation of the Follow Up on Missing Clinical Psychology Records from the prior year during 2023/24 have provided the required level of coverage.

54. A summary of 2023/24 performance is shown in Section 3.

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

55. The FTF Partnership Board met in May 2024 and the 2023/24 budget was approved. The Partnership Board is chaired by the NHS Fife Director of Finance and Strategy and the FTF Client Directors of Finance are members. The FTF Management Team members are attendees.

56. We have designed protocols for the proper conduct of audit work to ensure compliance with the service specification and the PSIAS.

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

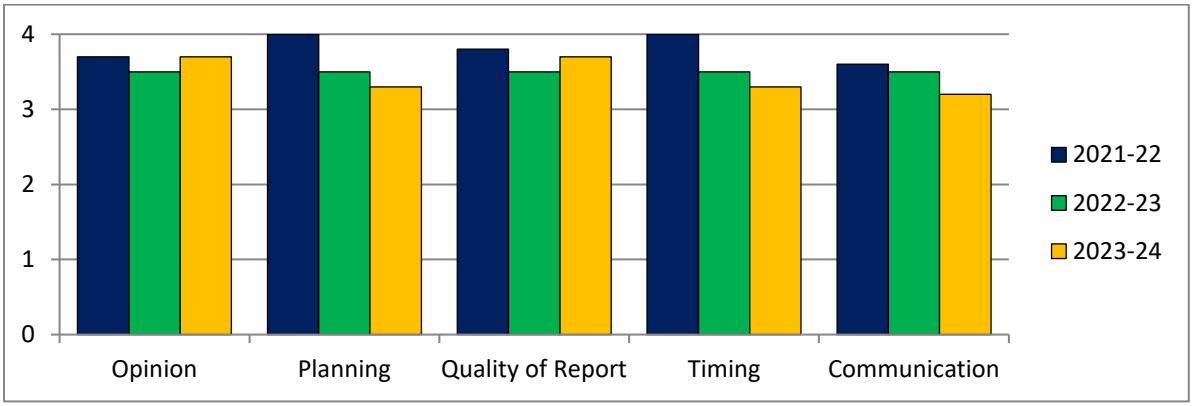
58. Internal and External Audit liaise closely to ensure that the audit work undertaken fulfils both regulatory and legislative requirements. Both sets of auditors are committed to avoiding duplication and securing the maximum value from the Board's investment in audit.

59. PSIAS require an independent external assessment of internal audit functions once every five years. The most recent EQA of the NHS Fife Internal Audit Service in 2018/19 concluded that, *'it is my opinion that the FTF Internal Audit service for Fife and Tayside generally conforms with the PSIAS.'* FTF updated its self-assessment during 2022/23 and a further EQA will take place in 2024/25.

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

61. Figure 2: Summary of Client Satisfaction Surveys

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



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

STAFFING AND SKILL MIX

63. In 2023/24 the audit was delivered with a skill mix of 76%, which substantially exceeds the minimum service specification requirement of 50% and reflects the complexities of the work undertaken during the year.

ACKNOWLEDGEMENT

64. On behalf of the Internal Audit Service, I would like to take this opportunity to thank all members of staff within the Board for the help and co-operation extended to Internal Audit throughout my tenure as Chief Internal Auditor.

65. My team and I have greatly appreciated the positive support of the Chief Executive, Director of Finance, the Assistant Director of Finance – Infrastructure and the Audit & Risk Committee.

J Lyall, Bacc (Hons), CPFA
Chief Internal Auditor

Corporate Governance

Strategic Risk:

- **1316 – Development of Strategy – Current risk exposure 16 (High), Planned risk exposure 12 (High), Within appetite**

Strategy

A Route Map and timetable for the development of Strategy was presented to Board on 25 April 2024, with the launch planned for March 2025. The Board report set out activities undertaken between January 2024 and March 2024 and plans for the year ahead, including a discussion document outlining the phased stakeholder engagement approach to be directed by the Board.

This should allow the Board to seek assurance regarding the development of the Strategy through the route map and development timetable, and to agree how future assurance should be provided. The next stakeholder Strategy session is on 25 June 2024 and a Board Development Event is also planned for January 2025.

The Board Development Plan includes an action for the Board to '*be fully engaged as key stakeholders in the development of the Board's refreshed strategic plan which will reset the priorities of the organisation and restate the Board's values and ways of working*.' The status will be reported through the Annual Delivery Plan (ADP) Strategy workstream and performance reporting.

A Strategy should be a key enabler of financial sustainability, with an emphasis on early intervention and prevention of ill health. A national population health strategy is expected to be published in summer 2024 and it is anticipated that this national strategy and additional guidance will follow from Scottish Government to inform local strategic plans.

The second assurance report on strategic risk 1316 Development of Strategy was presented to the Board in February 2024, without a level of assurance or information on the current risk score. It was noted that the risk rating would be re-evaluated following approval of the ADP. The focus of this risk should continue to be the development of a Strategy that contains all required elements to achieve the Board's key priorities, as well as the building blocks of successful implementation of the strategy.

Operational Planning

The 2024-27 Delivery Plan was approved by the Board on 25 April 2024, and by Scottish Government on 14 May 2024. A Portfolio Management office (PMO) will be established to provide consistent monitoring and reporting arrangements at operational level. However, it is not clear how scrutiny at governance level will be provided for. The Delivery Plan is not currently included on the 2024/25 assurance and workplan for the P&RC.

A new approach to monitoring Delivery Plans is being developed by the Scottish Government, with the expectation that this will draw performance information from existing reporting sources and that Boards will prepare performance trajectories, in conjunction with the Scottish Government, and aligned to finance and workforce plans.

The Quarter 3 and Quarter 4 combined Progress Report on the 2023/24 Annual Delivery Plan is currently being finalised and will be presented at the June 2024 P&RC meeting.

Performance

NHS Tayside's performance continues to be regularly reported to the Board and P&RC. Both action points from internal audit T16/22 Performance Management are complete and in our view performance reports are of a high quality and are clear, consistent, user friendly, and effective with a focus on key objectives.

As set out in the Board Development Plan a revised performance reporting framework is to be established by September 2024.

Evidence provided routinely to the Board will be reviewed and refocused to provide a clear picture of performance and the intention is to move towards integrated performance and risk reporting by 2025.

We reiterate that performance reports should continue to identify where performance is below expectations and provide meaningful narrative on the underlying causes and barriers to achievement, proposed solutions and vitally, an objective, evidence based assessment including where available benchmarking data of the effectiveness of previous actions. This will need to be accompanied by a culture of rigorous but supportive challenge, with information presented in a way that allows Members to see and be assured when plans are making a difference.

In common with many Health Boards, NHS Tayside is finding achievement of national targets extremely challenging in certain areas, particularly against targets for patients treated within 18 weeks and patients starting cancer treatment within 62 days of receipt of referral (which has deteriorated in comparison to the 2022/23 year end).

Whilst not meeting national targets, activity levels across inpatients, outpatients and diagnostic tests are all close to or exceed planned levels. NHS Tayside also continues to have the highest performance across Scotland's mainland Boards against the 4 hour A&E target.

Code of Corporate Governance

Updates to the Code of Corporate Governance were approved by Board in April 2024 after being previously considered by the Corporate Governance Review Group and Audit & Risk Committee. Changes related to the change in name for the endowment funds, now the NHS Tayside Charitable Foundation, levels of delegation for these funds, membership of committees, and updates to the fraud standards.

Blueprint for Good Governance – Board Development Plan 2024/25

The Blueprint for Good Governance survey was issued to Executive and Non-Executive Board Members, Directors, and Senior Managers for completion in November 2023. The results of the survey were discussed at a Board Development Event on 25 January 2024 and the subsequent 2024/25 Governance Development Plan was approved by the Board on 25 April 2024 for submission to the Scottish Government.

The 2024/25 Plan is centred around seven high level actions, linked to interdependencies, timelines and intended good governance outcome.

To support the delivery of the 2024/25 Board Development Plan, a Culture and an Agile Steering Group have been established with both Non-Executive and Executive membership. A schedule of Board Seminars in 2024/2025 is in place. The outcomes from the working groups and from the Board Seminar programme will be key in supporting delivery of the Governance Development Plan.

Good governance has always been a priority for NHS Tayside and the strategy, engagement, risk, assurance, and performance management actions in the Governance Development Plan are fundamental in ensuring an integrated and clear system of governance that meets the changing needs of the organisation.

Implementation of the Board Development Plan is a significant task and as accountability measures change and develop it is important to ensure that governance arrangements continue to support and respond to the needs of the organisation. Non-Executives must continue to provide robust scrutiny and have a responsibility to ensure that they are effective in their review of assurances on key risks and actions.

As previously reported by Internal Audit there should be no over reporting or duplication and the Board and Committees should be driven by high priority objectives, associated risks, legislation, and the opportunity to add value, with only matters of sufficient materiality meriting inclusion on agendas. The right level and number of reports which provide an appropriate level of detail and do not contain extraneous information should be provided.

The Board should be formally updated on implementation of the Plan, including completion of action agreed at the Board Seminars and care should be taken to ensure no diminution in governance during the life of the Board Development Plan.

At an appropriate time, the new arrangements should be evaluated to ensure the original objectives have been achieved and robust systems of control continue to operate as required.

Culture and Values

The Blueprint for Good Governance states that "An organisation's culture comprises its shared values, norms, beliefs, emotions, and assumptions about "how things are and should be done around here". These 'things' include how decisions are made, how people interact and how work is carried out."

A key theme running through the 2024/25 Board Development Plan is the importance of embedding organisations governance and practices to support and embed an appropriate organisational culture. As reported in the Staff Experience section of this report, there was limited evidence of progress reported to the SGC on the Collective Leadership and Culture Strategic Framework. The 2024/25 SGC work plan specifies Collective Leadership and Culture updates to the April, June, October, and December meetings. The successful delivery of planned work around organisation culture and the new Culture and an Agile Steering Group, linked to the delivery of the 2024/25 Board Development Plan will be vital in supporting the Board to embed and demonstrate appropriate behaviours and cultures and governance.

Integration

IJB minutes and Briefings continue to be presented to the NHS Tayside Board, with the Chief Officer typically in attendance to provide briefings to the Board.

As we reported in our 2023/24 ICE the significant financial challenge for NHS Tayside and its IJB partners, and the unprecedented 2024/25 financial challenges in the wider health and social care sector will require NHS Tayside and the IJBs to fully work together in partnership. Collaborative governance, a key feature of the Blueprint for Good Governance, requires a clear understanding of where responsibilities lie and requires trust and willingness from all parties to work together, with the right culture in place to support all those involved.

When health and social care systems come under pressure, there is a risk that collaborative governance is not achieved. Partners will need to work together to ensure that they deliver on the integration agenda and must ensure they are clear on their responsibilities in line with the Integration Schemes, and that they fulfil their roles accordingly in the true spirit of integration.

Action within the Board Development Plan 2024/25 demonstrates the need for continued work in this area.

Board and Assurance Committee Annual Reports

Standing Committees' draft annual reports are due to be presented to the Audit & Risk Committee on 20 June 2024. The Remuneration Committee and Public Health Committee have not approved their annual reports as their respective meetings in April and May 2024 were stood down. Approval of these annual reports has been rescheduled to 11 June and 18 June 2024 respectively, before Audit & Risk Committee review of Committee Annual Reports on 20 June 2024.

Whilst the annual reports were broadly in line with the FTF Committee Assurance Principles, only the Remuneration Committee's draft annual report 2023/24 sets out future actions to be taken for 2024/25. Consideration could be given to highlighting areas for improvement in committee annual reports.

Risk Management

The NHS Tayside Risk Management Strategy and Framework was due for review by May 2024. The February 2024 Strategic Risk Management Group (SRMG) discussed proposals for the establishment of a Short Life Working Group to review the approach to risk management including risk reporting arrangements, risk appetite and tolerance, and linkages between risk and performance reporting, which will culminate in a review of the RMS. Approval for this approach is to be sought from the 27 June 2024 meeting of Tayside NHS Board.

The Risk Management Annual Report 2023/24 and Work Plan for 2024/25 were presented to the May 2024 Audit & Risk Committee providing a substantial level of assurance, alongside the Strategic Risk Management Group's (SRMG) Annual Report for 2023/24 and terms of reference and workplan for 2024/25.

At year end, the Strategic Risk Profile 2023/24 comprised of 18 agreed Strategic Risks, 17 of which were fully recorded within the Datix system:

- 7 are rated red/very high
- 9 are rated amber/high
- 1 is rated yellow/medium

Many of the risk scores have remained static during the year. As previously reported by Internal Audit, achievement of the target risk score within a reasonable timeframe remains challenging, reflecting the fragile external environment.

Development work should ensure that planned risk exposure scores are rated at challenging but realistic levels and achievable timescales for delivery. As a driver for prioritisation and action, risk appetite statements should be based on a realistic assessment of what can be delivered.

Annual review of the Strategic Risk Profile to identify the proposed strategic risks for the organisation during 2024/25 commenced in February 2024 and was discussed at the Board Development Session on 21 March 2024. A programme of individual meetings with Risk Owners has been completed. The revised risk profile is to be presented to the ELT and Board in June 2024 for approval.

As reported to the May 2024 Audit & Risk Committee, ten risks were overdue for review. Whilst work is ongoing on a substantially revised new risk profile for 2024/25, we would stress that existing risks should continue to be managed to ensure there is no gap.

The Risk Management Risk Maturity self-assessment was approved by the Audit & Risk Committee on 16 May 2024, having been validated by the Chief Internal Auditor. The paper provided Reasonable Assurance and concluded that of the 15 characteristics within the Institute of Internal Auditors risk maturity tool, five were enabled, seven were managed, two were defined and one was categorised as aware. As in

previous years the Chief Internal Auditor noted that that Executive Directors' objectives should explicitly reference an objective of moving towards the stated target risk.

We continue to conclude that overall risk management arrangements within NHS Tayside are robust, based on the continuing operation of the overarching risk management arrangements and associated governance arrangements.

Risk Appetite

The system for enhanced monitoring of risks above appetite is operating as expected and as reported to the May 2024 Audit & Risk Committee, for the 17 recorded strategic risks: -

- 6 were above risk appetite and subject to enhanced monitoring
- 9 were within risk appetite
- 2 were below risk appetite

Internal Audit have previously commented on the need for further development of risk appetite to include greater detail on how the risk appetite will affect Strategy, decision-making prioritisation and budget setting and organisational focus, i.e. the 'so what' question, which is important in making risk appetite real. This subject is included in the proposed development work to be taken forward by the Short Life Working Group on risk management, subject to approval by the June 2024 Board.

Audit & Risk Committee / Internal Audit

Following a period of improvement, the May 2024 Audit Follow-Up paper provided limited assurance that timely action has been taken by Responsible Officers as expected, to address identified control weaknesses. The 3 June 2024 ELT discussed actions required to complete outstanding recommendations.

Four limited assurance internal audit reports have been issued since 1 April 2023 but not all have been reported to the relevant standing committee, for example T13/22 Health & Safety issued in August 2023.

The May 2024 Audit & Risk Committee meeting received a self-assessment of the committee against the good practice checklist contained within the Scottish Government Audit and Assurance Committee Handbook. Substantial assurance was provided. The Committee agreed that the Audit & Risk Committee was effective in achieving its remit in 2023/24 and agreed that there were no significant areas of non-compliance that would require disclosure in the Governance Statement or Committee Annual Report.

Assurance Principles

Internal Audit continue to promote the use of the Committee Assurance Principles, which provide complementary guidance to the Blueprint for Good Governance through facilitation of the Assurance Mapping Group, Risk Management work and though individual internal audits. Committee Assurance Principles remain an important tool to support non-Executive members in discharging their responsibilities.

Policies

At 31 May 2024, 13 of 125 policies were in breach of their review date and extensions were granted for 15 policies. 18 NHS Scotland Once for Scotland Polices were launched on 1 November 2023 and replaced 15 NHS Tayside Corporate Policies.

In February 2024 the SGC considered a Policy Update report and in June 2024 the P&RC considered the Policy Oversight Group Assurance Report – Facilities. These reports both provided Reasonable Assurance.

In June 2024, the Clinical Governance Committee (CGC) considered the Clinical Policy Governance Group (CPGG) Annual Report which provided Reasonable Assurance. To address quoracy issues of the group, '*there was consultation with members for their preferred day/time of meetings and this was reflected in the meeting schedule for 2024/25'*.

In May 2024, the Audit & Risk Committee considered the Policy Oversight Group Annual Assurance Report which provided substantial assurance. In our opinion the policy review process is well established.

Draft Internal audit report T12/24 Compliance with Laws and Regulations was issued in May 2024. Actions to be taken in response to our findings are awaited from management.

Anchor Strategy

The 27 October 2023 the Board approved the Anchor Strategy for submission to Scottish Government. Feedback received commented that this is a comprehensive and exemplar strategy in place with clear plans to progress activity in the three key strands as well as on Environmental Impact. The Anchor Strategy is one of the workstreams for the Delivery Plan 2024-27.

Executive and Non-Executive roles

There have been a number of changes to the Non-Executive membership of Standing Committees and the IJBs. Following approval by the Board meeting in February 2024, Non-Executives now focus membership on two committees and the minimum number of Non-Executive members of committees has been reduced from 6 to 5 (Except the Public Health and Remuneration Committees who will have 6 Non-Executive members).

Two newly appointed Non-Executive members took up post on 1 February 2024 with one also taking on the role of Whistleblowing Champion from 1 April 2024. Membership of committees and IJBs as well as champion roles were approved by the Board in February 2024, filling previous vacancies.

During 2023/24, there have been significant changes within the Executive cohort. Officers have been appointed to the roles of Interim Chief Executive, Deputy Chief Executive, Chief Officer for Angus Health and Social Care Partnership, Medical Director, Director of Workforce, and Director of Facilities; a new Chief Executive has now been appointed and is expected to take up post by the end of July 2024. The risk score for the ELT risk has reduced significantly from 12 to 4.

Best Value

In response to a previous internal audit recommendation and to allow Board and Committee Report Cover papers to succinctly capture how a report demonstrates achievement of Best Value characteristics, the report template and guidance document have now been updated to include additional narrative in relation to Best Value and this is in place for 2024/25.

This will provide the information to enable an assessment regarding the application of the Best Value Framework to be gathered from a review of each of the Committees Annual Reports in 2025.

Sustainability

Internal audit review of Board and P&RC papers evidenced that financial sustainability is given appropriate priority. Our view remains that it will be extremely difficult to achieve financial sustainability wholly through operational efficiencies and a strategic approach including robust prioritisation will be necessary.

A previous internal audit recommendation remains ongoing. In April 2024, the NHS Tayside Board were advised that NHS Tayside received Scottish Government feedback on the draft Financial Plan 2024/25 to 2026/27. Whilst the Scottish Government letter acknowledges the approach being taken to bridge the

financial gap, and to balancing high performance and the delivery of safe patient care within the finances available, the outcome is that Scottish Government cannot agree the Plan at this stage. Next steps to be taken are outlined under the financial governance section of this report.

The P&RC monitors Strategic Risk 807 – Climate Emergency and Sustainable Development. Scottish Government's ambitious targets in relation to net-zero will be a serious challenge to deliver in the prescribed timescales. As financial resources are put under increasing pressure the benefits from reductions in energy consumption and moving towards sustainable healthcare are clear. However, meeting the challenging targets also requires investment and resourcing and the Board need to be assured that measures taken will ultimately benefit NHS Tayside and its service users.

Resilience

Assurances on resilience arrangements are reported to SRMG and to the Audit & Risk Committee in the SRMG Annual Report. The Resilience Planning Update Report (1 September to 30 November 2023) to the February 2024 SRMG stated that 178 active Business Continuity Plans (BCP) are available on Staffnet, an increase of two from the previous reporting period. At 1 December 2023, 71% of the BCPs were in date against a target of 75%. The update report provided substantial assurance.

Following a tabletop exercise undertaken in October 2023 on the NHS Tayside Major Incident Plan, a summary of the work undertaken to review the plan was presented to the February 2024 SRMG who agreed their endorsement.

Information on the work that has been undertaken to enhance and improve the Critical Services and Critical Support Services document (which forms part of the Corporate Business Continuity Plan) as well as the approach for the next phase of work to identify priority ratings for each of the critical systems was provided to the February 2024 SRMG.

An updated Resilience Planning Framework which describes the systems and processes that are in place to support a high level of preparedness to any significant business-disrupting event or major incident was approved by the April 2024 SRMG.

Action Point Reference 1 - Board Development Plan

Finding:

To support the delivery of the 2024/25 Board Development Plan a Culture and an Agile Steering Group to include both Non-Executives and Executives has been established, and a schedule of topics for Board Seminars in 2024/25 has been developed. The effective operation of this group linked to the Board Seminar programme will be key in supporting the Board deliver on the Plan including, culture, strategy, and integration.

The areas for development highlighted in the high-level actions are fundamental building blocks of good governance for the organisation including risk, assurance, and performance management arrangements.

Audit Recommendation:

The Board should be formally updated on implementation of the Board Development Plan, including completion of action agreed at the Board Seminars and care should be taken to ensure no diminution in governance during the life of the Plan.

At an appropriate time, the new arrangements should be evaluated to ensure the original objectives have been achieved and there has been no diminution in control.

Assessment of Risk:

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

Management Response/Action:

An update report on the Board Development Plan is due to be taken to the Board on 29 August 2024. Going forward the Board Executives and Non Executives will continue to be involved in the Development work required to deliver the outcomes within the Action Plan.

Action by:	Date of expected completion:
Margaret Dunning, Board Secretary	**31 March 2025**

Action Point Reference 2 - Committee Annual reports	
Finding:	
Whilst the Committee Annual Reports were broadly in line with the FTF Committee Assurance Principles, only the Remuneration Committee's draft annual report 2023/24 sets out future actions to be taken for 2024/25.	
Audit Recommendation:	
Consideration could be given to highlighting areas for improvement in committee annual reports.	
Assessment of Risk:	
Merits attention 	There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**
Management Response/Action:	
The Standing Committee Annual Report template will be reviewed in conjunction with the Standing Committee Chair and Executive Lead to incorporate areas for improvement for Annual Reports for 2024/2025.	
Action by:	**Date of expected completion:**
Margaret Dunning, Board Secretary	**31 January 2025**

Clinical Governance

Strategic Risks:

- **1339 – Waiting Times and Patient Outcomes - Current risk exposure 20 (Very high), Planned risk exposure 20 (Very high), Within appetite**
- **1374 – Sustainable Primary Care Services – Current risk exposure 20 (Very high), Planned risk exposure 12 (High), Within appetite**
- **1412 – Patient Reported Outcome Measures - Current risk exposure 20 (Very high), Planned risk exposure 6 (Medium), Within appetite**
- **1405 – Substance related morbidity and mortality – Current risk exposure 20 (Very high), Planned risk exposure 20 (Very high), Within appetite**

Audit Follow Up

In each section of the clinical governance narrative the latest position on implementation of improvements previously recommended by Internal Audit is colour coded using a RAG status**.** There is strong evidence that much has been achieved in implementing previous recommendations and this report aims to consolidate remaining actions.

Clinical Governance Framework

Report and Action Point	Subject	Newest Update
T08/22-5	**Clinical and Care Governance Framework**	**Extended to October 2024** Revised Clinical and Care Governance Framework to be presented to the Care Governance Committee (CGC) on 3 October 2024. Framework encompasses Acute Services, Mental Health services, the three HSCPs and Public Health. Regular updates have been provided to CGC.

The CGC was provided with an update on progress on the revised Clinical and Care Governance Framework in February 2024 and a Communications & Engagement Plan for the framework is being drafted. The project plan needs to be updated and Management have informed us that this was due for completion by end of May 2024, and that work is on track for presentation of the new Framework to the October 2024 CGC. Important areas are yet to be completed including Public Health, Realistic Medicine, Person centredness and clinical effectiveness.

Improvement work has been ongoing at operational level in the Acute Unit, including a review of the Acute Services Clinical Governance Committee and monitoring arrangements.

Assurances to Clinical Governance Committee

Report and Action Point	Subject	Newest Update
T08/23-3	**Clinical Governance Improvements**	**Extended to October 2024** • Ensuring a consistent approach to quality of clinical governance assurances will be addressed alongside the work of the newly established 'Agile Governance Group' and review of reporting to standing committees. • Effectiveness of care – at the Board Development Event on 21 March 2024 it was proposed that the strategic risk for Patient Reported Outcome Measures (PROMs) would be updated and amended to a wider Clinical Effectiveness strategic risk, with PROMs as one of the controls and mitigating measures. A new strategic risk will b8e developed for Organisational Culture, and actions identified from the Due Diligence Review will also be incorporated into this risk as controls and mitigations. • A mapping exercise of national and local audit data highlighted that there should be wider discussion at CGC regarding clinical effectiveness data, which will be incorporated into service reports. Work to progress will be taken forward by the newly appointed Associate Medical Director for Patient Safety and Clinical Governance. • KPIs for adverse event management – see detailed provided under action point T08/24-6 below. • External reviews – see detailed provided under action point T08/24-5 below.
T08/24-2	**Clinical Governance Framework**	**Not yet due (October 2024)** Assurance reporting to the CGC to be reviewed, including volume and presentation, with the aim of refining reporting arrangements to ensure clarity and simplicity of message. An Implementation & Delivery Plan to be developed for the new Framework, setting out how assurance will be provided from ward to Board and addressing all outstanding previous internal audit recommendations including: • A review of the existing standard template. • A clear assurance framework for all clinical governance activities and controls from ward to Board. • Consistent use of data that supports analysis. • Ensuring clearly defined quality performance indicators.

		• Consideration of how to report on clinical governance in Primary Care and Public Health. • An organisation-wide system for collecting and analysing PROMs. The Implementation & Delivery plan has been developed for the new single Clinical Governance Framework and is currently available as a draft document. The template report for assurance reporting to CGC has been adapted and amended; it will be further developed in line with the revised Clinical Governance Framework, and services will continue to be supported to report and present data more consistently. There will be a focus on reporting of the 'effectiveness' domain of clinical governance over 2024, which will include clinical audit and PROMs. Current clinical governance reporting arrangements for Primary Care (through Angus HSCP) and Public Health (through the Public Health Committee reporting directly to the Board) will be evaluated in 2024.

The CGC continued to receive Health & Social Care Partnership (HSCP) assurance reports (incorporating community mental health and learning disability services) at alternate meetings, as well as reports from Acute Services, Pharmacy, a Board Retained Mental Health & Learning Disability Services (MH&LD) and a strategic assurance report for Midwifery and Maternity. Exception reports are provided to the interim meetings.

With the exception of Board retained MH&LD, all services provided reasonable assurance. The CGC receives reports on KPIs, Adverse Events and Complaints Management, Healthcare Associated Infections, Equality & Diversity, Spiritual healthcare, Organ Donation, Radiation Safety, Hydration and nutrition, Falls, and Falls Prevention.

The Patient Safety, Clinical Governance and Risk Management team Annual Report to the February 2024 CGC meeting stated that '*reporting templates to CGC will be further developed with services in line with the revised clinical governance framework and services will continue to be supported to report and present data more consistently'.* The Annual Report outlined initiatives including developing a mechanism to enable services to manage actions from reviews to ensure a consistent approach to learning and sharing of information to support the prevention of future harm.

Conclusion of this work will be dependent on the improvement work ongoing at operational level to ensure consistent reporting from ward to board.

Clinical Governance Arrangements

The CGC approved their draft Annual Report 2023/2024 in April 2024. We recommend that areas where only limited assurance has regularly been provided during the year, such as Board retained MH&LD services assurance, should be highlighted to the Board alongside plans for improvement. A related action point is included within the corporate governance section of this report.

Reporting arrangements for the CGC were updated in line with the Integration Schemes and now include provision for '*feedback to each of the three IJBs on the outcome of discussion on their assurance report, confirming the level of assurance that was provided and highlighting any action required'.* The CGC Terms of Reference agreed for 2024/25 clarify that this will be the responsibility of the Lead Executives.

Action points from the October 2022 CGC workshop remain ongoing**.** The work of the newly established Culture and Agile Governance Steering Groups to support the delivery of the 2024/25 Board Development Plan should be instrumental in addressing these**.**

Risk Management

Report and Action Point	Subject	Newest Update
T08/24-3	**Assurance on Waiting Times Risk**	**Not yet due (30 June 2024)** We recommended that assurance reporting to the CGC on the waiting times risk should be based on the updated current risk and an updated assurance report was provided to the February 2024 CGC. The report included information on long waits and the support provided for patients, and the previously requested neurodevelopmental waiting times information. In addition, a further review of this risk and current controls is planned.
T08/24-4	**Delivery of Mental Health Strategy Risk**	**Extended to July 2024** The strategic risk relating to the MH & LD Whole System Change Programme was identified at a workshop in July 2023. The MH&LD Executive Leadership Group and Programme Board receive monthly/bi-monthly updates to the programme risk log. The Deputy Chief Executive (Interim) has assumed Executive Lead responsibility for Board for retained inpatient MH & LD services and the strategic risk is being developed for presentation to ELT and Tayside NHS Board in June 2024 for approval. At the NHS Tayside Board Development Session held on 21 March 2024 it was agreed that NHS Tayside does not hold the risk in relation to the Delivery of the Mental Health Strategy. However, it has been recommended that NHS Tayside do hold a risk in relation to the delivery of in-patient mental health services.

Since issue of our 2023/24 ICE there has been no movement in the scores of the four risks aligned to the CGC and all four remain scored at 20 – very high.

Whilst now within appetite, the Primary Care Services risk continued to be reported to each meeting of the CGC in year in accordance with a decision taken by the December 2023 CGC.

The new Waiting Times and Patient Outcomes risk has been live on Datix since May 2023. Assurance reports provided to the CGC in 2023/24 referenced controls and performance from the old Waiting Times

risk until February 2024 when the updated assurance report was presented. In addition, a further review of this risk and current controls is planned.

The 9 August 2023 SRMG approved a new strategic risk for Substance Related Morbidity and Mortality which is now live within Datix. This risk as aligned to the CGC, but reporting has not commenced. At the Board Development Session on 21 March 2024 it was proposed that the risk is to be widened and a reframed risk will be presented to ELT and Tayside NHS Board in June 2024 for approval.

The 'Clinical Effectiveness evaluated by PROMs' strategic risk is now live on Datix. The first assurance report for this strategic risk was presented to the February 2024 CGC. It was proposed the risk will be updated to a wider Clinical Effectiveness strategic risk, with PROMs as one of the control and mitigating measures for that strategic risk, subject to Board approval.

The previous NHS Tayside Mental Health strategic risk was agreed for archiving in May 2022 and no targeted assurance has been provided on controls in mitigation of this risk since then. Mental health was not included in the NHS Tayside 2023/24 risk profile. Internal Audit have maintained the view that there should be structured risk based assurance to the CGC (or other delegated committee) on this strategic, volatile, high risk and high profile area.

Following the December 2023 meeting the SRMG Chair wrote to Chief Officers to expedite development of the risk on delivery of the Mental Health Strategy, having agreed it would be replicated across all IJB risk registers and would be a strategic risk for NHS Tayside. At the 21 March 2024 Board Development Event it was recommended that NHS Tayside hold a strategic risk in relation to the delivery of in-patient mental health services. The risk is being developed and will be presented to ELT and Tayside NHS Board in June 2024 for approval.

Mental Health

NHS Tayside continues to be escalated to level 3 (enhanced monitoring and support) on the Scottish Government framework with mental health performance being the primary factor noted.

Updates on the MH&LD Whole System Change Programme continue to be provided to Board by the Perth and Kinross IJB Chief Officer, in their capacity as Lead Partner. In December 2023 the Board agreed to rationalise this reporting to three formal reports per year in 2024, with a verbal update in between.

Executive responsibility for Board retained mental health services now rests with the Deputy Chief Executive. Clinical Governance assurance on Mental Health comes from reports on Board retained services as well as through the Community Mental Health elements of the HSCP assurance reports. HSCP Assurance reports to the April 2024 CGC show that works continues on the development of a suite of KPIs across Tayside although reporting has not yet commenced.

The NHS Tayside Performance Report has been expanded to cover measures for Mental Health Emergency Admissions, Readmissions within 28 days of discharge, Mental Health Outpatient Appointments, and Community Mental Health Outpatient Appointments. The reporting continues to evolve and is to include outcome measures in future.

The Scottish Government has developed new core system wide mental health standards derived from the national Mental Health and Wellbeing Strategy key measures and NHS Tayside will be a pilot Board. The expectation is that services will monitor and report on the standards and they will be embedded in governance processes.

This programme is one of the 10 workstreams within the 2024/25 Annual Delivery Plan (ADP), with reporting under the new performance assurance framework to be established. As presented to the April

2024 NHS Tayside Board meeting as part of the Delivery plan '*a suite of whole system Mental Health and Learning Disability metrics for 2024/25 are being developed and will be available for reporting in-year'.*

During 2023/24, three of the four assurance reports on General Adult Psychiatry and Learning Disability Services (GAP&LD) provided limited assurance. This was escalated in the Chair's Assurance reports to Board. The April 2024 assurance paper stated that the GAP&LD service has a Care Governance Improvement plan to strengthen the systems of governance across the range of services provided. The service intends to embed these improvements before offering a reasonable level of assurance with the next report to CGC due in August 2024.

External reviews

Report and Action Point	Subject	Newest Update
T08/24-5	**External Reviews**	**Extended to October 2024** The Head of Patient Liaison Response Team is working with service leads to map out the process for external reviews to ensure accurate and timely information is reported to the appropriate Committee. This will be supported by the performance measures as well as the audit for monitoring implementation of action and improvement plans. This work is now a key objective for the Team. The procedure will be reviewed to include earlier reporting to CGC when NHS Tayside commission an external review. This process will have a suite of performance measures as well as a process to share learning and improvements from action plans. Improvements will be reported to CGC by 31 October 2024. Learning and reflection from issues identified through internal and external assurance systems is reported to CGC either through assurance reports or through standalone reports. Triangulation of this data to identify themes is not currently explicit within reporting. Internal Audit will continue to work with Clinical Governance colleagues to progress overt reporting in this area.

In February 2024 the Health Secretary appointed chairs for the Public Inquiry and Independent Clinical Reviews into the actions of Professor Eljamel, and how the circumstances were handled by NHS Tayside.

A paper to the April 2024 CGC provided reasonable assurance on the progress of actions to address the recommendations within the NHS Tayside Due Diligence Review of documentation held relating to Professor Eljamel. Actions have been connected to wider organisational improvements around strategic risk, culture, and clinical effectiveness. Progress on these actions will also be key to addressing ongoing internal audit recommendations.

A final report on the Invited Oncology Review by the Royal College of Physicians was provided to the April 2024 CGC, providing substantial assurance that the recommendations have been reviewed and completed within an appropriate governance structure.

The HIS Unannounced Mental Health Infection Prevention and Control Inspection of Kingsway Care Centre report was presented to the April 2024 CGC without a cover paper explaining how the report requirements will be addressed, monitored and assurance provided. This inspection resulted in three areas of good practice and four requirements. This underlines our outstanding action point on reporting external reviews.

Completing a previous internal audit recommendation, the Acute Services Assurance report to the February 2024 CGC includes details of upheld SPSO cases alongside information that action plans will be reported to the Acute Care Governance Committee.

Adverse events and Duty of Candour

Report and Action Point	Subject	Newest Update
T08/24-6	**Adverse events**	**Extended to October 2024** Graphical representation of 'completed actions' for Significant Adverse event reviews is now included in the KPI report to CGC. The quality of assurances provided by internal systems will be addressed alongside the work of the newly established 'Agile Governance Group' and review of reporting to standing committees. Internal Audit will work with Clinical Governance colleagues on triangulation.

Revision of the Adverse Event Management Policy has been extended from April to August 2024 and work is ongoing.

Data on the number of times NHS Tayside activated the Duty of Candour procedures and implementation of 'agreed actions' following significant adverse events is now reported to CGC. A previous action point in relation to triangulation of adverse event reviews is outstanding. When material issues arise from adverse event reviews, the CGC should receive reports which explicitly highlight the implications for the quality of assurances provided by internal quality systems.

The 2023/24 annual Duty of Candour report is due to be presented to the CGC on 1 August 2024, in line with the timetable for previous annual Duty of Candour reports.

Triangulation

The Chief Internal Auditor and the Head of Patient Safety, Clinical Governance and Risk Management agreed that internal Audit will work with Clinical Governance colleagues to progress overt reporting of triangulation of issues identified through internal and external assurance systems. A first meeting to discuss has been held and this will be further explored when the draft Clinical Governance Framework is available.

Public Health

Internal audit report T10/23 Public Health Governance was issued in May 2024 and provided limited assurance.

We reported, whilst there is evidence to demonstrate that the Public Health Directorate and Committee have achieved much in recent years, there are significant and increasing expectations on public health as a key driver to support the delivery of sustainable health services, now and into the future. The report includes recommendations to ensure that Public Health objectives are clearly articulated, there is clear visibility of the population health risk within the organisation, development of the public health performance framework and for the Public Health Committee's assurance reporting to mature. The management responses show work is already in progress in a number of these areas and provided details of plans going forward.

Staff Governance

Strategic Risks delegated to Staff Governance Committee (SGC)

- **734 - Health and Safety - Current risk exposure 12 (High), Planned risk exposure 9 (Medium), Above appetite**
- **1330 - Workforce - Current risk exposure 20 (Very High), Planned risk exposure 12 (Moderate), Below appetite**

Strategic Risk delegated to Remuneration Committee (RC):

- **1371 - Executive Leadership Team – Current risk exposure 4 (Medium), Planned risk exposure 4 (Medium), Below appetite**

Governance Arrangements

The Staff Governance Committee (SGC) has updated its Terms of Reference in response to a 2023/24 ICE report recommendation and the action to include reference to whistleblowing in the remit should be addressed at the June 2024 SGC meeting.

Papers that provide 'Limited Assurance' will now be monitored more closely until 'Reasonable Assurance' is achieved.

Workforce Strategy/Planning

Internal audit T23/23 Workforce Planning recommended a review of the Workforce Plan Action Plan with progress regularly reported to the SGC. The updated Action Plan was presented to the October 2023 SGC and members were informed that the work relating to the Corporate Workforce Plan had been incorporated as part of the Quarterly update to the NHS Tayside ADP. Detailed updates on the Workforce Plan were not reported throughout the year as a SGC standing agenda item, as recommended by internal audit. An annual Corporate Workforce Plan update is planned for the October 2024 SGC meeting and progress updates on the ADP are provided to the P&RC.

The Workforce strategic risk score remained static at 20 (very high) all year. Whilst reporting against the risk includes a detailed narrative, there is no clear monitoring of the impact and effectiveness of actions taken and how this relates to workforce data.

An extension to December 2024 has been agreed on our previous action point to quantify future levels of anticipated workforce need for the next workforce plan. Management have informed internal audit that '*Review of the approach for the next iteration of the workforce plan is being finalised and will commence in the coming weeks. The use of data has developed significantly with key links being formed to allow the joint use of HR and Finance data. Local options are in use to analyse this data to respond to queries and this same approach will be used to inform the workforce plan. Consideration will also be given to the modelling available through the Scottish Government tool on TURAS Data Intelligence.*

A high level workplan has been created for the year in preparation for the development of the next Corporate Workforce Plan to respond to the requirements in the ADP workstream and to support managers and services to develop their local plans utilising the relevant and appropriate data'.

Safe staffing levels

The Programme Board for implementation of the Health & Care (Staffing) (Scotland) Act 2019 (Safe Staffing Legislation) started to report to the SGC in February 2024 with minutes being provided for noting. However, this reporting is not referenced in the 2024/25 assurance and workplan for the SGC.

Risk Management

Since August 2023, a new ELT risk has been delegated to the Remuneration Committee and we previously reported that we would expect a full risk assurance report to be presented to the Committee. Verbal assurance on the risk was provided to the November 2023 meeting. The score of this risk reduced to its planned score in December 2023 and archiving of the risk has been discussed, with approval to be sought from ELT and the Board in June 2024.

Reporting of workforce metrics

The SGC continued to receive quarterly Staff Governance reports setting out workforce metrics. In June 2023, the SGC requested a greater emphasis on the quality and analysis of data presented with a focus on areas of concern which require assurance. Minutes of the February 2024 SGC show that the way of presenting the data continues to be developed.

In the 2023/24 ICE report we recommended that data is interpreted and reported so the reader can clearly see its impact on assurance to the related strategic risk. The completion date has been extended to July 2024, on the basis that the outcomes of the deliverables within the People & Culture workstream within the ADP, and the identified KPIs are to be reported to the SGC.

Staff Governance Standard

The process for providing assurance against the Staff Governance Standard has continued as reflected in the SGC Annual Report for 2023/24, with most areas noted as substantial or reasonable assurance.

As in 2022/23, limited assurance was provided for the Valuing People, Staff Appraisal & Personal Development areas. The paper presented to the February 2024 SGC set out issues, solutions, and actions around the 3 'C's of Culture, Communication and Configuration of the system alongside communications and training resources and the Committee's discussion was detailed. The issue is also to be discussed at Workforce and Governance Group (WAG), with recommendations to come to SGC thereafter.

The 2022/23 National Annual Monitoring Return was approved for submission to Scottish Government at the October 2023 SGC. Feedback was received in April 2024 and will be presented to the SGC in June 2024.

Staff Experience

Following the update on completion of the Collective Leadership and Culture Strategic Framework 2018 – 2023 provided to the June 2023 SGC meeting, a verbal update in October 2023 noted that work on refreshing the framework continued. Since then, no formal update on a refreshed Collective Leadership and Culture Strategic Framework has been provided to the SGC, although the workplan for 2024/25 specifies updates to the April, June, October, and December meetings. To support the delivery of NHS Tayside's Board Development Plan 2024/25 (in response to the Good Governance Blueprint Self-Assessment) it was agreed to establish a Culture Steering Group and we would expect work on the Framework to be progressed through this group.

In 2023/24 the Facilities Directorate provided an update on the key themes arising from iMatter. In April 2024 the three HSCPs provided updates and the remaining directorates are scheduled on the 2024/25 workplan.

The Director of Medical Education Annual report to the December 2023 SGC provided reasonable assurance but noted concerns on non-compliant rotas and associated financial consequences. Internal Audit T22/24 Doctors Rostering System (DRS) – New Deal will review the DRS system processes.

The Staff Wellbeing Update to the February 2024 SGC provided reasonable assurance and reported development of a new three year Wellbeing Strategy. Minutes of the group were also provided in April 2024.

Succession planning

There has been limited progress against the succession planning element of the Talent Management Strategy first approved in 2019. Updates have been deferred from the December 2023, February and April 2024 meetings and are now planned for June 2024 to allow additional work to be undertaken following the appointment of the Director of Workforce. The SGC's Annual Report for 2023/24 states that this work has been identified as a key pillar of the People and Culture Workstream, which is part of the ongoing work in relation to the development of the Annual Delivery Plan and full information will be provided to a later SGC meeting.

We have previously stressed the importance of this work and would expect the SGC to be updated on progress. We will continue to monitor this area in our 2024/25 ICE report.

Whistleblowing

Internal audit report T25/23 on Whistleblowing provided reasonable assurance on NHS Tayside's Whistleblowing arrangements with actions due to be completed by July and November 2024. The new Non-Executive Whistleblowing Champion took up post in April 2024.

The Whistleblowing Review Group Annual Assurance Report presented to the April 2024 SGC also provided reasonable assurance.

Remuneration Committee

The draft Remuneration Committee Self-Assessment for 2023/24 was reported to the April 2024 Committee and identified two areas as not met:

- Agreeing objectives for executives before the start of the year in which performance is assessed.
- Does the Remuneration Committee manage and monitor performance of senior officers throughout the year?

These align to the findings of internal audit report T10/24 which assessed the 2022/23 self-assessment and provided limited assurance. Actions agreed with Management are due to be completed by July 2024.

Appraisals

At 30 January 2024 30% of Agenda for Change appraisals had been completed against a national target of 80% and an organisational ambition of 95%. A further 23% were reported as in progress. There has been limited improvement in completion of appraisals over a number of years. Appraisals are part of the value-based employment journey under the Talent Strategy and Culture frameworks and should be a key focus to developing the internal workforce, contributing to the workforce plan and a key control and mitigation within the workforce risk, with robust monitoring by the SGC.

The 2022/23 Consultants' Appraisal Annual Report presented to the October 2023 SGC meeting reported 91% compliance (85% in 2021/22). Difficulty in retaining the required number of appraisers is highlighted as an issue. An update to the February 2024 SGC reported that the organisation is on course to deliver as high or higher figures for 2023/24.

A Primary Care Annual Appraisal Report will be presented to the 18 June 2024 SGC. Whilst this report offers substantial assurance and provides information on appraisers in place and the process undertaken, it does not provide any data on completion rates of primary care appraisals.

Sickness Reporting

The absence rate for Quarter 3 was 6.67% (6.35% as at 31 August 2023), compared to 6.45% for NHS Scotland and against the target of 4%. The report states that initiatives are being developed to enhance absence intelligence reporting, with the implementation of these changes being aimed at addressing absence related challenges more proactively.

Conclusion

NHS Tayside's draft Delivery Plan for 2024-2027 included an action on the People and Culture workstream, which is to focus on ensuring the Board has the right professionals, doing the right work, in the right place, at the right time, in a supportive environment with the culture and conditions for people to do their best work.

In 2023/24 reporting to the SGC on critical elements for organisational success has been limited, including the workforce plan action plan, the Talent Strategy and succession planning and the culture framework. We reiterate our recommendation that the SGC has ownership and oversight of key workforce issues to effectively support the achievement of the Board's operational and strategic objectives.

We recommend that the 2024/25 assurance and workplan for the SGC are updated to include assurance on the workforce workstreams, but particularly people and culture, which correlates to this internal audit assessment of staff governance.

Action Point Reference 3 – Workforce Plan Actions

Finding:

Internal audit T23/23 Workforce Planning recommended a review of the Workforce Plan Action Plan with progress regularly reported to the SGC. The revised and updated Action Plan was presented to the October 2023 SGC and work relating to the Corporate Workforce Plan had been incorporated as part of the Quarterly update to the NHS Tayside Annual Delivery Plan.

It was not reported as a SGC standing agenda item as planned and an annual Corporate Workforce Plan update is planned for the October 2024 SGC meeting, not the detailed regular reporting recommended by internal audit.

The Workforce strategic risk score remained static at 20 (very high) all year. Whilst reporting against the strategic risk on Workforce includes a detailed narrative, there is no clear monitoring of the impact and effectiveness of actions taken and how this relates to workforce data.

Audit Recommendation:

As the Standing Committee with delegated responsibility for Workforce Planning, the SGC should be provided with updates on effectiveness of actions to deliver the workforce plan and to update the workforce plan for the future. Where available, reporting on effectiveness of actions taken should be supported by data.

Assessment of Risk:

Moderate 

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

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

Management Response/Action:

The Action Plan for the 2022-25 Corporate Workforce Plan will be updated and presented to APF and Staff Governance Committee in August and September 2024. The longer -term nature of the actions described in the action plan mean that more regular reporting would become repetitive. It should also be noted that the Staff Governance Committee receive the quarterly information report and much of the business also supports workforce planning overall.

At the same time the People and Culture Workstream has been established, as one of the ten workstreams within the Annual Delivery Plan. The People and Culture Workstream has a comprehensive action plan and associated KPIs. Oversight of the People and Culture Workstream will be provided by the Staff Governance Committee. Incorporated within the People & Culture action plan is a specific deliverable related to Workforce Planning with a KPI around the completion of local workforce plans. Work will also be undertaken to understand areas where the workforce can be redesigned to align with the budgeted establishment and service demand.

Much of this work is dependent on data and information, therefore work is underway to enhance the corporate dataset available to managers to support decision making. One important element

of this information is the funded establishment gap, which is currently described in the strategic risk report and compared to recruitment activity.

As the People and Culture Workstream develops then the impact of these activities, and the performance against the associated KPIs, will be noted in the progress updates provided to Staff Governance and ELT. These actions can also be described in the Strategic Risk Report and will better inform the assessment of the risk that is faced. Two KPIs will support this objective, the first "80% of the workforce have adopted a local workforce plan by 31 March 2025". A second KPI will be defined following initial discovery work in August 2024, and will relate to assessment of current staffing and funded establishment.

Preparation is also underway for the 2025-28 iteration of the three-year plan, with draft guidance received from Scottish Government about the information being sought at this level. The focus on future service demand and gap analysis against existing workforce will also be reflected in the strategic risk report.

Action by:	Date of expected completion:
Director of Workforce/Head of Workforce Planning	**30 April 2025**

Action Point Reference 4 – Assurance principles

Finding:

In 2023/24 reporting to the SGC on critical elements for organisational success has been limited, including the workforce plan action plan, the Talent Strategy and succession planning and the culture framework.

There are some areas key to controlling the overall workforce risk where performance requires improvement, such as completion of appraisals and PDPs for Agenda for Change staff.

Audit Recommendation:

We would stress the need for the SGC to have ownership and oversight of key workforce issues to effectively support the achievement of the Board's operational and strategic objectives. This should include:

- Workforce action plan
- Collective Culture Framework and any related workstreams
- Talent Strategy and succession planning

The SGC should have a focus on areas where performance requires improvement, especially where there are longstanding issues. In line with the committee assurance principles, these areas should be considered for inclusion in the SGC annual report.

Assessment of Risk:

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

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

Management Response/Action:

Since the beginning of 2024, discussions have been underway to review the approach to key workforce issues, including those outlined above. The outcome of this work is the development of the People and Culture Workstream, one of the ten workstreams within the Annual Delivery Plan. The People and Culture Workstream has a detailed Action Plan and KPIs covering seven themes:

- Internal workforce controls
- Workforce Planning & Redesign
- Talent Supply
- Health and Wellbeing
- Culture
- Leadership Development
- Talent Management (incorporating succession planning)

The People & Culture action plan will incorporate work done under these themes to date, and consolidates the work being done over the next three years to ensure we are taking a holistic

approach to how we create the conditions for our workforce to do their best work. It is anticipated the People and Culture Workstream will form the basis of a longer-term People Plan for NHS Tayside, which will be a foundational enabling element of the NHS Tayside Strategy.

Following approval of the Delivery Plan by Scottish Government, it was formally confirmed at the Staff Governance Committee meeting on 18 June 2024 that Staff Governance will have ultimate oversight of the outcomes of the People and Culture Workstream and associated action plan. This will allow for a more integrated discussion at SGC regarding the agreed deliverables as part of an overall plan.

Going forward, the SGC work plan will be adjusted to allow for updates on the progress of the People and Culture action plan, and the agenda will be guided by this work, as well as the Staff Governance Standards.

Action by:	Date of expected completion:
Director of Workforce	**31 March 2025 (for status update, reflecting ongoing work)**

Action Point Reference 5 – Safe Staffing

Finding:

The Programme Board for implementation of the Health & Care (Staffing) (Scotland) Act 2019 (Safe Staffing Legislation) started to report to the SGC in February 2024 with minutes being provided for noting.

There is no reference in the 2024/25 assurance and workplan for the SGC and it is not clear how the committee will continue to monitor this area.

Audit Recommendation:

The SGC Should consider how it will continue to receive assurance on the implementation of the Health & Care (Staffing) (Scotland) Act 2019 (Safe Staffing Legislation). This should include the financial and operational impact where possible.

Assessment of Risk:

Moderate 

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

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

Management Response/Action:

The Health and Care Staffing Programme Board is a standing agenda item for the Staff Governance Committee, and the programme Board will provide a report at least four times each year to provide assurance on the Board's activities in regard to the Act. Specifically;

- An internal assurance report on behalf of the Board professional leads with an analysis of progress with compliance with the Act across all professional disciplines and clinical settings working in Health (as detailed in duty 12IF of the Act).
- An assurance report with an analysis of any high-cost agency spend as defined in the Act, and reasons why this level of spend was required (as detailed in duty 12IB of the Act).
- An annual assurance report on the Board's compliance with the Act, identifying any areas of ongoing work to ensure the appropriate systems and processes are in place to support the duties of the Act, and any challenges or risks identified, and actions to address these. This assurance report will provide a summary and analysis of the detailed return Boards are required to submit to Scottish Ministers on the 30 April each year.

Note the annual report will build on the Q3 internal quarterly report and constitute compliance with Q4 internal reporting (relevant to Duty 12IF on the Act).

The Programme Board will work with the operational and professional leaders within the organisation to help capture any financial and operational impacts where relevant and reflect this within the assurance reporting.

The SGC will review these assurance reports from the Programme Board, and provide assurance to the NHS Tayside Board on how NHS Tayside is complying with the duties within the Act, highlighting areas of good practice and shared learning, as well as any risks or challenges, and actions in place to address these. The first quarterly internal report will be presented to the August 2024 meeting of the Staff Governance Committee.	
Action by:	**Date of expected completion:**
Director of Workforce / Deputy Director of Workforce	**31 December 2024**

Financial Governance

Strategic Risks:

- **723 - Long Term Financial Sustainability – Current risk exposure 25 (Very High), Planned risk exposure 20 (Very High), Above appetite**
- **1336 - Finance Annual Plan 2023/24 – Current risk exposure 20 (Very High), Planned risk exposure 20 (Very High), Above appetite**
- **1337 - Finance Capital Plan 2023/24 – Current risk exposure 12 (High), Planned risk exposure 12 (High), * Reflects the year-end financial position, Within appetite**
- **1217 - Healthcare Environment – Current risk exposure 16 (High), Planned risk exposure 12 (High), Within appetite**
- **312 - NHS Tayside Estate Infrastructure Condition – Current risk exposure 16 (High), Planned risk exposure 6 (Medium), Within appetite**
- **807 - Statutory Obligations in Relation to Environmental Management - Current risk exposure 16 (High), Planned risk exposure 4 (Medium), Above appetite**
- **615 - Effective Prescribing – Current risk exposure 16 (High), Planned risk exposure 9 (Medium), Above appetite**

Financial Performance

The Draft Three Year Revenue Financial Plan 2023/24 to 2025/26 was endorsed by the Performance & Resources Committee (P&RC) on 13 April 2023 and approved by the Board on 27 April 2023, noting the requirement to submit a revised financial plan by 30 June 2023.

The revised financial plan was resubmitted to Scottish Government at the end of June 2023. The revised trajectory showed an initial financial deficit of £70.8m in 2023/24 mitigated by £30m efficiencies, reducing the projected deficit in 2023/24 to £40.8m. The cumulative deficit over the three years was projected at £237.8m before annual savings of £30m, reducing to £147.8m if achieved, and excluding brokerage repayment from prior years.

The draft financial outturn position to 31 March 2024, subject to external audit review, is:

- A marginal revenue underspend of £193,000, following approval of £16.1m additional financial support (brokerage) for Board Directed Services, against the core Revenue Resource Limit of £1,228.4m.
- Breakeven against the core Capital Resources Limit of £29.6m.
- Workstreams to deliver £30m recurring savings delivered £10.3m confirmed to date, £6.2m of which is recurring, along with £5m other savings and local corporate flexibility (including slippage in the use of funds, the commitment of earmarked allocations and technical accounting measures) of £25.6m (total £40.9m).
- Of the total £40.9m savings, £14.6m are recurring.

Delegated services are projecting a breakeven position as follows:

- Angus IJB - £4.1m operational surplus; breakeven reported – surplus taken to reserves.
- Dundee City IJB - £3.7m operational deficit; breakeven reported – reserves utilised.
- Perth & Kinross IJB - £4.8m operational deficit; breakeven reported – reserves utilised.

Financial Reporting

Finance reporting to Board and P&RC by the Director of Finance has consistently and clearly articulated the severe financial challenges. Financial projections have fluctuated in line with an extremely volatile external environment. The Director of Finance, in each finance paper, has repeated the 'journey' that the Board has taken to reach the point in the report and this transparency is helpful for the reader.

Savings Challenge

Nine specific workstreams were identified to deliver the £30m savings in 2023/24, all of which were recurring and in line with national cost improvement targets. Mid-way through the year the Director of Finance reported that the savings target would be delivered but it would be achieved substantially through other means, for example local corporate flexibility and other savings.

The 2023/24 savings target of £30m has been exceeded, with £40.9m delivered. £10.3m (34%) of the £30m planned workstream savings had been confirmed, with £6.2m of this identified as recurring, other savings and local corporate flexibility making up £30.6m.

The Director of Finance explained at the February 2024 Board that local corporate flexibility included slippage in the use of funds, the commitment of earmarked allocations and technical accounting measures. It is important that the P&RC and Board understand the implications of each measure that has been implemented and understand the corporate flexibility accounting treatment.

The Director of Finance's Revenue Report to the P&RC for the period ended 28 February 2024 warned that "*the workstream programme is challenged due to the extent of inflationary and demand pressures across the whole system. This impacts on the delivery of recurring savings, with the consequence that the financial position continues to rely heavily on non-recurring efficiency measures.*"

Internal Audit and others have reported previously that to achieve financial sustainability, the NHS will need to embed it within a coherent strategic approach that includes robust prioritisation and which places financial balance at the heart of all decision making.

The NHS Tayside Delivery Plan 2024-2027 articulates how NHS Tayside are approaching the challenge of balancing high performance and delivery of safe patient care with financial performance. This recognises the need for large scale change and identifies 2024/25 as a bridging year.

Revenue Financial Plan 2024/25 to 2026/27

A draft Financial Plan and a subsequent update were considered by the P&RC prior to Board approval in April 2024.

The Plan reflected that the scale of the financial challenge, uncertainty of funding in future years and the unstable economic environment meant that assurance on delivery of a balanced financial position for 2024/25 could not be provided, nor could the current Plan meet the Scottish Government brokerage limit of £17.2m.

The Director of Finance, in relation to the magnitude of savings required, stated that "*this level of savings cannot be delivered in a way that does not significantly adversely impact on people and performance*".

As reported in the April 2024 Board paper, the table below sets out the deficit over the three years.

	2024/25	2025/26	2026/27	Total
	£m	£m	£m	£m
Underlying deficit	(67.9)	(43.5)	(39.9)	(151.3)
Additional funding	0.0	0.0	0.0	0.0
In-year growth	(15.1)	(11.7)	(13.9)	(40.7)
Financial gap	(83.0)	(55.2)	(53.8)	(192.0)
Level 1 and Level 2 Savings	37.6	30.0	30.0	97.6
SG Support – New Medicines Fund	7.8	0.0	0.0	7.8
Forecast deficit	(37.6)	(25.2)	(23.8)	(86.6)
Brokerage Cap	17.2	0.0	0.0	17.2
Distance from Target	(20.4)	(25.2)	(23.8)	(69.4)

Scottish Government correspondence dated 4 April 2024 provided feedback on the financial plan and acknowledged the steps being taken by NHS Tayside, however the Scottish Government did not approve the plan.

The Scottish Government have allocated funding to Territorial Boards on a recurring basis, specifically to protect planned care performance. NHS Tayside's share of this will be £3.9m. This reduces the gap in the brokerage limit from £20.4m to £16.5m for 2024/25.

The unbalanced three-year plan 2024/25 to 2026/27 above sets out a deficit of £86.6m over three years and does not include repayment of brokerage of £9.6m received in 2022/23 and £16.1m for 2023/24.

The next steps that Scottish Government require the Board to undertake ahead of Quarter 1 in-year reporting are:

- Progress delivery of a minimum 3% recurring savings in 2024/25 and develop plans to deliver any savings options identified as being of medium or high risk.
- Continue to progress with the areas of focus set out in the 15-box grid.
- Engage and take pro-active involvement in supporting national programmes as they develop in 2024/25.
- Develop further measures to reduce the Board's residual financial gap towards the brokerage cap set.
- Provide an update on the financial risks outlined within the financial plan to assess likelihood of these materialising and the impact these could have on the Board's outturn.

Should the Board be unable to meet the brokerage cap, an overspend may need to be shown in the financial statements.

Capital Funding

Internal audit report T33/23 - Departmental Review: Property Department – Facilities Directorate, was issued 9 May 2024 and reported that the change in direction nationally to a Whole System Plan, with its emphasis on service-informed infrastructure investment strategy, is an opportunity for the Board to move

on from previously intractable property and asset management issues, to learn the lessons from the past, and to ensure that the new approach is, from the outset, informed by senior clinical and service leads.

A review of governance arrangements in relation to property and asset management is being undertaken by the Deputy Chief Executive and the Director of Facilities. The outcome will impact on the role and remit of the Asset Management Group (AMG) going forward therefore the Terms of Reference and Work Plan of the AMG for 2024/25 is interim with further discussion ongoing at Executive level.

The P&RC Work Plan for 2024/25 includes Property Asset Management Strategy in August 2024. The P&RC receive the risk reports in relation to Strategic Risk 1217 – Healthcare Environment and these reference the change to whole system planning, acknowledging that the current controls in DATIX require to be refreshed in the near future.

The AMG Annual Report, approved 15 May 2024, provides assurance to the P&RC that adequate and effective governance is in place to support the Committee. This was after the approval of the P&RC Annual Report 2023/24 on 11 April 2024. Within the P&RC Annual Report 2023/24 it states that "AMG also present an annual report which is considered by the Committee, with substantial assurance". The scheduling of Annual Reports should be organised in such a way that the Assurance Committee has received all Annual Reports from groups that report to them before preparation of their Annual Report.

The most recent 6 Monthly Project Monitoring Update Report, presented to the AMG on 17 January 2024, noted that there are challenges in completing project post-monitoring returns within the mandatory six-month period. This has been linked to resource capacity. Failure to successfully complete these for projects over £1.5m impacts on NHS Tayside's ability to comply with regulation and national guidance but also to benefit from the learning opportunities that this provides. The AMG has been assured that a plan is in place to progress this work. However, this issue was not highlighted in the AMG's Annual Report 2023/24.

Climate Emergency & Net Zero Requirements

The NHS Tayside Annual Climate Emergency & Sustainability Report 2022/23 was presented to the Board on 29 February 2024 highlighting a total reduction of 4.3% of Co2 tonnes between 2021/22 and 2022/23.

Internal Audit T33/23 provided a reasonable level of assurance on the adequacy of initial steps to ensure compliance with DL (2021) 38 – A Policy for NHS Scotland on the Global Climate Emergency and Sustainable Development. We made a significant recommendation that a timescale to complete the strategic assessment of current resourcing, specifically quantifying the cost of compliance with DL (2021) 38 should be included in the work of the Climate Change & Sustainability Board. Management provided a full management response and do not anticipate that fully costed compliance projections will be available before April 2026.

The Annual Climate Emergency & Sustainability Report 2022/23 itself highlights that the current financial climate poses a considerable risk to future efforts. Climate Change is one of the 10 savings workstreams included in the NHS Tayside Delivery Plan 2024-2027.

Strategic Risk 807 – Climate Emergency/Statutory Obligations in Relation to Environmental Management is aligned to the P&RC. The score in April 2024 was 16 (high) with a target of 4 (medium). As the workstreams continue to embed and projects progress, it is anticipated that the risk score will reduce. However, any gains in this respect could be offset by the current lack of funding and dedicated support to deliver projects. There are 17 controls in place and 10 planned and proposed controls. The current assurance level is limited due to the capacity issues i.e., no dedicated team or resource to deliver the scale of change required and the short timescales to achieve Net Zero. These challenges are not unique to NHS Tayside and the risk is amplified with further retraction of Scottish Government and external funding.

Financial Risk Management

The Director of Finance reports on the strategic risks linked to either revenue or capital within the financial reports presented to each P&RC meeting. The revenue and capital reports detail service risks associated with each area.

In April 2024, strategic risk 723 - Long Term Financial Sustainability, had a score of 25 which had remained unchanged throughout 2023/24, with a planned risk exposure of 20. This recognises that, even with all planned actions in place, there will still be a significant financial risk with 'major' consequences. Strategic risk 1336 - Finance Annual Plan 2023/24 started the year at 25 and ended at 20, reflecting the fact that the overspend is within Financial Plan parameters. Following the annual reports and accounts sign off, this strategic risk will be closed. A new Financial Sustainability strategic risk will be developed for consideration by the Board in June 2024. The two ongoing strategic finance risks – 723 and 1336 – remain above risk appetite.

The assessment of the adequacy of the current controls for both the long-term financial sustainability and the Financial Annual Plan 2023/24 strategic risks are recorded as "incomplete", meaning that the controls are appropriately designed but not consistently applied.

In February 2024, strategic risk 1337 – Finance Capital Plan 2023/24 – had a risk score of 12, reduced from 20 to reflect confidence in meeting the CRL target in 2023/24. This was in line with the planned score. The continuing pressures around the availability of capital funding nationally in future years, and the impact this may have on planned projects, was acknowledged in the risk reporting.

The assessment of the adequacy of the current controls for strategic risk 1337 is recorded as "incomplete". Emerging issues that will impact on the Capital Plan and capital funding requirements are routinely reported through the AMG.

Action Point Reference 6 – Scheduling of Annual Reports

Finding:

The AMG Annual Report was approved on 15 May 2024, after the approval of the P&RC Annual Report which was approved at the P&RC on 11 April 2024. The AMG report provides assurance to the P&RC that adequate and effective governance is in place to support the Committee in considering issues of asset management, key infrastructure risks, and the development of major capital investment business cases. Within the P&RC Annual Report 2023/24 it stated that "*AMG also present an annual report which is considered by the Committee, with substantial assurance*".

Audit Recommendation:

Annual Reports should be scheduled in such a way that the Standing Committee has received all Annual Reports from groups that report to them before approval of the Standing Committee Annual Report.

Assessment of Risk:

Moderate 

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

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

Management Response/Action:

The timing of the production and approval of the AMG Annual Report 2024/25 will be reviewed to ensure that it is submitted to the Performance and Resources Committee in April 2025, being the same meeting which considers the Performance and Resources Committee Annual Report.

Action by:	Date of expected completion:
Louise Lyall, Assistant Director of Finance – Infrastructure (Lead Officer for AMG)	**30 April 2025**

Information Governance

Strategic Risks:

- **680 - Digital Cyber Security Attack – Current risk exposure 16 (High), Planned risk exposure 8 (Low). Above appetite**
- **679 - Digital Technical Infrastructure Legacy Debt Current – Current risk exposure 16 (High), Planned risk exposure 8 (Medium), Above appetite**

Governance and Assurance

The Information Governance and Cyber Assurance Committee (IGCAC) continue to provide assurance to the Audit & Risk Committee through Network and Information System Regulation 2018 (NISR) updates and provision of IGCAC minutes and a Chair's Assurance Report. The IGCAC is supported by the Cyber Resilience and Governance Group (CRGG) which provides governance and assurance on implementation of cyber controls in line with the Public Sector Cyber Resilience Framework and the security of Network & Information Systems (NIS) regulations.

The NHS Tayside Information Governance and Cyber Assurance Report is presented to every second meeting of the Strategic Risk Management Group (SRMG) to provide assurance that legislative requirements are complied with. The SRMG annual report concluded positively on this aspect.

The Digital Transformation Partnership (DTP) is responsible for the creation, review and implementation of the Digital Strategy and underpinning digital and information technology change programmes. The P&RC Workplan requires presentation of DTP minutes and Chair's Assurance Report, but the Chair's Assurance Report was not provided on one occasion in 2023/24.

A Senior Information Risk Owner (SIRO) and a Data Protection Officer (DPO) are in place.

Each meeting of the IGCAC, CRGG and DTP in 2023/24 had a high level of apologies. The Chair of each group should take steps to ensure attendance by members or deputies.

IG Assurance Reports to IGCAC and Departmental Reporting

The IGCAC Assurance Report Template, Protocol and Programme has evolved during 2023-24 and the timetable of reporting to the IGCAC to be reassessed during 2024/25 to ensure assurance on IG activities and compliance with legislation is provided.

IG assurance reports are provided to each meeting of the IGCAC with an overall assessment of assurance provided. The report for the three months to 31 January 2024 provided reasonable assurance and covered all relevant areas.

During 2023/24, 1,133 FOISA requests and 22 Environmental Information Requests (EIRs) were received, an increase of 15% in FOISA requests and a 100% increase in EIR requests on the previous year. 89% (target 100%) of the requests received in the reporting period were responded to within the 20-working day deadline.

There has been no increase in the last 6 months of information assets recorded on the Information Asset Register, with a lack of engagement in several areas reported in the IGCAC Assurance reports. Our extant recommendation to identify alternative approaches to improve engagement is provided within the AFU section, with the due date now extended to 31 October 2024. Management have informed us this has not been progressed due to competing demands placed on the IG&CA team.

A business case to increase the capacity of the IG team was approved by the NHST Vacancy Advisory Group in April 2024 to allow 4 posts to be filled. This will allow the IG team to progress work that over the last few years has increased in both volume and legislative requirements.

Compliance with Mandatory Safe Information Handling is 92%.

Risk – IG and Digital

IG risks reporting to the IGCAC is quarterly and an update on IG risks was included within the IG Assurance report to the SRMG on 21 February 2024. Following a review of IG related service level risk which all have arisen within Clinical Governance, three information governance service level risks have been confirmed and will continue to be monitored by the IGCAC. These risks all link to a related strategic risk. It is noted that discussions are ongoing with Clinical Governance to discuss these risks and the processes on how these risks are to be managed within the organisation.

The P&RC receives assurance reports for the Technical Infrastructure and Modernisation Programme strategic risk (rated high) and the Cyber Security Attack strategic risk (rated high), with both risk ratings reflective of the current environment.

The Cyber Security Attack Strategic Risk is subject to enhanced monitoring by the P&RC with the score reflective of required improvements to controls as reported in the external NIS review from April 2023. Actions to enhance cyber security training were recommended in the NIS review and a tabletop exercise for key personnel was undertaken in January 2024.

The risk exposure for the Technical Infrastructure and Modernisation Programme risk remains as 'high'. It is recognised that the required work will not reduce the risk from high to moderate without significant and continued further work.

Information Governance Policies and Procedures

The status of IG related policies is reported to the IGCAC and SRMG. All NHS Tayside IG policies have been granted an extension until June 2024 when Once for Scotland IG policies should be available. No mention on the status of policies was in included in the IGCAC Annual Report for 2023/24. We would expect this to be included in future Annual Reports from the IGCAC.

IG Incidents and Reporting

IG Incident Reporting Assurance reports to the IGCAC include the necessary information on breaches, including incidents reported to the Information Commissioner's Office (ICO), feedback and outcomes.

During 2023/24 no breaches resulted in any action being taken against NHS Tayside, but the ICO has recommended actions to improve working practices and action plans have been implemented by NHS Tayside.

Missing Psychology Records

Internal audit report T30/23 was considered in full by the Audit & Risk Committee at its meeting in May 2024. Whilst the report did not provide a level of assurance because the audit was at the request of Management, we can confirm that key actions taken in response to report T29/22 have been completed.

NHS Tayside received the ICO Closure report on 13 March 2024. The ICO advised that NHS Tayside should consider taking steps to improve compliance with the UK GDPR, as follows:

- "*NHS Tayside should ensure that staff have read and understood the relevant transportation and escalation procedure. These should be re-circulated to staff on a regular basis to ensure full compliance.*
- *We also note that there was a change in transportation procedure. Whilst this was not the cause of the breach in this case, NHS Tayside should consider completing a Data Protection Impact Assessment (DPIA), where there is a change in procedure in future.*"

An update will be provided to the next meeting of IGCAC on 14 June 2024 and thereafter to the Audit & Risk Committee through the IGAC minute and Chairs Assurance Report.

Internal Audit will undertake a review of the Significant Adverse Event Review (SAER) for the Missing Psychology Records in the 2024/25 Internal Audit Plan.

The IG Risk report to the December 2023 IGCAC included risk 1255 Transportation of Papers records. Discussions at the IGCAC confirmed this risk as an organisational risk as all controls have been reviewed by the IG team and no further mitigations are required. This service level risk has been linked to the Health and Safety Strategic risk. Management has advised this is proposed for downgrading subject to Board approval at the June 2024 meeting.

Network & Information Systems Regulations (NISR)

NHS Tayside was fully audited in April 2023 under the revised Scottish Government Public Sector Cyber Resilience Framework (PSCRF) and achieved 57% overall.

The Action Plan to address the PSCRF recommendation and the NISR audit, which has been extended and has an increased number of control requirements, are reported to the IGCAC. The May 2024 update to the Audit & Risk Committee reported that NHS Tayside is now achieving 49% against the target of 60%. The draft Governance Statement included a section on the activity for NISR and makes reference the poor performance against the national target.

The most recent NISR review is to be reported in June 2024.

Information Commissioners Office (ICO) Audit

In March 2023, NHS Tayside was audited by the Information Commissioner's Office (ICO). Whilst the audit reported a reasonable level of assurance that processes and procedures are in place and are delivering data protection compliance, scope for improvement in existing arrangements to reduce the risk of non-compliance with data protection legislation was identified. Progress with these recommendations has not been made due to staff resource issues within the IG team. As noted above recent approval of new posts will allow this important area to progress.

Digital and eHealth Strategy

NHS Tayside's Digital Health Strategy (2022 – 2027) was formally approved by the P&RC in April 2022.

The digital updates to the P&RC should provide a clearer update on work to deliver the Digital Strategy 2022-27. Internal audit reported this in ICE and Annual Reports over the last few years. A meeting between Digital and Finance management and Internal Audit to address the outstanding elements of this action point took place on 20 May 2024. It was agreed that the format of the report will be updated to include benefits realisation, clear links to digital strategy and financial reporting by project. This report will be provided to P&RC and the format may evolve over time.

Health Records Committee

A Health Records Committee has now been reinstated at the request of the Board Secretary, with the first meeting held on 5 March 2024. This committee will provide assurance on health records activity and will report into the IGCAC.

Action Point Reference 7 – Attendance at meetings and Chair Assurance Report

Finding:

The IGCAC, CRGG and the DTP all have a high level of apologies for each meeting.

The DTP minutes are presented to the PRC, but there is no Chairs Assurance Report provided as required by NHS Tayside Governance processes.

Audit Recommendation:

We strongly encourage that all required members of a committee or group attend each meeting and a suitable deputy should attend where required.

For all DTP meetings in the future a Chairs Assurance report is provided to the P&RC.

Assessment of Risk:

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

Management Response/Action:

The Board Secretary will reinforce to the members of the IGCAC and CRGG the requirement to attend meetings and if not to send a suitable deputy.

A Chair's Assurance report from the Digital Transformation Partnership (DTP) has been prepared by the Director of Digital for consideration by the Performance and Resources Committee on 8 August 2024, and will be actioned for all subsequent meetings as required.

Action by:	Date of expected completion:
Margaret Dunning, Board Secretary **Laic Khalique, Director of Digital (DTP Chairs Assurance Report)**	**30 August 2024** **Actioned**

Key Performance Indicators

Planning	Target	2022/23	2023/24
Strategic/Annual Plan presented to Audit & Risk Committee by June.		Draft presented to 23 June 2022	Draft presented to 22 June 2023
Annual Internal Audit Report presented to Audit & Risk Committee by June	Yes	Yes	Yes
Audit assignment plans for planned audits issued to the responsible Director at least 2 weeks before commencement of audit	75%	100%	82%
Draft reports issued by target date	75%	54%	50%
Responses received from client within timescale defined in reporting protocol	75%	92%	90%
Final reports presented to target Audit & Risk Committee	75%	69%	64%
Number of days delivered against plan	100% at year-end	75%	96%
Number of audits delivered to planned number of days (within 10%)	75%	64%	50%
Skill mix	50%	89%	76%
Effectiveness			
Client satisfaction surveys	Average score of 3 or above	Figure 2 Bar Chart – average 3.4	

Assessment of Risk

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

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

Update of Progress Against Actions		
Management Actions with Dates	**Progress with Management Actions**	**Assurance Against Progress**
Corporate Governance		
T06/24 Action point 1 - Financial Sustainability **Priority: Significant** **Due March 2024** Future financial sustainability through: • contingency plans • savings workstream • congruence with overall Strategy • capacity and capability sufficient to drive strategy, and the associated transformation programme • staff resource and cultural changes to ensure that this area is given the required priority.	Scottish Government feedback on the draft Financial Plan 2024/25 to 2026/27 with key steps to be taken (See financial governance section). An updated Financial Plan paper reflecting these actions will be submitted to Tayside NHS Board meeting on 27 June 2024. Updates on progress on the workstreams continue to be provided to the P&RC. A proposal for a Portfolio Management Office to provide support to the ADP workstreams is currently being taken through ELT. Progress in relation to the development of strategy is set out against T15/23 above.	 **Slippage** Extended to June 2024
T08/24 Action point 1 – Best Value **Priority: Moderate** **Due March 2024** Report template and guidance document will be updated to include a Best Value paragraph and to ask report authors to provide detail regarding how the Best Value characteristic has been evidenced. Information to enable an assessment regarding the application of the Best Value Framework will be gathered from a review of each of the Committees Annual Reports.	The Best Value Framework report template and guidance document have now been updated to include additional narrative in relation to Best Value and this is now in place for 2024/25. This will provide the information to enable an assessment regarding the application of the Best Value Framework to be gathered from a review of each of the Committees Annual Reports in 2025.	 **Slippage** Extended to April 2025
Clinical Governance		
T08/22 Action point 5 - Clinical Governance Strategy **Priority Moderate** **Due Date March 2024**	Update provided in the clinical governance section of this report.	 **Slippage** Extended to October 2024

T08/23 Action point 3 - Clinical Governance Improvements **Priority Significant** **Due March 2024**	Update provided in the clinical governance section of this report.	 **Slippage** Extended to October 2024
T08/24 Action point 2 - Clinical Governance Framework **Priority: Moderate** **Due October 2024**	Update provided in the clinical governance section of this report.	 **On track**
T08/24 Action Point 3: Assurance on Waiting Times Risk **Priority: Moderate** **Due June 2024**	Update provided in the clinical governance section of this report.	 **On track**
T08/24 Action Point 4: Delivery of Mental Health Strategy Risk **Priority: Significant** **Due April 2024**	Update provided in the clinical governance section of this report.	 **Slippage** Extended to July 2024
T08/24 Action Point 5: External Reviews **Priority: Moderate** **Due March 2024**	Update provided in the clinical governance section of this report.	 **Slippage** Extended to October 2024
T08/24 Action Point 6: Adverse Events **Priority: Moderate** **Due February 2024**	Update provided in the clinical governance section of this report.	 **Slippage** Extended to October 2024
Staff Governance		
T08/24 Action Point 7: Staff Governance Metrics Linked to Risk **Priority: Moderate** **Due April 2024**	This work is intrinsically linked with the work underway under the People & Culture workstream of the Annual Delivery Plan. The outcomes of the deliverables within the People & Culture workstream, and the identified Key Performance Indicators (KPIs), will directly impact the strategic risk	 **Slippage** Extended to July 2024

Data is interpreted and reported in such a way so the reader can clearly see its impact on or provision of assurance to the related Strategic risk.	identified, and will be reported to the SGC. These KPIs will form the basis of the workforce dashboard that will ultimately be provided to Scottish Government. With this in mind, the timeline for this work is being extended to July 2024 to allow for these connections to be made.	
T08/24 Action Point 8: Staff Governance Standard **Priority: Moderate** **Due February 2024** Where performance on a strand of the Staff Governance Standard is reported as limited, the SGC should request information on required actions and monitor progress to ensure NHS Tayside fully complies with all aspects of Staff Governance Standards.	The Staff Governance Committee (SGC) have agreed that papers that receive 'Limited Assurance' will now be monitored more closely until 'Reasonable Assurance' is achieved. The Terms of Reference have been updated to reflect this.	 **Complete**
Information Governance		
T08/23 Action point 9 – Digital Reporting to PRC **Priority - Moderate** **Due Date January 2024** More robust reporting of digital activity to include: • Updates on the capital and revenue spend in relation to the programmes/projects. • Progress of the Digital Strategy especially non delivery and the impact on services and transformation. • Benefits realisation reviews. • Digital Transformation Partnership Annual Report in line with its ToR and using the standard template, with explicit assurance provided on the creation, review and implementation of the digital strategy and underpinning digital and information technology (IT) change programmes.	A meeting between Digital and Finance management and Internal Audit to address the outstanding elements of this action point took place on 20 May 2024. It was agreed that the format of the reporting will be updated to include benefits realisation, clear links to digital strategy and financial reporting by project. This report will be provided to P&RC and the format may evolve over time.	 **Slippage** Extended to August 2024
T06/24 Action point 4 - Information Asset Register **Priority – Merits Attention** **Due by March 2024** Alternative approaches should be taken to ensure the required engagement of Information Asset Owners to provide the required information.	Due the competing demands placed on the IG&CA team; this action point remains ongoing. Following a recent business case additional staff are to be recruited. An extension has been agreed to 31 October 2024 to allow the new staff to be appointed and inducted to their roles.	 **Slippage** Extended to October 2024