ITEM No …13……..

REPORT TO: **PERFORMANCE & AUDIT COMMITTEE – 20 MAY 2026**

REPORT ON: **DUNDEE INTEGRATION JOINT BOARD INTERNAL AUDIT PLAN PROGRESS REPORT**

REPORT BY: **CHIEF FINANCE OFFICER**

REPORT NO: **PAC19-2026**

1.0 PURPOSE OF REPORT

1.1 This paper provides the Performance & Audit Committee (PAC) with an update on progress of the one remaining review from 2024/25 and the 2025/26 internal audit plan.

1.2 This report also includes internal audit reports that were commissioned by the partner Audit and Risk Committees, where the outputs are considered relevant for assurance purposes to Dundee IJB.

2.0 RECOMMENDATIONS

It is recommended that the PAC:

2.1 Notes the ongoing work on the 2024/25 and 2025/26 plan.

2.2 Note that the Annual Internal Audit Plan for 2026/27 and Internal Audit Charter will be presented to the September 2026 PAC meeting.

3.0 FINANCIAL IMPLICATIONS

3.1 None.

4.0 MAIN TEXT

4.1 The Global Internal Audit Standards require that the Chief Internal Auditor reports periodically to the PAC on activity and performance relative to the approved annual plan. We have previously set out that audit work is planned to allow the Chief Internal Auditor to provide the necessary assurances prior to the signing of the accounts.

4.2 The PAC approved the 2025/26 Internal Audit Plan at the September 2025 meeting. Internal audit work undertaken to deliver the 2025/26 plan and the one remaining review from 2024/25 is set out in Appendix 1.

4.3 FTF Internal Audit, working with our partners in Dundee City Council, is committed to ensuring that internal audit assignments are reported to the target PAC. The progress of each audit has been risk assessed, and a RAG rating added showing an assessment using the following definitions:

Risk Assessment		Definition
Green		**On track or complete**
Amber		**In progress with minor delay**
Red		**Not on track (reason to be provided)**

4.4 An update on the progress of all the IJB's Internal Audits is shown in Appendix 1. Resources to deliver these audits are provided by the NHS Tayside and Dundee City Council Internal Audit Services.

Following an initial delay due to work pressures and other priorities within the Dundee City Council Internal Audit Service, and initial engagement with officers to progress the review, fieldwork on Internal Audit D05-25 Lead Partner Services is complete with a draft report to be issued during May 2026.

4.5 In order that all parts of the system receive appropriate information on the adequacy and effectiveness of internal controls relevant to them, including controls operated by other bodies which impact on their control environment, an output sharing protocol was developed and approved by all partners' respective Audit and Risk Committees. This protocol covers the need to share internal audit outputs beyond the organisation that commissioned the work, in particular where the outputs are considered relevant for assurance purposes. The following reports are considered relevant and are summarised here for information. It should be noted that the respective Audit and Risk/ Scrutiny Committees of the commissioning bodies are responsible for scrutiny of implementation of actions.

NHS Tayside reports:

Report Description	Assurance	Key findings
T11/26 Internal Control Evaluation	Reasonable	The Internal Control Evaluation (ICE) provided assurance on the overall systems of internal control that support the achievement of the Health Board's objectives. This review provided early warning of any significant issues that may affect the Governance Statement. The final report included 18 audit findings intended to embed good governance principles and to ensure coherence between Governance Structures, Performance Management, Risk Management and Assurance. Each audit finding contained an assessment of risk. For the 18 audit findings, three have been assessed

		as 'significant', 13 as 'moderate', and two as 'merits attention'. The ICE report provided Reasonable Assurance that governance arrangements are sufficient to control and direct the organisation to ensure delivery of sound strategic objectives. Internal Audit have concluded that: - • Corporate Governance arrangements continue to operate effectively and efficiently, with robust and dynamic leadership provided by the Chief Executive and Chair. There have been several changes in governance arrangements at Board and Committee and at Executive level. These enhancements continue to evolve and become embedded. • The operation and assurance provided to the Clinical Governance Committee (CGC) has developed and strengthened under the leadership of the Executive Medical Director and Executive Nurse Director, as the Accountable Officers for clinical governance. Three new clinical governance risks have been introduced in 2025/26 with reporting and review planned for the latter part of the year. The CGC work plan will continue to evolve and be refined as arrangements continue to mature. • Full delivery of the Staff Governance Committee work plan 2025/26 should ensure adequate coverage of the five strands of the Staff Governance Standard. The focus of the strategic workforce risk has shifted from the previous risk alignment to the 'Better care' corporate objective to the 'Improve staff experience and wellbeing' corporate objective. • While the financial position remains challenging, financial governance and reporting is transparent and comprehensive. Finance reports clearly state that current service models are unaffordable, and the savings required to close the financial gap will significantly adversely impact on people and performance. Corporate Objective 13 focuses on financial sustainability and is reporting an amber RAG status. • Data and Information Governance assurance is now reported through the CGC and Performance and Resources Committee and included is a finding on assurance provision in this high-risk area. Digital redesign will continue through the year and into 2026/27. Completion of cyber training remains an area for improvement. Capacity within the Information Governance and Cyber Assurance team is a known risk and has been escalated to Executive level. The full report can be accessed on page 84 here: Tayside Health Board Audit & Risk Committee 10 February 2026
T14/26 Risk Management – CIA validation of self-assessment	Reasonable	NHS Board Chief Executives commissioned a review of current risk management practices across NHS Scotland via a questionnaire sent to members of the National Risk Group (NRG), with the aim of providing

2025/26		an accurate picture of the individual approaches to risk management with Boards. To assess risk management practices during 2025/26, NHS Tayside completed a self-assessment against the questionnaire. Validation of the findings was reserved to the Chief Internal Auditor who independently provided a score and opinion for each question. No significant areas of non-compliance were identified; however there were slight variations in the scores for three of 31 questions, with feedback recognising that a risk improvement plan is to be developed and implementation commenced during 2026/2027. The NHS Tayside self-assessment score was 117/150 and the Chief Internal Auditor appraisal was 114/150. While there is a minor difference in scores, there was no material difference of opinion. This demonstrates NHS Tayside's well established and continuously improving approach to risk management, clear strategic governance structure and regular oversight at Board and Committee level.

Dundee City Council reports:

Report Description	**Assurance**	**Key findings**
Multi Agency Screening Hub (MASH) Intake Process	Substantial	Multi Agency Screening Hub (MASH) intake processes are generally sound, with most expected controls in place and operating satisfactorily. However, we observed that the service retains insufficient information to gain assurance over compliance with referral handling timescales set out in Inter-Agency agreements. We found that controls could be strengthened by standardising referral logs, monitoring the time taken to action referrals, and formalising the coordination between Children and Adult services. Further, reinstating management scrutiny over MASH activities could strengthen the controls over the process.
Mosaic Payments	Limited	Processes for the administration of payments to Fostering Agencies are not well defined. The controls in place are not fully effective and there are areas where controls which could mitigate errors leading to overpayment are absent. Gaps in control have the potential to lead to significant financial risk given the volume, frequency, and relatively high value of these payments. We have raised a number of high priority recommendations and one critical recommendation, which are intended to reduce the likelihood of payment errors arising, enhance the ability of management to detect such errors, and to mitigate their potential financial value.

5.0 POLICY IMPLICATIONS

5.1 This report has been subject to the Pre-IIA Screening Tool and does not make any recommendations for change to strategy, policy, procedures, services or funding and so has not been subject to an Integrated Impact Assessment. An appropriate senior manager has reviewed and agreed with this assessment.

6.0 RISK ASSESSMENT

6.1 This report has not been subject to a risk assessment as it is a status update and does not require any policy or financial decisions at this time.

7.0 CONSULTATIONS

7.1 The Chief Officer, Regional Audit Manager and Chief Internal Auditor were consulted in the preparation of this report.

8.0 BACKGROUND PAPERS

8.1 None.

Christine Jones
Acting Chief Finance Officer

Date: 24 April 2026

This page is intentionally left blank

Ref	Audit	Indicative Scope	Target Audit Committee & current RAG status	Planning Commenced	Work in Progress	Draft Report	Completed	Grade
2024/25								
D01-25	Audit Planning	Audit Risk Assessment & Operational Planning.	Complete 	✓	✓	✓	✓	**N/A**
D02-25	Audit Management	Liaison with management, Pre-Audit Committee liaison with Chief Finance Officer, preparation of papers and attendance at PAC.	Ongoing/ May 2025 	✓	✓	✓	✓	**N/A**
D03-25	Internal Control Evaluation	Holistic assessment of the internal control environment in preparation for production of the 2024/25 Annual Report. Follow up of previously agreed governance actions including Internal Audit recommendations.	IJB meeting June 2025 	✓	✓	✓	✓	**Both the Internal Control Evaluation (ICE) and the Annual Report 2024/25 were reported at the June 2025 IJB meeting. Progress to address ICE findings will be reported to the IJB PAC within the Governance Action Plan.**
D04-25	Annual Report 2024/25	Chief Internal Auditor's annual assurance statement to the IJB with fieldwork to support this.	IJB meeting June 2025 	✓	✓	✓	✓	

Ref	Audit	Indicative Scope	Target Audit Committee & current RAG status	Planning Commenced	Work in Progress	Draft Report	Completed	Grade
D05-25	Lead Partner Services	Lead Partner Governance and Assurance arrangements Scope to review status of information sharing related to finance / financial outlook / risks / clinical and care governance / activity and strategic planning. **Update:** Fieldwork complete and draft report is with FTF Chief Internal Auditor for review, prior to issue to the IJB officers to provide management responses.	~~May 2025~~ ~~September 2025~~ ~~November 2025~~ ~~February 2026~~ 20 May 2026 	✓	✓			
2025/26								
D01-26	Audit Planning	Audit Risk Assessment & Operational Planning.	September 2025	✓	✓	✓	✓	**N/A**
D02-26	Audit Management	Liaison with management, Pre-Audit Committee liaison with Chief Finance Officer, preparation of papers and attendance at Audit Committee.	Ongoing May 2026	✓	✓	✓	✓	N/A
D03-26	Internal Control Evaluation (reported in March)	Holistic assessment of the internal control environment in preparation for production of 2024/25 Annual Report. Follow-up of previous agreed governance actions including Internal Audit recommendations. **Update:**	~~May 2026~~ June 2026 IJB meeting 	✓	✓			

Ref	Audit	Indicative Scope	Target Audit Committee & current RAG status	Planning Commenced	Work in Progress	Draft Report	Completed	Grade
		Note that D03/26 Internal Control Evaluation will be issued as a final report by 31 May 2026 and will be formally reported to the IJB in June 2026, as part of the Internal Audit Annual Report for 2025/26.						
D04-26	Annual Report 2025/26 (reported in July)	CIA annual assurance statement to the IJB and fieldwork to support this.	IJB Meeting June 2026	✓				
D05-26	Partner Bodies Support Services	Review of support services received from partner bodies (NHST and DCC) as stated within the Scheme of Integration: *'It will be the responsibility of the Parties to work collaboratively to provide the Integration Joint Board with support services which will allow the IJB to carry out is functions and requirements', including 'professional, technical and administrative resource."*	TBC	✓				

This page is intentionally left blank