ITEM No …15……..

REPORT TO: **PERFORMANCE & AUDIT COMMITTEE – 25 SEPTEMBER 2024**

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

REPORT BY: **CHIEF FINANCE OFFICER**

REPORT NO: **PAC34-2024**

1.0 PURPOSE OF REPORT

1.1 This paper provides the Performance and Audit Committee (PAC) with an update on progress on the 2023/24 Internal Audit Plan and non-discretionary aspects of the 2024/25 internal audit plan.

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 progress on the 2023/24 internal audit plan and initial work on the 2024/25 plan.

3.0 FINANCIAL IMPLICATIONS

3.1 None.

4.0 MAIN TEXT

4.1 The Public Sector Internal Audit Standards (PSIAS) 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 2023/24 Internal Audit Plan at the September 2023 meeting and progress is set out in Appendix 1.

4.3 The draft 2024/25 Internal Audit Plan is presented to this Committee for approval as a separate agenda item. We have made an adjustment to the planning cycle and the 2024/25 Plan now includes the 2024/25 Annual Internal Audit Report, as well as other planned outputs. Internal audit work undertaken in 2024/25 is also set out in Appendix 1.

4.4 Working with our partners in Dundee City Council, we are 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)**

4.5 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 NHS Tayside and Dundee City Council Internal Audit Services.

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**
T06/25 - Annual Internal Audit report 2023/24	Reasonable	The Chief Internal Auditor 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 The following areas related to IJBs in Tayside were highlighted within the report: • 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. • 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. • 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 Clinical Governance Committee Terms of Reference agreed for 2024/25 clarify that this will be the responsibility of the Lead Executives. The summary report was presented to the NHS Tayside Audit and Risk Committee in June 2024 and can be accessed at page 9 in the following link: idcplg (scot.nhs.uk) The full report, with management responses, was finalised in August 2024 and will be presented to the NHS Tayside Audit and Risk Committee on 12 September 2024.
T10/23 – Public Health Governance	Limited assurance	We concluded that 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 included 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. The full report can be accessed on page 277 here: idcplg (scot.nhs.uk)
T33/23 – Departmental Review: Property Dept – Facilities Directorate	Reasonable Assurance	The key findings from the review are summarised: Property and Asset Management The Property and Asset Management Strategy (PAMS) does not reflect the current changed environment following the end of the pandemic, nor the materially different financial landscape. The recent shift to Whole System Planning is an opportunity for the Board to move on from previously intractable issues, to learn the lessons from the past and to ensure that the new approach is, from the very start, informed by senior clinical and service leads. Implementation of property and asset strategy is a complex area that needs to be service-led and the continued lack of engagement from senior clinical and service leads presents a risk to success. The process to prioritise projects could be improved through better clinical and service involvement. The Asset Management Group (AMG) is currently considering all Strategic Assessments and other proposals without a filtering mechanism to screen out any projects that are not viable, a role previously fulfilled by the

		Strategic Assessment Review Group, which itself had challenges in securing adequate and appropriate senior clinical and service level membership and engagement. In response to the report findings, the Director of Facilities is reviewing the current arrangements for the Service Planning Group and, in collaboration with Head of Corporate Governance, is to extend the group remit of the Asset Management Group. A key function of this group is the development and review of an annual workplan. This plan will include the principal objectives and deliverables related to asset management including financial outcomes. The Property and Finance teams will work together to update the SFIs, and the Capital Approvals Process and Business Case Guide will be reviewed to reflect the requirements of DL (2024)02. These will be assessed by the AMG and formally approved as part of Code of Corporate Governance updates to the Board and Audit and Risk Committee. <u>Environmental Management</u> NHS Tayside have put in place a framework of governance and reporting which should allow the Board to receive the required assurances on compliance with DL (2021) 38 - A Policy for NHS Scotland on the Global Climate Emergency and Sustainable Development. Resourcing, in particular financial, is a key risk and it is recommended early work is undertaken to quantify the projected costs, and any potential savings in delivering the DL requirements. In response, management advised that given the scale of the task ahead due to the dispersed and complex infrastructure of the NHS Tayside estate, timeframe for delivery of net zero and recent announcements by the Scottish Government regarding changes to national target completion dates, we do not anticipate that fully costed compliance projections will be available before April 2026.
T30/23 Interim report - Missing Clinical Psychology Case Records – Follow up review	N/A – review completed at request of Management	This audit concluded on whether: • Actions taken to address the recommendations within internal audit report T29/22 - Missing Clinical Psychology Records have alleviated the identified control risks. • The Oversight Group is operating in line with its Terms of Reference, specifically ensuring that the recommendations from both the internal audit report and ICO report are addressed. The full report can be accessed on page 310 here: idcplg (scot.nhs.uk)
T24/24 NHS Scotland National Payroll System – ePayroll updates	Substantial	This audit substantively tested changes to national payroll masterfiles, specifically changes to pay scales, paybands and allowance/deduction codes amendments and considered whether amendments to the pay scale/band masterfile were as notified in the update letters and whether amendments processed had been authorised. Audit testing confirmed that all amendments to the pay scale/band masterfile were as notified in the update letters and all amendments processed had been appropriately authorised.
T12/24 Compliance with Laws and Regulations	Limited Assurance	Internal Audit provided limited assurance that the Board has received and actioned all circulars and directions received from Scottish Government. There is a risk that a direction or regulation could inadvertently be breached.

		Management have accepted all recommendations and a robust action plan is in place to drive improvement. The audit opinion reflects the following key issues: • The control spreadsheet containing details of Circulars received is incomplete, 15 out of 115 (13%) are missing when compared with the list of Circulars and other publications issued by NHS Scotland. A reconciliation between the two is not carried out. • Testing identified non-compliance with the NHS Tayside procedure 'Identification and Communication of Legislation, NHS Circulars, The procedure requires to be updated to reflect the controls in operation • The NHS Tayside procedure stipulates a quarterly follow-up process, but we found no evidence of any quarterly follow-up of responses, or follow-up with Managers who have not met the 28 days to return Status Forms.

Dundee City Council reports:

Adaptations and Equipment for People with Disabilities	Limited Assurance	The Community Independent Living Service (CILS) together with Dundee H&SCP management should examine options to ensure that electronic client records are consistently accessible to all staff, within the integrated teams, regardless of the pathway by which a particular client accesses the service. To support integration, prevent duplication, ensure client safety, provide consistency and efficient & effective communication, this should include consideration of all CILS staff using Mosaic as their main system for recording client assessment information. The Community Occupational Therapy Team should put in place arrangements and secure adequate administrative support to collate management information sufficient to provide assurance that its processes are operating effectively and underpin the management of risk. This should include monitoring timescales for the completion of client visits and assessments and recording the completion and outcomes of case note audits. The Community Occupational Therapy Team Manager should explore whether automated reports could be provided by the Strategy and Performance team for statistics such as the actual time taken from receipt of the referral to the client being visited. Depending on the success of the automated reports, this could be considered for further development within the other teams working within the partnership. The funding arrangements for adaptations to the homes of people with disabilities should be reviewed with a view to simplifying the arrangements. The Council should consider whether any or some of the budgets can be pooled and thus made accessible via a single process, reducing duplication and the risk of differential treatment as a consequence of the interaction of the criteria and the budget from which funding is drawn. This should be done with reference to the "Guidance on the Provision of equipment and adaptations," published in January 2023 by the Scottish Government, but also considering Housing Revenue Account (HRA) funding requirements and rules. Consideration should be given to whether it would be appropriate for assistance currently categorised as adaptation to be provided as equipment. Potential implications for budgets, client needs, and

		health and safety should be considered and addressed as part of considerations. The Private Sector Services Unit (PSSU) and the Community Occupational Therapy Team within the CILS should seek guidance from the Corporate Procurement Team on bringing their processes into compliance with procurement legislation and Council policies. This should include investigating making use of the National Framework for Property Maintenance and Refurbishment. In advance of the Corporate Procurement Manager developing a Contract Strategy for adaptations, the PSSU and the Community Occupational Therapy Team should carefully consider what is required in terms of adaptations contracts to ensure that an efficient, cost effective, flexible, and timely service can be provided.
Procurement	Substantial Assurance	Several areas of good practice were identified: Key Governance documents required by statutory guidance are in place, including a Procurement strategy and periodic reporting on progress against the objectives of the strategy and on procurement activity within the Council. Procurement processes, as they are applied in practice, are consistent with published good practice guidance, including procedures for evaluation and scoring of tenders. There is a process to capture, approve, and report on instances in which the Council makes use of exceptions to the procurement regulations permitted by the governing legislation. The following areas for improvement were identified: Development of comprehensive process documentation is underway, however at present procedural requirements are distributed across different documents and sources of guidance. Clearly documenting processes removes ambiguity and promotes consistency, reducing the Council's exposure to compliance risk. Once contracts are awarded, there is limited guidance or supporting policy to define responsibility for ongoing contract management and maintenance of supplier relationships. Establishing principles for determining when formal contract management is required, and a consistent approach across Services would help to ensure that the Council continues to receive best value throughout the life of awarded contracts. The level of authority required to instigate non-regulated procurements should be clarified. In practice the risk of unauthorised procurement is mitigated by purchasing controls, however including a check within the procurement process would further mitigate the risk. Record keeping and the maintenance of audit trails is complicated by the absence of a single repository for documentation which is required to demonstrate compliance with procurement regulations. Implementing a single location which holds all critical documentation in relation to each procurement exercise will reduce the risks presented by the possibility of challenge by unsuccessful tenderers. While adequate information is retained where approval is granted to waive procurement processes, the justification for their use could be more clearly recorded. While the process of recording approvals is robust, not all of the relevant information is captured in the register which is compiled to support scrutiny and reporting. Strengthening these record keeping processes reduces the risk of the Council being unable to demonstrate compliance, if called upon to do so.

Service Design and Business Improvement	Substantial Assurance	A number of areas of good practice were identified: Senior Management carried out a review of the previous phase of the Transformation Programme and incorporated its findings into the development of the current phase. A Governance Structure has been implemented in the form of the Transformation Board, and its work is underpinned by a framework of processes designed to provide assurance that projects comply with reasonable standards of project management. The selected project management approach includes clear requirements for proposal and approval of projects. The process for project proposal and approval includes a requirement for identification and consultation with stakeholders, including other Services where appropriate. The Council's approach to Change and Transformation is consistent with that of Peer Local Authorities. The following areas for improvement were identified: The Transformation Board has not clearly evaluated or addressed the need to upskill staff in transformation, improvement, and project management methodologies. While this is recognised in the initial proposals for the composition of the Transformation Programme, it is unclear whether proposed work to deliver training reached all required individuals. The content of the Transformation Programme is not well defined and does not proceed according to a clearly articulated plan. As a consequence, it is difficult to gain assurance that its objectives are being delivered. A delivery plan prepared with due cognisance of available resource would allow management to gain clearer insight into the extent to which the programme is on track. Projects do not explain in their initiation documentation how the benefits that form the basis of their business case have been estimated or can be subsequently measured to confirm that the project has achieved its objectives. Robust reporting of the realisation of project benefits can only be accomplished where measurable benefits are clearly articulated at the outset of projects. The adopted approach to service redesign is narrow in scope relative to other Councils, as it relies on reviews of specific business processes or functions being proposed and approved individually, as opposed to the implementation of a broader programme of service design reviews.
Community Justice Liaison with COPFS and the Courts	Substantial Assurance	A number of areas of good practice were identified: Administration Processes for the receipt and triage of Orders and requests from the Courts are generally robust and provide assurance that the service proactively identifies expected incoming requests. The Service derives assurance over the level of qualification and continuing professional development of staff from professional registration requirements, which can be verified with reference to the Scottish Social Services Council. There is a clear delineation of responsibility where an individual's case management plan involves a partner organisation, ensuring that there is always a specified individual responsible for overseeing the implementation of a case management plan.

		The Community Justice Outcome Improvement Plan reflects the key requirements established in national guidance and defines a clear governance structure. The plan includes performance indicators and actions which are designed to support statutory reporting requirements and performance management of the Service. The following areas for improvement were identified: Process documentation has been prepared to support training of administrative staff which, if formalised, would help to ensure consistency of working practice and enhance the resilience of the Service. Processes for monitoring the outcomes of Court appearances work well, however there is scope for ambiguity in record keeping. Our testing found that in certain circumstances records could be unclear if a Court appearance does not take place as originally diarised. Management information related to workloads is used to inform decisions on allocating reports and Orders. This is enhanced by the operation of monitoring and supervisory processes. However, there is potentially scope to free up management time if key information could be reported automatically as opposed to manually compiled. Tracing report preparation from requests through to their return to the Court found no significant issues, although we observed some instances in which "Nil reports" were returned to the Court without clear approval in instances where individuals could not be contacted, and reports could not be prepared. The Service plans to review its internal guidance following the Scottish Government's update of the National Outcomes and Standards. As part of its review, the Service should clarify the circumstances in which approval is required before reports are returned to the Court. A structured quarterly process for case review and quality assurance has been established, but capacity issues meant one report could not be completed and tracking issues and trends over time will also provide a more robust basis for continuous improvement. Reporting arrangements outlined in the current Community Justice Outcome Improvement Plan had not yet operated in practice at time of review. The Plan was approved in November of 2023, and commits the service to quarterly reporting. Implementing the planned reporting arrangements will enhance scrutiny and accountability.

Other Tayside IJB reports:

No applicable reports currently.

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, Chief Internal Auditor and the Clerk were consulted in the preparation of this report.

8.0 BACKGROUND PAPERS

8.1 None.

Christine Jones
Chief Finance Officer

Date: 30/08/2024

Ref	Audit	Indicative Scope	Target Audit Committee & current RAG status	Planning Commenced	Work in Progress	Draft Report	Completed	Grade
2023/24								
D01-24	Audit Planning	Audit Risk Assessment & Operational Planning.	Complete 	✓	✓	✓	✓	**N/A**
D02-24	Audit Management	Liaison with management, Pre-Audit Committee liaison with Chief Finance Officer, preparation of papers and attendance at PAC.	Ongoing/ May 2024 	✓	✓	✓	✓	**N/A**
D03-24	Annual Internal Audit Report (2022/23)	CIA annual assurance statement to the IJB and fieldwork to support this.	June 2023 (IJB) 	✓	✓	✓	✓	**N/A**
D04-24	Governance & Assurance	All actions have now been added to the Ideagen performance management system following completion of the mapping exercise by Internal Audit. Officers across the Partnership are now in the process of updating each of the actions uploaded to Ideagen; a full overview of progress across all actions on the Governance Action Plan	~~September 2023~~ ~~May 2024~~ ~~September 2024~~ November 2024	✓	✓	✓		

Ref	Audit	Indicative Scope	Target Audit Committee & current RAG status	Planning Commenced	Work in Progress	Draft Report	Completed	Grade
		will therefore be available for submission to PAC at the November 2024 meeting.						
D05-24	Internal Control Evaluation	Holistic assessment of the internal control environment in preparation for production of 2023/24 Annual Internal Audit Report. Follow-up of previous agreed governance actions including Internal Audit recommendations. Incorporated into the Annual Internal Audit report 2023/24 and reported to the June 2024 IJB meeting	Dundee IJB meeting June 2024 	✓	✓	✓	✓	**N/A**
D06-24	Workforce	Related risk: Staff Resource Scope: coherent, co-ordinated, adequate and effective approach to managing significant workforce risks. Strategic & operational responses across the totality of the workforce, including contracted services and 3rd sector. IJB officers reviewed the description and mitigations for the relevant risk. The scope has now been agreed with the Acting Chief Officer and audit fieldwork is ongoing.	~~February 2024~~ ~~September 2024~~ November 2024 	✓	✓			
2024/25								
D01-25	Audit Planning	Audit Risk Assessment & Operational Planning.	Complete 	✓	✓	✓	✓	**N/A**

Ref	Audit	Indicative Scope	Target Audit Committee & current RAG status	Planning Commenced	Work in Progress	Draft Report	Completed	Grade
			See separate agenda item					
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 	✓	✓			